

St. Catherine's Hospice Limited

# St Catherine's Hospice - Crawley

## Inspection report

Malthouse Road  
Crawley  
West Sussex  
RH10 6BH

Tel: 01293447333  
Website: [www.stch.org.uk](http://www.stch.org.uk)

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### Ratings

Overall rating for this service	Outstanding 
Is the service safe?	Good 
Is the service effective?	Good 
Is the service caring?	Outstanding 
Is the service responsive?	Outstanding 
Is the service well-led?	Outstanding 

# Summary of findings

## Overall summary

St Catherine's Hospice is a charity which provides specialist end of life care and support to adults living within the local area. It provides an 18 bed in-patient beds unit, a day hospice and a community service. A range of other services are also provided including occupational therapy, physiotherapy, counselling, spiritual care and a nursing service to help people with lymphoedema (fluid retention and tissue swelling). The service runs its day hospice and outpatient services from its main site in Crawley and from its site in Caterham. Services are free to people and St Catherine's Hospice is largely dependent on voluntary fund-raising.

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.

People valued their relationships with the staff team and felt they often go "the extra mile" when providing care and support. There was a focus on people's wellbeing and providing emotional support. People and their relatives spoke positively about the caring approach of staff. We were told "To be quite honest with you, the staff make the job, nothing is too much trouble, they are conscientious and have the right type of manner which makes you feel good. They're attentive, they all take the time to introduce themselves and they make me feel good".

Staff are highly motivated to offer care which was kind and compassionate and were creative in overcoming obstacles faced to achieve this. Bereavement services were tailored to people's individual needs and were provided over a significant period of time. People's spiritual needs were considered in the care that they received. Chaplaincy support was available for people and their family. Relatives were invited to a remembrance service once a year.

Staff are exceptional in enabling people to remain independent and had an in-depth appreciation of people's individual needs. People were encouraged to set goals and to focus on their possible achievement. The registered manager spoke about their focus on promoting people's independence and told us "It's about being there and not taking over".

People's care was planned in partnership with them and their family. Staff knew people well and understood how they liked to be supported and used innovative ways of communicating with people to ensure that they were listened to. Staff also had a good understanding of how people may feel when considering their end of life care. Staff ensured that they responded to people's feelings in an understanding and compassionate way and the services was flexible and responsive to people's individual needs. Each care plan was person centred and unique to ensure that people felt valued and understood. People told us that staff involved them in decision about their care and listened if they preferred for things done another way. When we asked one person if they felt involved they told us "absolutely I'm involved".

The hospice was involved in the local community and focused on building a strong positive profile in the community. We spoke with the Patient and Family Support Team who told us about their links with the local schools. They visited local schools and spoke with students about the hospice and provided advice for students that may be experiencing or have experienced the loss of a family member. A staff member spoke with us about one student that had spoken with them about the loss of their family member of the support their family received through the hospice.

There was a strong emphasis on continually striving to improve and staff also told us "Quality is at the heart of this place". Quality assurance systems were in place to regularly review the quality of the service that was provided. The hospice was working towards achieving an accreditation to the CHKS (Comparative Health Knowledge Systems) accreditation scheme. Accreditation provides independent recognition of the hospices commitment to continuous improvement; the program provides a tool for the hospice which helps them to put improvement systems in place. This allows the hospice to assess their performance in relation to the accreditation standards and identify ways to improve. This accreditation scheme ensures there is a focus on the quality of care provided to people and focus on people's experience.

The hospice continuously reviewed the service they provided to ensure that the care and support provided reflected the changing needs of the community and that changes to the future support could be planned for. We reviewed the 2013-2018 hospice strategy and saw that this took into consideration the increase in the population of the local community which the hospice supported and changing demographics and the importance of supporting people with non-cancer conditions such as Motor Neurone Disease and organ failure. Training was now provided on specific health conditions such as dementia and neurological disease such as Parkinson's. We also saw that the hospice provided training to external agencies on managing non-cancer disease at the end of life. This training focused on conditions such as dementia, Parkinson's disease and Motor Neurone disease.

People told us they felt safe and well looked after. People were cared for by staff who knew how to recognise the signs of possible abuse. Staff were able to identify a range of types of abuse including physical, emotional and neglect. Staff were aware of their responsibilities in relation to keeping people safe.

Risk assessments were in place to identify individual risks and these were reviewed monthly or sooner if needed. Where someone was identified as being at risk actions were identified on how to reduce the risk and referrals were made to health professionals as required. Risk assessments were centred on the needs of people and were reviewed daily by nursing staff.

Accidents and incidents were recorded and monitored to identify trends and reduce the risk of reoccurrence. There were sufficient numbers of staff on duty to keep people safe and meet their needs. Safe recruitment practices were in place and records showed appropriate checks had been undertaken before staff began work.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines were managed, stored, given to people as prescribed and disposed of safely.

People's rights were upheld as the principles of the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS) had been adhered to. The registered manager told us that at the time of our inspection no-one was subject to DoLS.

Staff had undertaken appropriate training to ensure they had the skills and competencies to meet people's needs. Staff spoke with us about the range of training they received which included safeguarding, food

hygiene and moving and handling. There was also specific clinical practice training relevant to the administration of medicines and wound care management for clinical staff.

There was a formal supervision and appraisal process in place for staff and action which had been agreed was recorded and discussed at each supervision meeting. The annual appraisal focused on staff performance development plans. The appraisals allowed the opportunity for staff to receive feedback on their performance, looking at areas where they are performing well and those that may need improvement. This ensured that people were cared for by staff that were focused on continuously improving their practice and received the support they need to achieve this.

People spoke positively of the quality of the food and also the choice available. The menus were varied and well balanced. Individual preferences, special diets and allergies were recorded on admission to the In-patient unit and the catering staff were notified. There are two food and nutrition link nurses and they introduced a dietary requirements form which is completed on admission to the inpatient unit.

People were actively encouraged to give their views and raise concerns or complaints. The Voices of Experience group was set up in 2015 and met quarterly. The group was made up of people and family members. The various departments used this group to run ideas passed such as redecoration work to the premises and the introduction of new patient literature. Last year a representative from Crawley and Mid Sussex Clinical Commissioning Group attended the group for advice regarding end of life care delivery in the community. We saw feedback boxes throughout the hospice which people and family were able to post feedback forms in to ensure they were anonymous. Feedback provided by people, relatives and health professionals was analysed to monitor people's views on the care provided.

Staff were continuously striving for excellence through research and reflective practice. A post of a research nurse had been created that supported the lead for research (one of the hospice's medical consultants). The research lead spoke with us about the value of taking part in research relating to end of life care to ensure best practice and maintain the best quality of life for people. An example of a recent research project focused on the hydration of people receiving end of life care. There was also a research group made up of clinical staff and their responsibility to embed a culture of research in the hospice and participate in local and national research studies and undertake independent research when needed. This involvement in research helps ensure that the hospice follows best practice in the delivery of end of life care and that the care provided is evidence based.

