St. Catherine's Hospice (Lancashire) Limited

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Inspection report

St Catherine's Hospice
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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection was announced and took place on 16 and 21 June 2016. The service was last inspected in August 2014 and was rated overall as 'Good' using the pilot wave inspection methodology in place at the time.

St Catherine's Hospice cares for people across Chorley, Longridge, Preston and South Ribble who are affected by life limiting conditions. Whilst many of the people they support have cancer, they also support people with other conditions such as heart failure, motor neurone disease and parkinson's disease. St Catherine's has a multi professional approach in the provision of specialised care.

The in-patient unit can care for up to nineteen people. Outpatient care is offered through their day therapy unit. People can attend for a wide range of medical, nursing, physiotherapy and occupational therapy treatments, as well as complementary therapies such as reflexology and aromatherapy massage.

There was a registered manager in place who had worked at the service for 13 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.

We found the registered manager to be committed, caring and enthusiastic about the service and the comments we received from people and staff reflected this. As the registered manager had been at the service for 13 years this meant that there was stability in how the service was led, in addition to this the management style throughout the service was forward thinking and reflected feedback from staff, other professionals and people and families who accessed the service.

All of the people we spoke with who used the service told us they felt safe. There were robust safeguarding processes in place and we saw evidence that staff were trained in this area. Staff we spoke with could clearly demonstrate a good understanding of how to recognise and report potential safeguarding issues and that people's safety and comfort was of paramount importance to them.

We looked at recruitment processes and found the service had recruitment policies and procedures in place to help ensure safety in the recruitment of staff. Prospective employees were asked to undertake checks prior to employment to help ensure they were not a risk to vulnerable people. There were also robust procedures in place for the recruitment of the large numbers of volunteers the service used. We looked at recruitment files for individual staff and volunteers and found them to contain all the necessary information and to be well organised.

We looked at how the service was staffed, to ensure people's needs could be met safely. People we spoke with told us they felt there were always enough staff on duty, as did all the relatives we spoke with. We

observed staffing levels to be in place to meet the needs of the people in the service on the day of the inspection. The hospice used a dependency tool, which was regularly reviewed, to ensure that a sufficient number of clinical and care staff were present and the right skills mix was in place.

Medicines management processes were effective and staff received up to date training in this area. There was good evidence in place that medicines were audited. Procedures were in place to ensure access to emergency supplies of medication.

Staff we spoke with talked positively about the amount and quality of training they received. This included innovative practice such as 'skills blitz' days when staff could drop into training surgeries at a time that suited them. The hospice had a thorough induction process in place and staff who had recently been employed by the service told us it was detailed and tailored to their own background and development needs. Staff induction records were held on personnel files which we reviewed during the inspection and we found these to be thorough and organised.

The service was working within the principles of the Mental Capacity Act and followed the Department of Health guidance for hospices in relation to Deprivation of Liberty Safeguards. We discussed with the registered manager the need for care plans and other associated paperwork and the knowledge of some nursing staff to be in line with clinical staff and the hospices policies in this area.

We saw good evidence within people's care records that nutritional and hydration needs were being met. Staff were knowledgeable about people's needs in this area and people we spoke with told us they were happy with the food and drink they were offered.

People we spoke with were very happy with the approach of staff who supported them and the care they received. We received very powerful and personal comments from people in terms of how staff cared for them and treated them. This was also conveyed through the large amounts of thanks you cards, letters and messages received into the service.

It was evident when speaking with staff that they knew the people they were caring for well. Staff were able to describe people's personal needs, histories and preferences as well as their medical needs.

We saw evidence that end of life care was provided with sensitivity, dignity, respect and compassion. We observed this to be the case and were also told by people both in the hospice, and who received care at home, that staff showed them kindness and understanding. Bereavement support was in place for families and friends and regular remembrance services were held at the hospice.

Complaint procedures were in place and people were aware of how to raise concerns. We saw examples of how complaints had been investigated and dealt with.

Care plans contained relevant and appropriate information to ensure that people received the necessary medical and personal care they needed. Staff we spoke with were happy with the contents of people's care plans and felt that they gave them the information they needed to provide care and support for people. Work was taking place with a local children's hospice to share the costs of an electronic incident reporting system (Datix). Only the costs are shared, a legal agreement is in place to ensure that each service only accesses and uses data for its own service. This system will improve the efficacy and efficiently of incident reporting which has outgrown a paper based system.

An extensive range of activities were available to people who were staying at the hospice or visiting for day

therapy. People who were not well enough to engage in activities told us that staff were attentive to their needs and spent time with them if they were unable to attend planned activities.

People, relatives and staff we spoke with were extremely positive when talking about the culture within the hospice. They told us that it was a caring, professional and calm environment. All the inspection team found this to be the case and echoed these sentiments.

A number of areas for development had been identified to ensure the service was continually improving. These ranged from looking to improve governance arrangements, training, communication and record keeping. We found the management team and service as a whole to be forward facing and one that listened to what people and other professionals told them.

There were a number of partnerships in place with local businesses. This helped the service to look at ways to improve from leading businesses in the area that were not always in the care sector but had proven systems in place that could be adapted into a hospice setting. We saw examples of this that had already happened and plans in place for additional adaptions and improvements into the service as a result of partnership work with other businesses in the local community.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was Safe.

People we spoke with told us they felt safe at the hospice and if receiving care at home.

The service had policies and procedures in place in relation to safeguarding adults and child protection. Staff received training in this area and told us they felt confident in recognising and reporting issues. There had been no safeguarding alerts raised by the service or people external to the service within the 12 month period prior to our inspection.