## 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.

Staff had received safeguarding training and knew how to recognise and report abuse.

There were sufficient numbers of staff to make sure that people were safe and their needs were met.

Risk assessments were in place and were regularly reviewed to ensure that they reflected people's current level of risk.

Medicines were managed safely.

### Is the service effective?

Good ●

The service was effective.

Staff had received training as required to ensure that they were able to meet people's needs effectively

People were supported to maintain good health and were referred to health care professionals when needed

People's rights were protected as the principles of the Mental Capacity Act and the requirements of the Deprivation of Liberty Safeguards (DoLS) were followed

### Is the service caring?

Outstanding ☆

The service was outstandingly caring.

People value their relationships with staff and feel that they go the "extra mile" for them when providing care and support.

Staff were highly motivated and inspired to offer care which is kind and compassionate.

Bereavement services were tailored to people's individual needs and are provided for a significant period of time after the death of a loved one.

Staff were exceptional in enabling people to remain independent and achieve their goals.

Family support is seen as key to people's wellbeing and people's family are also supported.

### **Is the service responsive?**

The service was outstandingly responsive.

People described the services as "Exceptional" and "Faultless".

People's care and support is planned in partnership with them and staff use innovative ways to ensure that people are listened to.

People had an enhanced sense of wellbeing due to the individualised care and support provided.

The services offered are flexible and responsive to people's individual needs and preferences, staff find creative ways to enable people to live as full a life as possible.

People who use services are actively encouraged to give their views and raise concerns. The services viewed concerns and complaints as part of a drive for continuous improvement.

Staff have the skills to understand and meet the needs of people and their family in relation to emotional support and the practical assistance they need with day to day life.

**Outstanding** 

### **Is the service well-led?**

The service was outstandingly well led.

There was an open and positive culture which encouraged staff to raise issues of concern and feel confident that they would be acted on.

There was a strong emphasis placed on continuous improvement and on the provision of a quality service. The hospice strived to achieve outstanding practice and was in the process of achieving accreditation through the CHKS scheme.

The hospice continually strives for excellence through research and reflective practice.

The hospice worked in partnership with other organisations to

**Outstanding** 

ensure they followed best practice and provided a high quality service.

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# St Catherine's Hospice - Crawley

## **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.

Before the inspection we checked information that we held about the hospice and the service provider. This included previous inspection reports and statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We reviewed feedback from healthcare and social care professionals. We used all this information to decide which areas to focus on during our inspection

This inspection took place on 17 and 18 February and was carried out by one inspector, a pharmacist inspector and a specialist advisor. A specialist advisor provides specialist clinical advice to the inspection team.

We spoke with the chair of the board of trustees, chief executive, one member of the board of trustees, the registered manager, the medical director, three relatives, six people and eleven members of staff. We looked at six care records, four staff records, medication administration record (MAR) sheets, staff rotas, the staff training plan, logs of complaints, quality assurance audits and other records relating to the management of the service.

The service was last inspected 25 February 2014 and there were no concerns identified

## Is the service safe?

### Our findings

People told us they felt safe and well looked after. They said, "The staff understand what's going on in my situation and the side effects of my 'chemo'. I feel safe here, it's very peaceful for me." A relative told us "She feels safe - so much attention and comfort."

People were cared for by staff who knew how to recognise the signs of possible abuse. Staff were able to identify a range of types of abuse including physical, emotional and neglect. Staff were aware of their responsibilities in relation to keeping people safe. A member of staff explained that they would discuss any concerns with the registered manager and were confident they would respond appropriately to these concerns. They knew which Local Authority and external agencies to contact for advice and guidance. The registered manager was able to explain the process which would be followed if a concern was raised. There was a safeguarding lead who ensured that they stayed up to date on current best practice by attending safeguarding training days arranged by the local authority and reading current guidance. The safeguarding lead maintained a safeguarding log which recorded the details of safeguarding alerts raised and the outcomes. The senior management team were aware of the learning from any safeguarding investigations and allowed them to review the support people may need. This ensured that people were kept safe and staff were updated on actions which could be taken to reduce the risk of harm to people.

Systems were in place to identify risks and protect people from harm. Where someone was identified as being at risk, actions were identified on how to reduce the risk and referrals were made to health professionals as required. Risk assessments were centred on the needs of people and were reviewed daily by nursing staff. When people's risk had changed the assessments were updated to reflect these changes. Staff were aware of how to manage the risk associated with people's care needs and how to support them safely. For example assessments had been completed which measured and evaluated the risk of people developing pressure ulcers and guidance was provided to staff about how to monitor and mitigate this risk. There was a risk assessment for a person who was at risk of falls. The assessment contained clear guidance for staff to follow. A sensor mat had been put in place that could alert staff when the person got out of bed at times when staff may not be present; the person had been provided with a bed which could be lowered to ground level. Staff spoke with us about the importance of balancing risk against people's rights to make their own decisions and maintaining their quality of life. There was guidance for staff in the Inpatient unit on how to reduce the risk of falls for people. Falls were reported and analysed monthly to identify any patterns and triggers. This monitoring system helped reduce the occurrence of falls for people. Staff made sure that people's call bells were in easy reach to ensure that they could call staff when they needed help.

The registered manager reviewed the reports on accidents and incidents and carried out investigations when needed. There was an audit of accidents and incidents which identified trends and patterns, all clinical incidents were reviewed by the registered manager and following investigation an action plan was agreed. These incidents were also discussed at clinical management meetings. Audits of incidents and accidents were also discussed at clinical risk management meetings to explore how to mitigate any identified risk.

People told us they felt their medicines were well managed and they received their medicines when needed. They told us, "The other morning I woke up and my fingers were very stiff and painful, I was immediately offered two medicines for the pain." Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines were managed, stored, given to people as prescribed and disposed of safely according to these policies. Appropriate arrangements were in place for ensuring medicines were not used past their expiry date. There were detailed, clear records of medicines which had been ordered and received by the hospice. Emergency medicines and oxygen cylinders were available, in date and stored appropriately. Waste medicines were stored securely and disposed of appropriately. Medicines safety alerts and recalls were received and acted upon.

People's medicines were kept securely. Controlled drugs (drugs which are controlled by legislation), were stored securely in a separate locked cupboard fixed to the wall and were accurately recorded. Destruction of controlled drugs was undertaken and recorded appropriately. Staff conducted balance checks of controlled drugs. High strength preparations of controlled drugs were kept separately from other strengths in the CD cupboard to help prevent incorrect selection.

Blank prescription forms were stored securely and their use was tracked. This is important in preventing misuse of prescriptions. Medicines which required refrigeration were consistently kept between 2°C and 8°C which are the required temperatures to keep medicines safe to use. Prescribing was undertaken by in-house doctors and consultants, with some out of hours consultant cover provided by consultants from the local hospital. Pharmacists visited the hospice at least twice weekly for additional screening of prescriptions and to provide advice on medicines. The hospice had effective processes in place to allow patients to take out medicines when on day leave.

Processes were in place to ensure that medicines for the management of people's pain were administered in a safe and timely manner. We observed two trained nurses safely prepare a syringe driver for a patient (a portable pump which allows medicine to be administered by slow release over a period of 24 hours). Staff had good access to up to date resources which they may need for medicines administration, including guidance on the use of syringe drivers. The hospice had worked with their supplying pharmacy to produce a quick reference guide for nurses on the uses and common side effects of regularly used medicines, so that this information could be communicated easily with people being treated at the hospice.

Staff were able to clearly explain the information that patients were given about unlicensed medicines or medicines which are used off-label (licensed medicines which are used outside their normal terms). We spoke to staff about training and were able to view training records and assessments of medicines administration competencies.

We checked prescription and administration charts for three people. These were fully completed, inclusive of reasons for missed doses and people's allergies. The application of pain relieving patches was also checked on a daily basis. The hospice recently sought matrons from a local hospital to observe and review their medicines administration practice as part of a drive for continuous quality improvement.

Safe recruitment practices were used and appropriate checks had been undertaken before staff began work. These included criminal checks such as Disclosure and Barring Service checks (DBS). DBS checks allow the provider to check whether staff are suitable to work in a care setting. Staff files contained evidence to show, where necessary, staff were registered with appropriate professional bodies such as the Nursing and Midwifery Council. The Nursing and Midwifery Council regulate nursing staff and ensure professional standards; once they are registered they receive a pin number.

People told us there were enough staff to meet their needs. They told us, "My call bell is always answered quickly and I see the doctors every day" and "They [staff] seem to go out of their way to be helpful". There were sufficient numbers of staff on duty to keep people safe and meet their needs. We reviewed the staff rota that confirmed this. Staff told us they felt there were enough staff on duty. People's needs were responded to in a timely way. We looked at the staff rota for the past four weeks. The rota included details of staff on annual leave or training. And shifts had been arranged to ensure that staff absences were covered. There were four consultants in post, one of whom was the medical director. Each consultant was on site four days a week with protected off site time for supporting professional activities. They worked closely with the local hospital specialist palliative care team and shared the consultant on call rota with the hospital palliative medicine consultants so that staff in both settings had advice and guidance if needed. One consultant worked with each of the three community teams catchment areas. The hospice participated in a General Practitioner training programme. Trainee GP's spent four months at the hospice to enhance their knowledge of palliative care. We observed staff were available to help people depending on their wishes and people received unrushed care from staff that were patient and kind.

Throughout the hospice equipment was regularly maintained and serviced. There was as an electronic system in place which identified when repairs were needed and recorded any remedial action that had been taken. The system ensured that maintenance issues were responded to in a timely way. These records were reviewed and when equipment needed regular maintenance it was replaced in a timely way. This ensured that equipment was safe to be used and any issues were identified and resolved in a timely way.

The hospice had emergency procedures in place for emergencies such as fire. Guidance was available for staff on how to manage these emergencies. Staff were aware of how they should respond in an emergency and took part in regular fire drills to maintain their knowledge. Fire safety equipment was regularly checked and serviced. The premises were secure for people because there was a robust security system in place. This system identified visitors and monitored access to the In-Patient Unit.

## Is the service effective?

### Our findings

Consent to care and treatment was sought in line with legislation and guidance. 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 make 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, hospices and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the hospice was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS protects the rights of people by ensuring that any restrictions to their freedom and liberty have been authorised by the local authority to protect them from harm. The registered manager told us that at the time of our inspection no-one was subject to DoLS. People were able to make day to day choices and decisions, but where decisions needed to be taken relating to finance or health, for example, then a best interest decision would be made for people who lacked capacity. A best interest decision is where care professionals and relatives would make a decision on the person's behalf, taking into consideration their needs and wishes. Where possible, the person would also be invited to the meeting. Staff demonstrated a clear understanding of the need to ask for consent regarding care provided and also when sharing information with others. They also spoke with us about the importance of ensuring that people's consent was appropriately recorded.

Staff had undertaken appropriate training to ensure they had the skills and competencies to meet people's needs. Training was delivered in a variety of ways including e-learning and classroom based courses. The learning and development officer spoke with us about their focus on ensuring staff were well trained and told us their aim was about "Embedding a culture of learning". All staff essential training was up to date and included safeguarding, food hygiene and moving and handling. There was also specific clinical practice training relevant to the administration of medicines and wound care management for clinical staff. Staff received additional training around end of life care and specific health conditions such as dementia. This ensured that people were cared for by staff who had received the necessary knowledge and skills to carry out their role.

An issue had been identified with the recording of training and more informal training undertaken by staff was not always being recorded. A new training system was put in place; the effectiveness of this system was reviewed by a Learning and Development Group. A member of the group spoke with us about the improvements that this system had made in ensuring that training records accurately reflected the training undertaken by staff.

New staff undertook a comprehensive induction programme which included essential training and the shadowing of experienced care staff. Staff had completed the provider's induction checklist which involved staff familiarising themselves with the layout of the building, fire safety procedures, policies and procedures

and reading through care plans. There was a formal one to one supervision and appraisal process in place for staff and actions which had been agreed were recorded and discussed at each supervision meeting. The annual appraisal focused on staff performance development plans. Staff spoke positively of the one to one supervision provided and told us that this enabled them to carry out their roles effectively. This ensured that people were cared for by staff that were focused on continuously improving their practice and received the support they need to achieve this. Staff also received clinical supervision which gave them the opportunity to discuss the emotional aspects of their role and ensured that they received the support they needed. Additionally, staff had access to an external counselling service. Two members of staff spoke highly of their experience of using the external counselling service and of the positive impact this had had on their ability to consistently provide emotional support to people. Clinical supervision and the availability of counselling services allowed staff to ensure their own emotional wellbeing to allow them to continue to support people and family through difficult times.

Volunteers provided support in a variety of areas within the hospice. They were managed by a volunteer coordinator who ensured that they received the appropriate training and one to one support to carry out their role effectively. Clinical volunteers attended training specific to their role such as infection control and safe escorting techniques such as how to support people using mobility aids. Non clinical volunteers also attended training specific to their role such as dementia awareness and communication training. All volunteers attended safeguarding training and this was followed by a yearly update

People in the Inpatient unit told us they were regularly visited by the doctors and felt they were easy to speak to, they said "I see the doctor every day, all the doctors are very pleasant, I feel I can talk to them." Staff shared information about people's health needs and any changes to the care they received following the daily ward rounds. The medical team spoke with each person and ensured they were receiving the most appropriate treatment to manage their symptoms. Discussions took place between the medical and nursing staff to ensure that treatment plans were in place to address any concerns when difficulties arose. Handovers took place to ensure that staff passed on information about changes to people's health and about the support they needed. Staff discussed changes to the support people needed in regard to their personal care, appetite or medicines. This ensured that people received consistent care and that staff had up to date information on the care people needed.