Robust recruitment processes were in place to ensure that staff and volunteers were safely recruited.

Adequate arrangements were in place for the secure storage, administration and recording of medicines.

Is the service effective?

Good

The service was Effective.

Staff were effectively trained to provide the specialist care people required and training was linked into an on-going supervision and appraisal system.

The service was working within the principles of the Mental Capacity Act and followed the Department of Health guidance for hospices in relation to Deprivation of Liberty Safeguards. We discussed with the registered manager the need for care plans and other associated paperwork and the knowledge of some nursing staff to be in line with clinical staff and the hospices policies in this area.

We saw good evidence within people's care records that nutritional and hydration needs were being met. Staff were knowledgeable about people's needs in this area.

Is the service caring?

Good

The service was Caring.

People we spoke with were very happy with the approach of staff who supported them and the care they received. We received a number of powerful comments from people and relatives regarding the care they or their loved ones received.

People were involved in making decisions about how their care was designed and delivered and the hospice was looking to improve how this happened going forward.

People were supported to access advocacy services, should they wish to do so.

We saw evidence that end of life care was provided with sensitivity, dignity, respect and compassion and that bereavement support was given to families in a timely and sensitive manner.

Is the service responsive?

Good

The service was Responsive.

Complaint procedures were in place and people were aware of how to raise concerns. We saw examples of how complaints had been investigated and dealt with.

The service delivered person centred care which we observed throughout our inspection.

An extensive range of activities were available to people who were staying at the hospice or visiting for day therapy. People who were not well enough to engage in activities told us that staff were attentive to their needs and spent time with them.

Is the service well-led?

Good

The service was extremely Well-Led.

The hospice had a very experienced, committed and caring registered manager and management team in place that were forward thinking and looking to continuously improve the service.

We saw evidence that there was a large network of auditing and monitoring systems in place that feedback into service development and improvement.

People, relatives and staff told us that the culture of the hospice

was positive and caring.

Relationships were in place with other local business and providers that encouraged learning at all levels within the organisation.

St Catherine's Hospice (Lancashire)

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 16 and 21 June 2016, the first day was announced. We announced this inspection to ensure that key personnel in the service were available to speak with us and so people who used the service could be given notice of our visit and asked if they would be happy to talk with us.

The inspection team consisted of the lead adult social care inspector for the service, an expert by experience, and two specialist advisors. One of the specialist advisors was a pharmacist and the other had a nursing background with experience of end of life care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Phone calls were made to people who accessed the service in the community on the 21 June 2016 following our site visit on the 16 June.

Before our inspection we reviewed the information we held about the service including notifications the provider had made to us. This helped to inform us what areas we would focus on as part of our inspection. We had requested the service to complete a provider information return (PIR); this is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. The provider had submitted the PIR prior to our inspection. We used the information to help plan this inspection.

We spoke with a range of people about the service; this included six people using services, two relatives, nine members of staff including the Registered Manager, nurses and nursing assistants, the chef and maintenance manager.

We looked at the care records for five people who used the service and the personnel files for eight members of staff. We looked at a range of records relating to how the service was managed including training records, quality assurance systems, policies and procedures and the services website.

We contacted the local clinical commissioning group's performance team to obtain their views on the service, the comments we received back were very positive.

Good

Is the service safe?

Our findings

All of the people we spoke with who used the service told us they felt safe. One person we spoke with told us, "Super, absolutely super, I feel perfectly safe, it's peaceful, calm and quiet." Another person told us, "The whole atmosphere here is exceptional as are the people. You're relaxed as soon as you walk in, you feel like a person, and having people around you makes you feel safe, and they're all very good to you." People we spoke with who received a service in the community also told us they felt safe when visited at home.

Visiting relatives we spoke with told us they were happy with the safety of their loved ones whilst receiving care at the service. One relative told us, "The whole building is very secure. It's like you're at home. The staff are fantastic."

At the time of our inspection there had been no safeguarding alerts raised by the service, or people external to the service for the previous 12 month period. The home had a safeguarding and whistleblowing policy in place. This meant that staff had clear guidance to enable them to recognise different types of abuse and who to report it to if suspected. We spoke with staff about the home's safeguarding procedures. They were all aware of the provider's safeguarding policy and how to report any potential allegations of abuse or concerns raised and were aware of the procedures to follow. They were also able to tell us who they would report issues to outside of the service if they felt that appropriate action was not being taken and displayed good knowledge of local safeguarding protocols.

A member of the board of trustees was the nominated safeguarding lead for the service at board level. Safeguarding was covered during staff inductions and training was undertaken at two yearly intervals. Staff we spoke with told us that safeguarding training was of a good standard. As well as operational staff all trustees completed safeguarding training. The local Clinical Commissioning Group had recently undertaken a safeguarding audit of the service however the results of this were being awaited at the time of our inspection.

We looked at recruitment processes and found the service had policies and procedures in place to help ensure that professional and suitably qualified staff were employed. Prior to employment, prospective employees are subject to a robust selection process including measures to ensure they were not a risk to vulnerable people. We reviewed recruitment records of eight staff members and found that robust recruitment procedures had been followed including Disclosure and Barring Services (DBS) checks and suitable references being sought. Interview processes for clinical posts included an assessment of potential candidates' attitude, knowledge, dignity, team working abilities and clinical skills. Staff we spoke with confirmed they had undergone a thorough recruitment process including the completion of an application form and attendance at a formal interview.