People spoke positively of the quality of the food and also of the choice available. They told us, "The food is very good. I had roast lamb today and finished off with a cheesecake. We had a choice of lamb or fish parcels which I'm told were very good" and, "The food is very nice, I particularly like the soups as they make their own." The menus were varied and nutritiously well balanced. Individual preferences, special diets and allergies were recorded on admission to the Inpatient unit and the catering staff were notified. There was a food and nutrition link nurse who had introduced a dietary requirements form that was completed on admission to the Inpatient unit. This recorded any allergies and dietary requirement and was forwarded to the catering team. When an allergy and special diet was recorded for a person, an alert was entered on to their electronic care record to ensure that all staff were made aware.

We observed a lunchtime meal within the hospice day service and saw that people were supported to have enough to eat and drink. Staff were knowledgeable about people's dietary needs and preferences. Staff interacted with people throughout the lunchtime meal and people appeared to enjoy this as they were smiling. People's hydration needs were met within the Inpatient unit and day service. People were offered regular hot and cold drinks throughout both days of our inspection. Food and fluid intake charts were completed by staff at meals times to record and monitor how much people ate and drank. This information was recorded onto people's electronic records. The hospice is proposing to use the Malnutrition Universal Screening Tool (MUST) tool to identify whether people were at risk of malnutrition.

People told us their food likes and dislikes were taken into consideration including their preference on portion size. They told us, "If you don't like too much, they'll make you an omelette and will ask you about portion size". We spoke with a member of staff about people's preferences and how they ensured they were taken into consideration in the meals provided. The staff member told us "The word 'no' doesn't exist". A Scottish person in the Inpatient unit had requested Haggis. While this was not a regular meal on the menu a staff member had visited the local butcher to order this and the chef had ensured that this meal was prepared to the person's liking. A food hygiene inspection was carried out February 2016 by the Food Standards Agency and the hospice was awarded a maximum rating of '5'.

The service employed a range of healthcare professionals including a team of doctors who visited people on the Inpatient unit and also worked with people at the day hospice service and the community teams. There were daily ward rounds and multidisciplinary meetings where issues such as discharge planning and people's emotional needs were discussed. There was always a doctor on call including at weekend and overnight. People told us that the community nursing team had regular contact with other professionals involved in their care. We were told "they have been responsible for liaising with my GP to sort out my medicines, it's constantly monitored". This ensured that people received the support and advice they needed and changes to people's health was monitored and responded to.

## Is the service caring?

### Our findings

Staff placed a high value on building relationships with people and supported people in a way that ensured they felt understood and valued. People and their relatives spoke positively about the caring approach of staff. They told us, "To be quite honest with you, the staff make the job, nothing is too much trouble, they are conscientious and have the right type of manner which makes you feel good. They're attentive, they all take the time to introduce themselves and they make me feel good". A person in the Inpatient unit told us "What can you say; you can't praise them enough, so many people looking after me." We were also told "It's the little things that you can't put into words. They know what they are doing and they do it so well." A relative told us "Nurses and volunteers are wonderful. You can't fault them".

There was a focus on people's wellbeing and on providing emotional support. Staff told us of a person who had been admitted to the Inpatient unit. This person had spoken with staff about the enjoyment they took from visiting the local pub where they were known, and from having a specific drink. The person told staff they wished to visit the pub and two members of staff had accompanied them there before they had reached the end of their life. Staff told us they felt they had helped the person achieve what they had wanted.

People told us they felt they were treated with dignity and respect. People in the Inpatient Unit described staff approach as, "Wonderful. All the staff are kind and caring, nothing is too much trouble. I just ring the bell and they are here. We were also told, "Staff are very respectful, you get privacy, they always draw the curtains." We spent time observing care practices in the communal area of the hospice. We observed staff supporting people and ensuring that they maintained people's privacy. Staff knelt down when talking to people so that they were at the same eye level to facilitate good communication. The registered manager told us that treating people with respect and dignity was central to the care and support provided and this was focussed on in the induction of new staff; it was also regularly discussed at supervision and staff meetings.

There was an "extra mile award" every quarter for staff. Staff had the opportunity to nominate their colleague for going the extra mile either in contributions towards the hospice such as supporting people or other members of staff. This award encouraged staff to continuously improve their practice.

Staff were exceptional at helping people to support their views and often "went the extra mile". Staff told us about a person who was admitted to the Inpatient unit whose first language was not English. An interpreting service had been provided by the hospice to ensure that they provided the support as the person wished. Staff used an interpreting 'application' on their phone to ensure that they were able to communicate with this person at all times. Staff told us about another example of when they had gone the extra mile when caring for people. They were compassionate and understanding while focusing on people's emotional wellbeing. They spoke with us about a situation where someone had been admitted to the Inpatient unit and was not able to attend their family members wedding. Due to a suggestion from staff following the wedding a small reception was held in the hospice to ensure that the person was part of this special event.

Bereavement services were tailored to people's individual needs and were provided for as long as needed. People's families were encouraged to remain involved with the hospice after their family member had reached the end of their life. Following the death of their loved one family members received a bereavement pack which contained information from the Patient and Family Support Team about the bereavement services available including support groups. In collaboration with four other charities a support service for teenagers affected by cancer was set up to ensure that younger people received the support they needed. The service provided a telephone helpline, drop in services and support groups. St Catherine's provided the drop in centre which specifically supported for teenagers. This ensured that teenagers with a family member affected by cancer had the support they needed and were able to build friendships with other teenagers in a similar situation.

People's spiritual needs were considered in the care that they received. Chaplaincy support was available for people and their family. Relatives were invited to a remembrance service once a year. This provided family members with an opportunity to remember their loved one while spending time with people who had also lost someone. There was a quiet room/spiritual space close to the Inpatient unit where people and relatives were able to spend time alone or with family members. This room has a remembrance book where relatives could write a note of thought about their loved one. Staff referred to this room as a "Sacred space". This room was also used for sensitive conversations such as about advanced care planning.

There was a homely feel to the hospice day service and a relaxed atmosphere in which people were happily conversing with staff. People and their relatives told us that they felt staff understood their emotional needs as well as their health needs. There was a sociable atmosphere and people were encouraged to speak with staff and also to other people. Staff made time to speak with people and ensure that they felt heard. Staff used gentle touch where appropriate such as holding someone's hand or gently touching their arm to offer reassurance. As staff showed kindness and empathy and this ensured that people felt valued and listened to.

Staff spent time speaking with people and sharing appropriate jokes while supporting them. People appeared comfortable with staff and enjoyed these interactions. People were gently and kindly encouraged when walking from one room to another. Staff knew which people needed equipment to support their independence and ensured this was provided when they needed it.

Staff were highly motivated in ensuring that people remained as independent as possible. They focused on promoting people's independence; people were encouraged to set goals and to focus on these goals. Two members of staff told us how they ensured that people remained as independent as possible. They spoke with us about a person who was being nursed in bed and their goal was for their family members to see them walking. The staff had worked with this person daily to improve their mobility. This person's mobility improved gradually and over a period of time they had become able to stand using an aid. Staff continued to work with this person to improve their mobility and they were able to walk to the hospice coffee shop to meet their family for lunch. Another person in the community had told staff that their goal was to stand on Christmas day. They attended the hospice twice a week and with support from staff had used the rehabilitation gym. Staff had regularly visited this person at home to ensure that they received the support they needed to achieve their goal and they were able to stand on Christmas day. The registered manager told us how staff focussed on promoting people's independence and said, "It 'about being there and not taking over".

People in the Inpatient unit had a pain management programme. Staff spoke with people about the benefits of medicines and ensured that they were aware of side effects which may be experienced. Staff ensured that people were involved in discussions about their symptoms and pain management. They were encouraged

to express their views and preferences with regard to the care they would receive at the end of their life. These discussions were recorded in advanced care plans, to ensure that family and professionals involved in their care had clear information on each person's wishes. Staff spoke with us about the importance of ensuring that people's individual wishes were respected.

Comprehensive information was available for people and relatives about the hospice and what was available. Members of staff wore a badge which showed their name and role. There was a large television screen in the reception area which displayed information about members of staff and the colour of their uniform. This ensured effective communication between people and staff members as they had an understanding of who they were speaking with. Leaflets were available for people and family which addressed subjects such as how to discuss illness and dying with children. People were able to take the leaflets home and read these at times that suited them.

The hospice produced three newsletters; two of these newsletters were for staff and volunteers. One newsletter focused on updates regarding the hospice, while the other focused on clinical updates. The third was made available for people using the hospice, family and members of the community.

Family and friends were able to visit without restriction. Relatives were made to feel welcome and felt comfortable discussing any changes or updates to the care their relative received. A relative visiting a family member on the Inpatient unit told us, "Staff make tea for us and make us feel welcome. There's not a thing they won't do, they are actual angels." Another relative told us they felt able to phone the inpatient unit to discuss any changes to their family member's health or care. They told us, "When I phoned this morning, I knew they were busy but they told me not to worry, I must always call." There was a vending machine which sold ready meals and a microwave available to ensure that families can have hot food when coffee shop is not open.

Staff felt supported by colleagues and the management team. Time was spent during one to one supervision sessions, exploring the emotional aspects of their role. There were opportunities available for staff to take part in group counselling sessions offered by the patient and family services team within the hospice where staff could discuss this aspect of their role. Staff were able to access an external counselling service which gave them the opportunity to talk with a counsellor who was not connected to the hospice.

## Is the service responsive?

### Our findings

People and their relatives spoke positively of the care provided and told us they received care and support which was responsive to their needs. A person in the inpatient unit told us, "The way I look at it, the staff are St Catherine's. They are genuinely interested in me, they are exceptional." People described the hospice as "Faultless, they look after you so well. I can ring at anytime" and "If we paid privately, we couldn't have more." The registered manager spoke with us about the care and support they provide. They told us they focussed on "Care and compassion, understanding that the care is individualised; we are walking alongside them asking them what they need".

Within the hospice there was a community nursing team and a practical care team. People told us the community teams responded in a timely way and had a good understanding of their needs. We were told "It's a wonderful service they provide, we're very fortunate to have them here". People had regular contact with the community teams and felt able to contact them with any concerns or requests for advice and guidance. A relative told us "When my relative was first taken poorly they did pain management. They ring every two or three weeks to ask if all is ok with his medicines". The community nursing team also provided a triage service. This was a telephone contact service where people, their relatives, external health professionals and local care homes could call for advice or support. This service was available from 8am until 8pm. This ensured that if people's allocated community nurse was unavailable that they had access to the support and guidance they needed. This service also ensured that advice and support was provided to the community health staff effectively. The practical care team provided short term practical assistance to people whose preferred place of death was their home. A member of this team told us "We try to be as flexible as possible, we work closely with the district nursing team and work alongside other agencies to fill possible gaps in care". This service ensured that people had the assistance they needed if they chose to die at home.

The community nursing team worked closely with the Patient and Family Support Team. Following a home visit a referral could be made to the Patient and Family Support Team if people needed emotional support. A member of the community nursing team told us about a person who was reluctant to allow the nursing team access their home. The Patient and Family Support Team visited to provide emotional support and once a good working relationship had been built joint visits were carried out with the community nurse. After regular joint home visits the person agreed to be visited by the community nursing team without being accompanied by a member of the Patient and Family Support Team. This collaborative working ensured that good outcomes were achieved for this person who as a result received the care they needed. The hospice had recently secured a grant from the St James' Place Foundation to provide advice and support to local care homes on best practice when supporting people with dementia. The hospice was in the process of recruiting a member of nursing staff to undertake this role with their focus being on improving outcomes for people with dementia receiving end of life care in local care homes.

We saw positive practices used to support people when they were discharged home from the Inpatient unit. Additional advice and support had been put in place to ensure that people managed their medicines safely at home. For example, the hospice had worked closely with their supplying pharmacy to produce a "take-

home pack" for people with a range of resources. In addition to a clear list of discharge medicines, it also included advice on painkillers, on possible adverse effects of driving whilst taking certain medicines, and information about the use of unlicensed medicines in palliative care. The hospice had also worked with the pharmacy to produce a range of information sheets on medicines in palliative care which could be accessed via the hospice website by people, relatives and local healthcare professionals, such as GPs and pharmacists.

People spoke positively of the support provided by the Patient and Family Support Team, they said, "It's wonderful, the staff and volunteers are wonderful". The Patient and Family Support Team consisted of qualified counsellors, support visitors who are trained volunteers and the spiritual care team. There were specific staff with the skills to understand the needs of people and their family in relation to the emotional and practical assistance they need. There was a welfare advisor within the Patient and Family Support Team who offered support with benefit advice and housing applications. People told us "The welfare advisor came to see me at home and got me the attendance money that I had no idea I was entitled to." They also told us, "They have explained that if I have any problems I can phone up. I spoke to a lady regarding some benefits and she helped me to complete the forms and send them off, sometimes it gets too much if you have to do it on your own."

Staff knew people well and understood how they liked to be supported. Care plans included information on people's key relationships, personality and preferences. They also contained information on people's social and physical needs. Care plans contained information on people's life history which gave staff information about the person's life before their admission to the hospice. Care plans included information on people's wishes and their likes and dislikes. Staff were aware of these preferences such as what time people liked to have their breakfast or whether they preferred a bath or shower. We were told "They are very interested in me, myself like do I have any hobbies?". People's care was planned in partnership with them to ensure that their wishes were central to the care provided. The registered manager spoke with us about the importance of ensuring care was personalised and as people wished, they told us "We have one chance to get it right". Staff also had a good understanding of how people may feel when considering the planning of their care, and they ensured that they responded in an understanding and compassionate way.