There was also a robust recruitment system in place for the use of volunteers at the service. St Catherine's Hospice, at the time of our inspection, had 145 volunteers delivering regulated services via a wide range of roles and over 600 across the entire service. As the service received three quarters of its funding via charitable donations the recruitment and retention of a volunteer workforce was essential in providing its

services. We reviewed the files of two volunteers working at the hospice and saw that they underwent a thorough process complete with the relevant background checks which paid staff had. Volunteers also had to complete an application form and we saw examples of training within their files which included safeguarding training amongst many others. All staff had to complete a probationary period at the service. We saw evidence within staff personnel files that these were signed off formally.

We looked at how the service was staffed, to ensure people's needs could be met safely. People we spoke with told us they felt there were always enough staff on duty, as did all the relatives we spoke with. We observed staffing levels to be in place on the day of our inspection to fully meet the needs of all the people at the service and reviewed staffing rotas for the previous two week period to our inspection. We found staffing levels to be in place to meet the needs of the people using the service over that period. The service used a staffing and patient dependency tool to ensure that the right number of staff and correct skills mix were in place. Within the services 'Report to Patient Care Committee' in April 2016 a detailed section within the report was in place that explained how dependency levels were set and how this then translated into staffing levels and what skills were required to meet people's needs. We also saw that staffing levels and staffing issues were a permanent agenda item within the services monthly clinical governance meetings. Bank staff were available to cover for short notice absenteeism. Agency staff had not been used in the hospice for over two years. This meant that people at the hospice benefitted from the fact that a stable staff team was in place that knew each other and the systems and practices in place. This fact was further evidenced when speaking to both staff and people using the service who commented on how organised and professional the staff team were.

Risks around the hospice were managed and the premises had been well maintained. We found the service to have appropriate fire risk assessments in place which provided sufficient information to guide staff on how to react in the event of fire. We found fire safety equipment had been serviced in line with related regulations. Fire equipment had been tested regularly and fire evacuation drills were also undertaken periodically to ensure staff and people were familiar with what to do in the event of a fire. People had personal emergency evacuation plans (PEEPS) in place for staff to follow should there be an emergency. There were detailed emergency planning and evacuation guidance for people who used the service.

We looked at the systems for medicines management. We looked at how medicines were stored. The medication room was uncluttered and all the medication was securely stored in locked cabinets. There was no evidence of over ordering or excess stock. We reviewed how Controlled Drugs (CD's) were stored and administered. We randomly sampled products to check that the CD register matched stock levels. This was also done for injectable CDs as well as oral formulations and people's own drugs. We found the balances to be accurate and double signatures were in place. We checked the drugs allocated for destruction and again confirmed that the correct records were being kept in relation to CD destruction.

Medication requiring cold storage was stored appropriately and fridge temperatures were being recorded and monitored on a daily basis. We found one issue with a reconstituted bottle of amoxicillin in the fridge that had not been dated. It was therefore unclear if it was past its expiry date. The staff nurse disposed of this correctly and told us they would notify the team to remind them of the importance of dating bottles when they are opened or reconstituted.

The service used piped oxygen. We were able to check that this was adequately stored with appropriate monitoring of line pressure.

We spoke with one of the staff nurses who showed us the policies and procedures for medication. These were robust and thorough all though some had past the stated review date we saw that they were still fit for

purpose. We discussed the need to review some policies in line with the stated review date with the registered manager who told us that they would ensure all the policies in question would be reviewed.

All the staff we spoke with could explain the process for administering medication and how they would deal with a medication error. Whilst shadowing one nurse an error was identified so we were able to see this process in action and confirm that it was an effective and robust process. We spoke with the registered manager about error reporting and the process for ensuring that there was a culture of shared learning. We were able to see examples of documentation relating to medication errors that had been completed and how information was triangulated so that lessons could be learnt.

Nurses we spoke with explained the medication training that they received, including competency assessment and reflective practice, which contributed to their re-validation. Training records for staff relating to medicine management were up to date.

The hospice had a self-medication policy, so that following a risk assessment individuals with capacity could manage their own medication with the exception of CDs. The registered manager was aware of this process however, not all the staff we spoke with were aware of it. We were told that this would be remedied immediately by ensuring that all staff were made aware of the hospice's self-medication policy.

People we spoke with told us that they received their medicines on time and were informed by staff what their medication was for. People who were receiving pain relief told us that staff monitored them closely to ensure their pain was managed effectively. One person told us, "Medication is on time, as soon as I ring the bell they're here and I have extra. They explained it (the medication) to me." Another person said, "They're very good with medication, and yes I know what it's for."

We saw evidence that accidents and incidents were recorded effectively and investigated appropriately. Records of all accidents and incidents were kept and reviewed appropriately.

The service had an infection control team in place that identified incidences and the management of infection control. We discussed with staff their understanding of infection prevention control (IPC) and all the staff we spoke with were knowledgeable in this area. The training around IPC was innovative and received good feedback from staff. One example of such training was a room set up with various infection control issues which staff had to then identify and resolve. The notice boards around the hospice had information for all staff on infection control and hand sanitiser was available at entrances and exits to all parts of the building.

We saw evidence that several audits were carried out in relation to IPC including a hand hygiene audit which was completed six times per year. There was a cleaning schedule, both weekly and daily, with 'post discharge' room clean records. A deep clean of rooms was undertaken if a person had had an infection. We spoke with staff regarding infection rates and one staff member told us, "We don't really have a lot of infection, the last one was April but the patient came in with it. We managed it well and a deep clean of the room was undertaken following the patient's death."

There was also an annual IPC audit carried out. All IPC audit information was fed through to the Board via clinical governance procedures. Audit comparisons were carried out for 2015-2016 with any issues identified and a clear action plan to manage the identified issues.

Good

Is the service effective?

Our findings

People we spoke with told us they were supported by staff who had the appropriate skills and knowledge. We received very positive comments from people with regards to all the different staff based at the hospice and those deployed in the community. One person we spoke with told us, "I feel totally confident they (staff) know what they are doing and they're helping me." Another person said, "The staff I have had are highly motivated and they seem to love their work." Another person said, "Staff are top notch, ten out of ten." Visiting relatives were also very complimentary about the professionalism and skill of the staff employed by St Catherine's Hospice. One relative told us, "Somebody always seems to know the answer, you aren't made to feel silly asking questions, all the staff are really good."

We spoke to staff in relation to the training they undertook. Staff we spoke with talked positively about the amount and quality of training they received. We were given many different examples by staff of the training they undertook, one member of staff told us, "We get lots of training. I've recently done safeguarding, child protection, moving and handling, MCA and am booked onto a pain management course."

We spoke with staff within the knowledge exchange team who talked us through the hospice's training programme. The service had a mandatory training programme in place and in addition to this there was a clinical training and competency framework in place for clinical staff. There was also a health and safety training framework in place that all staff completed. We found each training area to be comprehensive, well planned and easy for staff to access. All the staff we spoke with understood what was expected of them in relation to their own competency levels and development. All training fed into the services appraisal programme which meant that individuals and managers could track people's training and progress. We were shown the current year's training matrix for staff which was designed and reviewed by the knowledge exchange team. We also saw examples within staff files of training certificates for staff.

The hospice also carried out drop in training called 'Skills Blitz' on site for staff to attend. These covered a range of topics and we saw a recent example that covered areas such as; skin care, wound care, pain relief medication and non-invasive ventilation. There was also targeted training that contributed to revalidation for clinical staff, a recent example being a masterclass in symptom management. All the staff we spoke with found these events very useful.

The hospice had a thorough induction process in place. Staff induction records were held on personnel files which we reviewed during the inspection. One of the members of staff we spoke with had only worked at the hospice for four months. They told us, "The induction was the best I have had in nearly 30 years of nursing. The induction pack was sent to me prior to starting and I have a named mentor. The induction has been tailored to my background. If I've needed to experience something or meet with different departments this has been done. I have even met the Chief Executive."

We were taken on a tour of the building by the director of care at the beginning of our inspection. As well as a large 'in-patient' unit the hospice had day therapy facilities which in-patients were also encouraged to use. People attending day therapy, which included some people receiving care in the community, were able to

receive complimentary therapies, take part in art and craft sessions, group sessions and 1-1 sessions across a range of subject areas. This included advance care planning; people learning more about their diagnosis and condition and work with occupational therapists. We saw examples of people's art work and were told that people were encouraged and helped to put together items such as memory boxes for loved ones, which may include cards and messages for loved ones significant birthdays or other milestone events in their lives.

All bar one of the rooms in the in-patient unit had a tracking hoist so people could be easily transferred. All rooms had free access to the internet and satellite television and were well thought out in their design. One room had a separate family area in the event of a person having a young family. This enabled people to have their family with them but also gave people a break out room for when they needed some privacy or rest. Mirrors in bathrooms were behind doors as some people did not want to see their reflection. There were also other communal spaces within the in-patient unit so people, their family and friends could sit somewhere other than their own room. One of these rooms could be converted into a sleeping area for relatives. There were free coffee and tea making facilities for visitors.

A multi faith chapel was available for people who wished to have religious support and guidance. The on-site social work team held a list of religious leaders who visited the hospice to deliver this support when needed. None of the people we spoke with had used this facility but they were aware of it and its location. A project had commenced at the time of our inspection to refurbish the in-patient area by the autumn of 2016. This included looking at ways to improve lighting, ventilation, improving the flooring across the unit and to generally improve the aesthetics. This also took into account enhancing the area for people with visual and psychological needs including dementia.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw that a policy was in place for MCA and Consent via a combined policy which had been recently updated and included; consent, assessment of capacity and best interests. There was documentation included to support the assessment and best interest process.

The service had been advised by the local authority to take a pragmatic approach regarding DoLS and to follow the Department of Health guidance for hospices. One of the doctors we spoke with was able to describe this approach, that where people had given consent to admission to the hospice prior to losing capacity and where their needs had not significantly changed then no DoLS would be applied for. This accounted for a reduction in DoLS applications from the hospice within the 12 month period prior to our inspection.

We saw some good examples of people's consent being gained within care plans. Bed rail risk assessments were in place and the document asked the questions; 'is consent form signed or is best interest

documented'. This was seen to be good practice, however, other documentation such as the consent form, stated that relatives could consent on behalf of the patient. All documentation used needed to be aligned with the services MCA policy.

When nursing staff were asked, "How do you assess people's capacity?" They described how they try and involve the person in the decision and that they also had conversations with people's families. They told us that social workers and doctors did the capacity assessments and DoLS applications. There was therefore no evidence of capacity assessments and best interests' decisions within the routine nursing care and treatment plans. We discussed this with the registered manager and head of nursing on the inpatient unit. It was evident that the service was compliant with MCA however we discussed the need for care plans and other paperwork, and the knowledge and 'ownership' of MCA with nursing staff, to catch up with the hospices policy and the knowledge of other clinical staff. We were assured that discussions and appropriate training would take place to address these issues.