Each care plan was person centred to ensure that people felt valued and understood. People and those that mattered to them were involved in their advanced care plans to ensure that the care they received at the end of their life was as they wished. We saw that records contained clear information about people's wishes about resuscitation. There were strategies in place on how to manage people's pain and symptoms and staff reviewed these on a continuous basis to ensure people's needs were met. When the support people needed changed that this was recorded which ensured that people received care that reflected their current needs. The registered manager had purchased computers-on-wheels which would allow the doctors and nurses to enter changes to this information while on ward rounds. This was to ensure that people's needs were recorded without delay ensuring that people received consistent care.

Admissions to the Inpatient Unit were normally Monday to Friday but there was flexibility for planned admissions at the weekend if needed as well as urgent admissions. People were admitted to the Inpatient Unit when they needed additional support to manage their symptoms, pain relief or respite as well as end of life care. A person had been recently admitted and we observed a multidisciplinary discussion had taken place before they were admitted for symptom control, to ensure their individual needs were met. There were two wards within the inpatient unit, Beeches and Heaselands, both accommodating nine people, with a mix of shared bays and single rooms. There was a family room available for relatives to stay overnight. This ensured that family felt able to visit without restriction and people were supported to maintain relationships with their loved ones.

The reception was bright and welcoming, we saw people's artwork was displayed on the walls and there was a coffee shop for people and family to use. There were four outpatient rooms and we saw that one room had toys and art materials for children. The additional of items for children encouraged children to feel comfortable in a new setting and created an opportunity for people to enjoy time with their children.

People told us that staff involved them in decisions about their care and listened to them if they preferred things done another way. When we asked one person if they felt involved they told us "Absolutely I'm involved". Due to the changing nature of people's needs, people were assessed daily or more often if needed. This ensured that people received care which reflected their current level of need. When people had been admitted to the Inpatient Unit for respite or to have their symptoms managed staff ensured that the hospice at home team had the information they needed to plan the support and care they would need at home. This ensured that people received consistent care by staff who had the most up to date information on the support they needed.

When people on the Inpatient unit were unable to participate in family events outside of the hospice, staff arranged a celebration for people. Staff told us "All occasions are celebrated at the hospice; it's so important to celebrate the normal things in life." They spoke with us about examples such as Valentine's day when people's meals were served with a rose on their tray and cupcakes decorated with hearts. There has been six weddings and two christenings held in the hospice over the last 12 months. The local ice cream van visited in the summer and provided people with daily ice creams free of charge. Staff spoke with us about the importance of people feeling included in events and "Bringing the community in".

People's social and recreational needs were assessed. Copies of the activities on offer were available for people to read through and they were displayed in the Inpatient Unit. There was an art therapist who worked alongside people on art and memory projects. The art therapist had a good understanding of the emotional support people required and how art could be used as a therapeutic tool to enhance people's feelings of wellbeing. Some of the activities included people making memory boxes or hand prints for their children as memory gifts. The art therapist told us they viewed their role as helping people to "Find where they are and what they want to achieve". They spoke with us about the therapeutic nature of the work people took part in, they told us the focus on their work was on "feeling proud of what they achieved, it gives them a feeling of self-worth". They described the gifts made by people as "Tiny little comforters for people". They told us "it's a privilege to be able to do it". There was a schedule of activities available for people on the Inpatient Unit such as hand massage and pet therapy. When people declined activities, staff respected this; some people chose to spend time in their room with their family or watching television.

Complementary services such as reiki and massage were available; people from the Inpatient unit or day services were able to choose if they wished to take part in these therapies. People we spoke with valued this time and they felt an enhanced sense of wellbeing.

The hospice has two day services, one is within the hospice grounds and the other is based within the community. People spoke positively of the day service and told us, "I'm quite happy, my oncologist thought this would be a good thing for me as I live alone and I have people to talk to who have similar problems, this is good for me. People are friendly and it's quiet here" and, "I visit once a week and it's something to look forward to. I like the music therapy and there's a person that comes in to do a quiz. I play draughts with another gentleman. Everyone understands." We were told that day hospice staff had regular one to one conversations with people to review their health needs and ensure that the pain management program remained effective. Lymphoedema therapy was offered at Crawley and at Caterham. If people had difficulty accessing the service staff arranged home visits. We saw that feedback from people was positive and clearly displayed throughout the hospice on noticeboards which read "what do our patients tell us?". Within the

lymphoedema clinic that 97% of people were extremely likely to recommend the hospice and 3% were likely. The feedback from people read "I've been treated at the lymphedema clinic for many years - it has changed my life for the better – emotionally and physically" another comment read "Excellent service at all times we're so lucky to have this clinic in Crawley".

Staff within the Patient and Family Support Team told us "We are as flexible and responsive as we can be. We play things by ear". The Patient and Family Support Team were also involved with a local doctor's surgery where they provided support to people and family members. Members of the spiritual support team also spent time training other faith leaders within the community on how best to support people through the grieving process.

Support groups had been set up which took into consideration the needs of certain groups such as male carers. The Patient and Family Support Team had identified a gap in the provision of emotional support for male carers as the attendance at the carers groups was mainly female and men had fed back that they did not always feel comfortable sharing their views in this environment. Following this, a group was set up specifically for male carers, which gave them the opportunity to seek support from people in a similar situation. There was a variety of support groups that included groups for people with lymphedema led by the lymphoedema nurse, and a support group for people following bereavement.

The Patient and Family Support Team held weekly debriefing sessions for staff. These sessions focused on the emotional impact that their role had on staff. The Patient and Family Support Team also provided advice and support for people on how to speak to children about illness and dying. To measure the effectiveness of the services a post counselling report was carried out. We reviewed the records for August 2015 to January 2016 which asked for feedback on the first meeting with the counsellor, ease of using the service and whether expectations were met. We saw that the feedback from people was positive and they found it easy to access.

People and family members were encouraged to give feedback on the services offered. The Voices of Experience group was set up in 2015 and met quarterly. The group was made up of people and family members. The mission statement of the Voices of Experience group was "Our purpose is to ensure that those affected by a life threatening condition or an end of life experience have their voices heard and that their opinions are used to shape future Hospice services". The group was facilitated by the Service User Engagement Coordinator. The various departments used this group to run ideas passed such as redecoration work to the premises and the introduction of new patient literature. Last year a representative from Crawley and Mid Sussex Clinical Commissioning Group attended the group for advice regarding end of life care delivery in the community. The new chair of trustees will be interviewed by members of the service user group as part of the appointment process to ensure that people using the hospice are involved in the decisions regarding the leadership team. We reviewed the minutes of the November 2015 Voices of Experience group and saw that it was attended by a member of board of trustee who had presented and discussed their role. People attending the group had stated that these meetings made them feel that their views were heard and valued. We saw that the November 2015 Voice of Experience group discussed concerns which had been raised about the length of time to collect equipment from people's home following the death of a loved one. The group decided that a letter should accompany any loan equipment which would be clearer on the expectations around the collection of equipment in the hope that this would help to manage people's expectations regarding collection of equipment. This ensured that the hospice proactively sought feedback from people and valued their views and ideas on how to improve.

We saw feedback boxes throughout the hospice which people and family were able to post feedback forms in to ensure they were anonymous. Feedback provided by people, relatives and health professionals was

analysed to monitor people's views on the care provided.