We saw evidence within people's care records that nutritional and hydration needs were assessed on their admission by the hospices medical and nursing staff. This incorporated the views of each person and their family as appropriate. This information was then passed on to the hospice's catering team so that people's individual preferences and needs could be effectively communicated. An eating and drinking care plan was an integral part of each person's care plan and was reviewed weekly or as people's needs changed.

We spoke with the chef at the hospice. They told us they were happy with the range of equipment they had at the service and the quality of the produce they used. They also confirmed that the budget they had was adequate. They told us they had the flexibility to meet people's needs at short notice and they could provide for people's nutritional needs outside of set meal times. We discussed the varying needs of people such as cultural needs, consistency of meals and portion size. The chef told us they had the facilities and knowledge within the catering team to provide for people with a wide range of needs. They told us communication was good within the multi-disciplinary team at the hospice and people's nutritional and hydration needs were discussed in detail.

People's nutritional intake was recorded daily on a food chart which was located in each person's room. This meant that care staff and family and visitors could see what people had eaten and drank clearly. The chef told us that when a person was at the end of their life their needs were assessed at each shift. Food was also offered to family members so they did not have to worry about their own meals at that time. We saw all nursing and care staff received nutrition and hydration training and that a Food Hygiene policy was in place. People who were staying within the in-patient unit who were well enough to attend, were offered their meals in the dining room which was located in the day therapy unit. This enabled good social interaction for people within a pleasant dining room.

A hospice food and nutrition focus group was in place and we saw the terms of reference and last minutes for this group. The group was chaired by the catering team but was also attended by clinical, care support and therapy staff as well as volunteers and the family support team. The purpose of the group was to develop a process that enabled person centred nutritional care for people with specialist palliative care needs with the hospice and within their own home. The group met every two months and had been meeting since February 2016. The meetings covered a range of areas including; analysing menus, gaining and analysing feedback, catering for families of people using the service and healthier snack provision.

A monthly evidence based practice workshop was ran at the service. Staff submitted ideas and presentations for discussion prior to each event. Recent topics had included the ethics of nutrition and hydration in end of life care and management of major haemorrhages. The meetings were also used as an

opportunity to present audit findings to staff.

We asked people within the in-patient unit and people accessing the day therapy unit if they liked the food they were offered. The responses were very positive. One person said, "Very, very good, absolutely wonderful. Every mouthful is good, and not too much, you get a choice." Another person said, "The food's very nice, but I'm off my food at the moment. This is the first meal I've had today." Another person told us, "The food has been wonderful. I can't fault it, and you only have to ask for a drink at any time."

We observed lunch within the dining room at which people on day therapy and staying at the hospice ate together. The dining room was very pleasant, there was water, orange and blackcurrant cordial on the table with condiments. Orders were taken prior to serving and people were asked what size of portion they wanted. There was a different menu for in and day care patients. There was no set cycle of menus as the service obtained produce at seasonal and best prices, however if someone didn't want what was on offer, they could have whatever they wanted provided the kitchen had the ingredients.

Good

Is the service caring?

Our findings

All the people we spoke with were very complimentary about the approach of the entire staff team and the care they received. People told us staff were caring, empathetic, professional and sensitive to their needs. One person told us, "They can't do enough for you, they are kind and always smiling, always asking if there's anything you need. They're brilliant." Another person said, "They are very good, they can't do enough for you." One of the people we spoke with who received a service in the community told us, "They are brilliant, the whole team have been. It's been like belonging to a private clinic. I'm very fortunate to live so close to such an amazing place."

Relatives we spoke with also spoke highly of the staff who cared for their loved ones. One relative we spoke with said, "They're always positive in negative situations, they're very comforting, so kind and caring. They're like angels, they've been brilliant with us." Another relative said, "It's difficult to explain but the answers you get when you ask questions, it's like it's their Mum's gone through it. Everyone is just so nice."

It was evident when speaking with staff that they knew the people they were caring for well. Staff were able to describe people's personal needs, histories and preferences as well as their medical needs. All the staff we spoke with were passionate about their role, the people they cared for and told us they worked in a very caring environment which also incorporated how they were treated by peers, senior members of staff and management. One member of staff we spoke with told us, "The support for people is great. As well as the staff here there are other specialist organisations available to give advice as well, that we can link in to. People are able to die at home or here if it is their wish to do so. I love working here and I hope it's a job for life as the dedication and commitment of all staff is there to see."

People told us that staff respected their privacy and treated them with dignity. We observed staff interactions with people during our inspection and found them to be warm and compassionate. Staff were friendly, patient and discreet when providing care. When personal care was being provided the person's door was closed to ensure their privacy and dignity was maintained. A sign was also put on the door stating 'care is in progress' to prevent others from walking in when people were receiving care. We observed that staff knocked on doors prior to entering throughout the day of our inspection. Staff were very attentive to people and people did not have to wait to any requests for assistance. One person we spoke with told us they needed assistance with personal care and said, "They had to change me last night, it was like it was my daughter doing it."

We saw evidence that end of life care was provided with sensitivity, dignity, respect and compassion. We observed this to be the case and were also told by people both in the hospice, and who received care at home, that staff showed them kindness and understanding. We saw a high number of thank you cards and messages from people and relatives. Some of the examples of messages were as follows; "Thanks for being there for me", "Thank you all for the kindness and care you provided for [name]", "A heartfelt thank you to all the dedicated staff for making the last days of [name] life as comfortable and dignified as possible" and "Thank you for all the care, kindness, respect and support shown to [name], we are so very grateful." There were many other examples of such messages we saw that displayed how the service had helped people in

their final moments and how grateful family and friends were for the support given to their loved ones and the entire family unit.

The registered manager told us that following a person's death bereavement support was offered to all family members. Bereavement support was in place via several different methods from one to one counselling, informal drop in sessions and fixed term bereavement groups. Quarterly remembrance services were held that staff and volunteers attended to offer support to people. Services take place in a hospice room large enough to hold the number of attendees. The hospice chapel was not used because it was too small and service activity could disturb people on the inpatient unit (the chapel is situated on the inpatient unit). The service takes a secular structure; for those who wish to attend prayers, a religious component is available as a separate component, Services were well attended and appreciated by families and friends. One of the community nurses we spoke with told us that they visited families following the death of the person being cared for. They told us they could refer people to specialist support if this was needed via the in-house social work team at St Catherine's.

We looked in detail at five people's care records. All the people and families we spoke with were aware they had a care plan in place and told us they had been given the opportunity to contribute to it. There was good evidence of advance care planning in place for people who wished to document their final wishes including preferred place of death discussions. The hospice had devised an advanced care planning document to aid people to consider holistic person centred care. We asked people if they were involved in decision making, everyone we spoke to told us they were. One person said, "I've been offered quite a lot, but everything's down to my decision." Another person said, "I've been asked a lot of questions but I am always given time to answer. I feel like I am in control as far as I can be."

People were assisted to remain as independent as possible whilst receiving care and support from the service. The hospice had established a befriending service in 2011 which was staffed by a team of trained volunteers. The aim of the team was to provide social support to people in their own home but this could also be extended to people within the in-patient unit at the hospice. The registered manager told us they were developing this service to enable people who were not housebound, but needed support, to access the community.

Work was commencing at the time of our inspection to achieve fix termed funding to improve rehabilitation services. This would mean that volunteers at the hospice would be trained to work alongside the physiotherapists and occupational therapists at the service. The rehabilitation service was looking to focus on mental stimulation and diversional activities, as well as physical rehabilitation, which would enable people to continue participating with hobbies and interests or engaging with new ones.

The hospice was working towards developing their IT system so people could access their own care records via a PC or laptop. This was still at the early stage of development and processes were being worked on to ensure that a robust management system was in place to ensure the appropriate data protection and confidentiality requirements were met. Work was taking place with a local children's hospice to share the costs of an electronic incident reporting system (Datix). Only the costs were shared, a legal agreement was in place to ensure that each service only accessed and used data for its own service. This system was designed to improve the efficacy and efficiency of incident reporting which had outgrown the paper based system in place. The registered manager was confident however that the system would be in place for later in the year and that the benefit to people and their families would include the opportunity to enhance the level of input they had into the care planning process. This evidenced that the service was looking to constantly improve how they could improve people's input into their own care.

People and their relatives told us that they were provided with all the information they needed prior to receiving a service at the Hospice. St Catherine's had an informative and easy to use web site that covered a wide range of information from the different types of care offered, including how to refer into the service, to support for families and details of the facilities and staff who work at the service. This enabled people to make an informed decision about accepting a place at the hospice. People we spoke with told us this continued once they had been referred into the service. One person said, "You get very simple, easy to understand advice. There is no jargon. It is well explained. You never feel rushed."

People were supported to access advocacy services, should they wish to do so. An advocate is an independent person, who will act on behalf of those needing support to make decisions. Advocacy information was visible throughout the service and staff we spoke with were knowledgeable about local advocacy services. The process of referring people to advocacy service was easier due to the on- site social work team at St Catherine's.

We saw that the hospice had equality and diversity policies in place that covered a range of different characteristic for people using the service and staff including age, race, gender, religion, disability and sexual orientation. None of the people, relatives of staff we spoke with raised any issues in this area.

Good

Is the service responsive?

Our findings

People we spoke with and their relatives told us they knew how to raise issues or make complaints, however, no one had cause to raise a minor issue yet alone a formal complaint. People told us they felt confident that if they had the cause to raise any issues they would be listened to. One person told us, "I've definitely not (complained). I'd write to the manager, but I've nothing to complain about." Another person said, "I've no complaints, this is a lovely place." One relative we spoke with said, "No complaints whatsoever." Another said, "Nothing at all" (to complain about).

The service had a complaints policy in place and details of the policy were on display in the hospice as well as being referred to within the welcome packs given to people and relatives. The policy referred to external organisations in addition to the hospice's own internal procedures in the event of a person not feeling able to raise issue within the hospice. Staff were made aware of the complaints procedure within their induction. We saw evidence of this within induction packs and staff spoken with also told us this area was covered. All the staff we spoke with told us that they were aware of the hospice's complaints policy and they were able to direct people, in how to make formal complaints, if this was necessary. Complaints were audited and possible themes identified. No themes had been identified within the last 12 months.

The hospice had received six formal complaints in the 12 month period prior to our inspection. Five of these had been resolved and another was still in the process of being investigated. The registered manager showed us how complaints were recorded electronically. We reviewed the latest resolved complaint and tracked it from the initial correspondence to acknowledgment, investigation, response and the production of an action plan to record any learning and change any practices as necessary. Each complaint had a unique reference number and it was clear if the issue(s) had been substantiated and/or resolved.