Within the day hospice there was a notice board which read " You said, we did". This notice board contained examples of feedback which had been given and how the hospice had responded. One comment read " Name badges for members of the group would allow me to remember people's names". The hospice "we did" response read "Made name badges available for all group attendees who wished to wear one". We also saw that the day hospice noticeboard contained feedback from people who used the services. Examples of people's comments read "A lovely, jolly, happy place to forget problems" and "Gives me great confidence, reassurance and friendship with people suffering the same illness. Staff and volunteers are excellent".

There was a complaints policy in place and the registered manager told us how they would respond to a complaint, that they would document the concern, respond promptly and ensure that the person or relative was keep informed throughout. All complaints whether formal or informal were investigated according to the hospice complaint policy. Through this process the senior management team had identified that complaints were often related to people's expectations of the hospice. Action was taken as a result and the services offered had been reviewed to ensure that services available where clearer for people. A member of the senior management team told us "Staff are open and transparent and are becoming more confident in flagging up complaints even if they are not sure it is an actual complaint.'

## Is the service well-led?

### Our findings

There was a positive and open culture with a focus on the experiences of people using the hospice. Staff told us 'It is an open organisation, hands on.' There was an effective leadership team responsible for the running of the hospice. Staff spoke positively of the chief executive and told us they spent time with staff to understand the challenges they may face. Staff described the chief executive as "Very upbeat, dynamic, approachable." We were told that the chief executive and the registered manager were visible within the hospice and knew people who used the hospice. The chief executive had recently received feedback from the managers; we reviewed this feedback which was positive. Staff also spoke positively of the registered manager and told us they were approachable. We were told "She's approachable, if I had a problem I could go and see her" another member of staff told us "I feel really valued." A member of staff also spoke with us about the support they received from the ward manager, they told us " he's approachable, doesn't get fazed. He looks after us."

The registered manager ensured the quality of the community service by accompanying staff to visit people in the community. They told us that they wanted to ensure that they were aware of what staff and patients were facing in the community. The registered manager also spent time in the triage office to gain an understanding of the challenges faced by staff and to "understand the clunkiness" to allow them to develop strategies to improve the hospice. The chief executive also spent time on the Inpatient Unit to see what challenges members of staff faced. The registered manager involved staff in the quality assurance of the hospice. Regular staff team meetings took place to allow staff to communicate their views about the care provided and raise any concerns about individual people's care. Members of staff from each department were involved in quality assurance checks for each section of the hospice. The registered manager told us they wanted to develop a "Learning organisation". They told us that they were continuing to work towards achieving this goal and gave us the example of 'Schwartz Rounds' which were to be introduced the week following our inspection. Schwartz Rounds are an opportunity for staff from the departments within the hospice to come together and talk about the emotional and social challenges of caring for people.

There was an annual audit schedule and a quality through audit group. The audit group has members of staff from each department. Member of staff are asked for ideas on areas which may be improved through an audit. The hospice uses the Hospice UK benchmarking audit to track the outcome of their audits in relation to the national average. The hospice used this tool to compare their performance with other hospice to encourage learning and good practice. Key quality indicators are used to demonstrate safe and harm free care. Hospices can then use this data to benchmark their performance against the performance of other hospices. This ensured that performance was being monitored and compared to ensure that good outcomes were achieved for people and if any areas of poor performance were identified and actions made. We saw from the most recent audit the hospice had similar outcomes on areas such as pressure sores, falls and medication errors as the national average. While comparable with national averages on pressure sores and falls a Patient Safety Group was set up with responsibility for identifying and implementing improvements in the preventions and management of falls and pressure sores. The group focuses on ensuring that risks are mitigated while people are supported to make choices. This ensured that there was a focus on continuously improving the care and support which was offered to people.

The hospice was working towards achieving an accreditation to the CHKS (Comparative Health Knowledge Systems) accreditation scheme. Accreditation provides independent recognition of the hospices commitment to continuous improvement; the program provides a tool for the hospice which helps them to put improvement systems in place. This allows the hospice to assess their performance in relation to the accreditation standards and identify ways to improve. This accreditation scheme ensures there is a focus on the quality of care provided to people and focus on people's experience. From the records reviewed we saw the hospice was 75% of the way towards meeting the targets set by the accreditation scheme and the aim was to achieve accreditation by summer 2016.

People spoke positively of the care and support provided by the hospice. We reviewed a selection of thank you cards the hospice had received. The comments read "How special you all were at this difficult time for us" and "Thank you so very much for all the love and care that you have showed to our lovely dad during the past two weeks and to his family also". Another read "Thank you to all the staff and volunteers for all the care and compassion you showed my mother in her last few days". The hospice also won charity of the year November 2015; this was awarded by the West Sussex County Times Community Awards 2015. This was awarded based on the number of people supported, fundraising, and the profile that the service/hospice maintained in the community. People were encouraged to share feedback and voice their opinions. Feedback from people and relatives was requested weekly and audited quarterly. Any issues from the feedback was reported to the chief executive. An action plan was compiled which highlighted comments and suggestions for improvement. Friends and family feedback forms were provided to people in the community by the community team, they have had 221 returned since October 2015. The feedback indicates that 98% of people would recommend the services provided by the hospice.

The hospice was involved in the local community and focused on building a strong positive profile in the community. We spoke with the patient and Family Support Team who told us about their links with the local schools. A member of the Patient and Family Support Team regularly visited the local school to talk with children about death and grieving. They visited local schools and spoke with students about the hospice and provided advice for students that may be experiencing or have experience the loss of a family member. A staff member spoke with us about one student that had spoken with them about the loss of their family member of the support their family received through the hospice. Following the visit to the local school a young girl had decided to volunteer to sing at the hospice. On the day of our inspection we saw them singing in the communal area near the Inpatient unit. People and family from the Inpatient unit and day services spent time in this area enjoying the singing. Volunteers and staff contributed to the fundraising events and were encouraged to take part in the local events.

The hospice continuously reviewed the service they provided to ensure that the care and support provided reflected the changing needs of the community. We saw that in 2015 23% of patients had a non-cancer diagnosis and the hospice was focusing on increasing the number of patients they support with a non-cancer diagnosis. A report profiling the end of life care needs for the community which the hospice covers had been compiled which reviewed the population in relation to categories such as age, ethnicity and gender. This report focused on the changes in the conditions which affect people supported by the hospice. It considered the increase in people with within the community who will be diagnosed with dementia. The 2013-2018 strategy focused on the aim to reach more people who have a diagnosis of a terminal illness. The strategy took into consideration the increase in the population of the community which the hospice supported and changing demographics and the importance of supporting people with non-cancer conditions such as Motor Neurone Disease. The impact and demand of these changes on the future provision of care and how the needs of future patients could be met was considered. The chief executive spoke with us about the focus on increasing the number of patients the hospice supports and ensuring that they support people with long term conditions. Training was now provided on specific health conditions

such as dementia and neurological disease such as Parkinson's. We also saw that the hospice provided training to external agencies on managing non-cancer disease at the end of life. This training focused on conditions such as dementia, Parkinson's disease and Motor Neurone disease. The hospice had been gifted land in someone's will and plans were in place to build a new larger hospice. A new build committee had been set up to focus on the design and layout of the new building and the importance of ensuring the needs of future patients was reflected in the design. Consultation had begun with staff from all departments to ensure that their views on how best to meet the needs of future patients was heard.