We saw that complaints were thoroughly investigated with the relevant staff interviewed which provided an opportunity to reflect on the concerns raised and to consider the complainants perspective. We found this to be reflective of the culture within the hospice in that any issues identified with performance or practice were analysed and discussed openly and any lessons learnt were passed on to the staff team affected.

The service received a large number of compliments, 129 had been received into the service in the 12 month period prior to our inspection. We looked at a number of letters and thank you cards and it was evident that the hospice provided a service that was highly regarded and appreciated by people and their immediate and wider families. Some of the messages were extremely personal and heartfelt and mentioned high levels of nursing care, support, love and kindness. Individual staff were also named in some of the letters and cards and proved that the service offered was highly personalised and professional.

We saw evidence that there was a network of agencies that the hospice signposted people to or referred people into, this was particularly useful in the prevention of social isolation. Staff confirmed this to be the case when we spoke with them. One member of staff we spoke with told us, "There is a really good network of other agencies we use, we have good links with Age Concern, care agencies, Lancashire Wellbeing and befriending services." All the staff we spoke with had a good awareness of the different range of services

available and that the on-site social work team were there to offer advice for people who needed assistance.

We looked in detail at five people's care plans and associated documents. Care plans contained relevant and appropriate information to ensure people received the necessary medical and personal care they needed. Staff we spoke with were happy with the contents of people's care plans and felt they gave them the information they needed to provide care and support for people. We discussed with the registered manager the need to make care plans more person centred as some of the documentation used within care plans were generic lists with the people's names written over the word 'patient'. Whilst there was a recognition that some people were only with the service for a limited time there was an acceptance that some documentation could be more personalised rather than using templates with pre populated statements. As the hospice was looking towards making people's care plans available for people and their families we were told that care planning documentation was being reviewed as part of this project. Nobody we spoke with had any concerns regarding the content of their own care records or having access to them.

We asked people if they felt their care was person centered. One person told us, "It's been pretty good, yes." Another person said, "Absolutely." Another person told us, "It covers everyone, but they will individually tailor it to you if you've any special needs." One of the relative's we spoke with told us, "Yes, definitely."

We asked people how they spent their day and if there were any activities for them to get involved with. The responses we received did depend on the health of the people we spoke with and people who were more able and could visit the day therapy room gave us many examples of different activities they took part in. One person told us, "I've done glass painting, I've never done it before, I make house numbers from slate." The majority of people we spoke with on the in-patient unit told us that they mainly spent time in their room due to their illness but staff were very attentive and did sit and talk with them. One person said, "I don't sleep much during the day, I listen to CDs and look out of the window at the beautiful gardens. I have lots of visitors." Another person told us, "I watch television and sit outside if the weather is nice, the gardens are wonderfully maintained and peaceful."

There was an art room on the day therapy unit, which was run by a volunteer and overseen by the Occupational Therapist. There were examples of lots of projects, artwork and group sessions. Some people on the in-patient unit as well as people coming for day therapy used the facilities and we saw artwork on display. There was some really meaningful activities that took place including people putting together memory boxes and messages for loved ones for future significant events. People were able to have their haircut and attend alternative therapies to help relax them.

There were up to date newspapers and magazines in the day therapy lounge, which people were reading. There was free flowing conversation during lunch and people seemed to know each other quite well, and discussed common interests. This gave people the opportunity to discuss their issues with people who were in a similar position to themselves. Staff and volunteers were also available if people wanted any advice.

We saw evidence the service responded well to people's wishes and choices. One example was accommodating family members to stay overnight or longer periods so they could remain with their loved ones in their final moments. The majority of rooms had a sofa bed and other rooms could be adapted to enable family to stay nearby. This was of great comfort to some of the people we spoke with. We saw that difficult conversations took place with people to ensure their wellbeing was maintained. One such example was that on occasion some people wanted to exclude certain visitors from seeing them. We were told that this also presented opportunities for people to talk about emotional or worrying aspects of their life. People's wishes were respected and measures were put in place to ensure their wishes were met. Reception

staff were trained to deal with such circumstances.

Good

Is the service well-led?

Our findings

There was a registered manager in place who had worked at the service for 13 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.

We found the registered manager to be committed, caring and enthusiastic about the service and the comments we received from people and staff reflected this. As the registered manager had been at the service for 13 years this meant that there was stability in how the service was led, in addition to this the management style throughout the service was forward thinking and reflected feedback from staff, other professionals and people and families who accessed the service. We found all the staff we spoke with, regardless of role, to be fully committed to providing meaningful care to people and that the culture within the service was positive. This included aspiring to improve and learning from any mistakes or errors made. We saw evidence of this in practice and it was not limited to department or role as learning was shared throughout the organisation.

We asked people and their relatives about the culture of the home, one person said, "It's a really caring place, it's brilliant. My [names of relatives] have been really pleased with the care." Another person said, "The atmosphere is good, everybody has a smile on their face." Another person told us, "It's very relaxed and welcoming."

We received very positive comments about the registered manager and all tiers of management from the staff we spoke with. We were told that managers were approachable, listened to what staff and people had to say and operated a genuine open door policy. Through our observations during the inspection it was apparent the registered manager knew staff well and that there was a good rapport in place within a professional and relaxed atmosphere.

We spoke with staff about the culture within the hospice. Staff told us that it was a very positive environment to work in and managers and peers were committed, driven and always willing to offer advice and give support to all staff and volunteers at the hospice. One member of staff told us, "Even the directors have an open door policy, you cannot question the support that is in place for the entire workforce." Another member of staff told us, "The culture I would have to say is fantastic. Everyone knows why we are here and that the patients and families are the priority. There are no dull moments and I look forward to coming to work." Another staff member said, "I don't see it as a job, it's brilliant. You feel guilty about getting paid for it. The support you get is brilliant."

Professionals we contacted following our inspection spoke positively about the registered manager and staff team. They told us that they were responsive, knowledgeable and caring in their approach. There was not one negative comment from the professionals we contacted.

The hospice board were visible to people, families and operational staff and were an important part of the organisations structure and helped form the caring culture of the service. A number of board members chaired local and national groups to ensure that the latest good practice was present at St Catherine's. All senior and middle managers had undertaken management training at ILM level five during the previous three year period. This meant that there had been an increased level of joint working between departments and a culture of cross learning. Attendance levels at the hospice had greatly increased and no staff grievances had been received across the entire workforce during the previous 12 month period prior to our inspection. There were other examples we saw of junior managers taking qualifications to improve their own and the services performance. We were told that St Catherine's was, and saw evidence of, a learning organisation that was continually looking to improve.

We saw there was a positive culture of learning from issues that could potentially affect people's safety. The outcomes of incidents, complaints, investigations and serious cases were reported to the clinical governance meeting as well as the trustee led patient care committee. Weekly multi-disciplinary meetings (MDT's) were held for both in-patient and community services at which lessons were learnt via the sharing of issues and concerns as well as good practice

We saw the service carried out a large number of audits that fed back into service delivery via comprehensive action plans that were constantly reviewed. Examples of audits we saw included; prescribing, hand hygiene, medicines, consent, end of life care planning and clinical reporting. There were mechanisms in place to feedback all auditing activity and results back into board level and operational staff meetings. We saw that practices were constantly evolving as a result of the monitoring and auditing of the service. One example was the end of life care planning audit which highlighted the need to consolidate verbal discussions with families with written information as not everyone at an emotional and stressful time could absorb all the information they needed. The audit had also highlighted a need for improved documentation within end of life care plans and a date and plan had been set to achieve this. There were many other examples such as this within the audits we saw, all of which were comprehensive in their content.

A large range of meetings took place at the hospice at various levels of seniority. As well as board and trustee meetings we saw clinical governance meeting notes. The notes covered areas including; governance, performance, revalidation, improvement, staffing, education and education and research. One good example we saw was that the IPC audit information was fed through to the Board via clinical governance and that audit comparisons were carried out with previous years, with issues identified and a clear action plan to manage the identified concerns. This meant that progress could be measured effectively year on year. Clinical governance meetings were held monthly. Staff told us that there were regular team meetings and that levels of communication were good and pertinent to their own role.

We saw that several committees were in place, which were chaired by trustees. We reviewed the notes of the latest Patient Care Committee. Within this the hospice's business plan was reviewed which monitored progress against set actions. A RAG (Red,Amber,Green) rating was used to set priorities and each action had a lead person and progress report. Key performance indicators were also reviewed as well as forthcoming developments being discussed and any other issues that were pertinent to the meeting. This was seen to be a very thorough and meaningful process and meant that the service continually developed as a result of reviewing what went well and what needed to be improved.

Twice-yearly mandatory staff seminars were held which included presentations, questions and answer sessions, workshops and quizzes. This was a more relaxed forum in which the Chief Executive Officer and managers could share information and work together with colleagues. It was also an opportunity to prepare

and monitor the hospice's annual business plan and a forum for each department to showcase their own achievements and learning with all staff.

We saw several good examples of how the service kept up to date with, and contributed to good practice. The Chief Executive was a board member of and chaired the North West Hospice UK meetings. All directors participated in the annual Hospice UK conference. There were many examples seen of directors supporting other groups and meetings throughout the North West, for example the medical director co-chaired the strategic clinical network group. A memorandum was in place with the University of Central Lancashire formalising the hospices interaction with the areas primary academic institution. We saw that leading specialist visitors attended the hospice to give lectures on areas such as cancer research and dementia.

A number of areas for development had been identified by the hospice to ensure the service was continually improving. These included ideas on how to improve training for staff, such as nursing staff demonstrating how to use specific equipment. Changes to the agendas, and terms of reference, to some key meetings were being considered to ensure that meetings did not stagnate and continued to be effective. New IT developments and more effective ways to communicate with staff and people and families were being worked through. A new staff forum had been introduced to create an added opportunity for staff to meet with the Chief Executive. A number of other initiatives were shared with us that displayed the progressive nature of the organisation.

There were a number of partnerships in place with local businesses. One of these partnerships was with the largest local employer in the area. From this partnership a number of learning lessons had been identified. One of these was the introduction of a weekly 20 minute stand up meeting attended by all departments to look at another way of improving communication across all teams. Learning was also in place from national reports such as the Keogh and Saville Reports. As a result of these reports an additional internal inspection by trustees across the service was introduced as well as the appointment of two trustees to vice chairs to improve the decision making processes.

The service sought feedback from people using the service and from their family and friends. This information was collated and created monthly 'Test' scores. Test scores were rated out of 100 that were then compared to measure progress in key areas. Examples included In patient care, Day therapy, clinical nurse specialists and clinics held at the hospice. We saw that scores obtained for recent test scores were consistently in the mid to late 90's. This was another good example of how the service used information, feedback and a range of intelligence to feedback into making improvements within the service. This was a recurring theme throughout the inspection.