Staff told us they felt consulted on any proposed changes. A member of staff told us "We have had a lot of changes but we know what is going on because we are told, we know before the general public." A comprehensive update had been made to the hospice electronic recording system which had improved the recording of information. The new updated system was due to start the week following our inspection to make information more easily accessible for staff on a day to day basis. Staff had been involved in discussions about the changes to the system and told us that they had suggested ways to find the information they needed more easily. This had ensured that the improvements to the system reflected what staff felt was needed from the recording system. Another member of staff spoke with us about concerns which the staff team had raised with the chief executive about changing the children's room into an office space. Staff told us they had discussed the importance of the room remaining as a space for children. Staff told us they felt their concerns were listened to and the room had remain as a children's room. A member of staff told us "If we're not happy it's our responsibility to say so". The open culture encouraged staff to felt confident voicing both positive and negative feedback".

Staff were aware of the safeguarding and whistleblowing policy and told us they would report to the registered manager if they had concerns. The registered manager notified the Care Quality Commission of any significant events that affected people or the running of the hospice. Staff said they felt valued, that the registered manager was approachable and they felt able to raise anything which would be acted upon.

There was a strong emphasis on continually striving to improve and staff told us "Quality is at the heart of this place". Quality assurance systems were in place that included a comprehensive schedule of audits relating to medicines, infection control, privacy and dignity, accidents/incidents, complaints and compliments. These audits were communicated to the Quality & Safety Group and were also considered at the board meetings. In addition to this, there were health and safety meetings that reviewed all incidents. All complaints and investigations were reviewed by the senior management team to make sure they were investigated appropriately.

There were robust systems in place for monitoring accidents and incidents; this ensured that information was responded to in a timely way. There was an extensive programme of clinical audits to ensure that the quality of the care provided was maintained. Quality assurance processes had identified that it would be beneficial to have an audit of pain management and controlled drugs, and as a result this had been implemented.

There was an open culture about reporting and investigating incidents. Staff told us there was not any blame culture about incidents and that learning was shared with them so they could change any practices they needed to. We saw that the monthly monitoring checked on slips, trips and falls. The December 2015 records showed that there had been four falls in the hospice, the falls policy and the use of bedrails procedure had been reviewed; additional training had been delivered to staff about how to mitigate risks of falls for people. A monthly newsletter was sent to all staff which included sharing any learning and outcomes from incidents and complaints. In addition learning was shared at staff meetings and changes were made to procedures where necessary.

Members of the board of trustees visited the hospice and carried out checks on the quality of the care being provided. Following the visit an action plan was written to address any identified concerns. A member of the board of trustees told us that these visits were helpful as they allowed them to get a picture of the day to day running of the hospice and spend time with staff. We reviewed the records relating to the Jan 2016 visit and saw that three member of the board of trustees had visited, alongside three members of staff from various departments. Visits were made to the inpatient unit, reception area, fundraising, family services and Personnel departments. During these visits, discussions took place with staff around the Care Quality Commission's recommended standards of care. The outcomes were positive and staff reported feeling well supported and that feedback was taken on board by the management team.

There was a quarterly organisational operation dashboard which measured the hospice compliance with targets such as occupancy on the Inpatient unit and the number of triage calls received. We saw that the target for the inpatient unit occupancy was 85% and the actual occupancy was 87%. This monitoring ensured that the hospice was aware of any risk to the service being provided. Areas such as staff training and vacancy rates were also monitored to ensure that any risk was identified and addressed. The monitoring systems ensured that the hospice was aware of potential risks that may compromise the quality of the service.

There was an effective system of communication between the chief executive and the board of trustees. They met monthly and spoke on the phone at least once a week. Monthly board meetings took place with the board of trustees and the senior management team. Updates were given to trustees on areas such as the care provided, finances and quality assurance. The December 2015 board meeting minutes showed a discussion had taken place about the management of people's skin integrity. The decision was made that a group would be set up to focus on the management of pressure sores. The first meeting was arranged for January 2016. There was also a variety of board subcommittees which meet four times a year such as resources and board development. There was an organisational risk register which considered risks to the hospice such as reductions in funding.

The quality of the care provided was central and the registered manager emphasised the importance of continuous improvement in all aspects of the care provided. Monthly management meetings took place to discuss aspects of the hospice including staff training and changes to policies and procedures. The chief executive and registered manager spoke with us about their focus on involving non clinical staff in clinical audits where appropriate. This allowed staff to get a more in depth perspective on the service provided and also ensured another perspective to the audit process.

Staff were continuously striving for excellence through research and a multi professional research group had been set up. One of the consultants in post led on research for the hospice and there was also a research nurse who supported with all aspects of research. Their research nurse role involved engaging staff on the value of research in end of life care. The focus was on external research however from April 2016 the research lead planned to undertake independent research projects which addressed gaps in the provision of hospice care. The research lead worked in collaboration with the local teaching hospital to ensure best practice. They also emphasised the importance of ensuring the research the hospice was beneficial for people using the hospice. An example of a recent research project focused on the hydration of people receiving end of life care. The research group had submitted a research strategy to the senior management team and the board of trustees which detailed the plans for undertaking further research and evaluating the impact that the research had on patients, family members of the local community.

The hospice worked in partnership with other organisations to ensure they provided a high quality service. The registered manager told us "We work together to get it right for the patient". They worked in

collaboration with Continuing Health Care (CHC), local authority departments and local hospital teams. The community nursing team also worked alongside local care homes to ensure that standards of end of life care were upheld. This involvement ensured that the end of life care people received outside of the hospice was monitored and guided by staff with specialist knowledge.

We spoke with the registered manager about what they were most proud of and they told us "My team. I am passionate about being able to provide a high standard of care. I have a large team and we are all about caring." They described to us an example of the caring and kind approach of staff, when a person was admitted to the hospice as they did not want to die on their own at home. Staff told us they were most proud of "The whole place, you feel you are doing an excellent job. Families know that their loved one is being looked after and then they can relax." They also told us "I'm proud of individual patient care, I believe it's at a very high level. If we can do it we will." Another member of staff told us "You can really make a difference."

Resources and support were available to develop the staff team and there was an awareness of the importance of ensuring the emotional wellbeing of staff to allow them to continue to support people at the end of their life. We spoke with staff about the challenges they faced. Staff told us "Seeing patients in pain or families in turmoil". Staff felt that this challenge was well managed by the senior management team as they receive emotional support through supervision, the external counselling service and debrief session provided by the Patient and Family Support Team.