

Keech Hospice Care

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Inspection report

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Ratings

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

Summary of findings

Overall summary

This inspection took place 29 and 30 June 2016 and was unannounced.

The inspection was carried out by two inspectors, a pharmacy inspector and a specialist advisor.

Keech Hospice Care is a purpose built hospice on the outskirts of Luton. The service provides 15 overnight beds, a palliative care centre and a hydrotherapy pool. The service provides nursing care to adults and children, many of who may be experiencing physical disability, life limiting conditions and or terminal illness.

There was a registered manager in post.

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 felt safe. Staff had received training to enable them to recognise signs and symptoms of abuse and how to report them. People had risk assessments in place to enable them to be as safe and independent as they could be.

Effective recruitment processes were in place and followed by the service which ensured staff working at the service were suitable. There were sufficient staff, with the correct skill mix, on duty to support people with their care and treatment needs.

Medicines were managed safely. The processes in place ensured that the administration and handling of medicines, including controlled medicines, was suitable for the people who used the service.

Staff received a comprehensive induction process and on-going training. They were well supported by the registered manager, Chief Executive Officer (CEO) and their line managers. Staff had access to a range of differing levels of support.

Staff had attended a variety of training to ensure they were able to provide care based on current practice when providing care and treatment for people.

Staff gained consent before supporting people or providing care and treatment. People were supported to make decisions about all aspects of their life; this was underpinned by the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff were knowledgeable of this guidance and correct processes were in place to protect people, children and young people.

People were able to make choices about the food and drink they had, and staff gave support when required. Catering staff had good knowledge of the types of diets people had and catered for them effectively.

People were supported to access a variety of additional health professional when required. Some medical procedures were carried out in the Keech Palliative Care Centre, which cut down on hospital appointments for people. Alternative therapy was available including; aromatherapy, Indian head massages and reflexology as well as music and art therapy.

There was a support programme, manned 24 hours to provide a single point of contact for additional support.

Staff provided care and support in a caring and meaningful way. They knew the people who used the service and their relatives. People and relatives, where appropriate, were involved in the planning of their care and support.

People's privacy and dignity was maintained at all times. People were asked for their feedback, which was analysed, and actioned if required. A complaints procedure was in place and accessible to all. People knew how to complain.

Effective quality monitoring systems were in place. A variety of audits were carried out and used to drive improvement if required.

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 were knowledgeable about protecting people from harm and abuse.

There were enough trained staff to support people with their needs.

Staff had been recruited using a robust recruitment process.

Systems were in place for the safe management of medicines.

Is the service effective?

Good ●

The service was effective.

Staff had attended a variety of training to keep their skills up to date and were supported by their line managers.

People could make choices about their food and drink and were provided with support when required.

People had access to health care professionals to ensure they received effective care or treatment and pain and symptom control.

Is the service caring?

Outstanding ☆

The service was very caring.

People were able to make decisions about their daily activities.

Staff treated people with kindness and compassion.

People were treated with dignity and respect, and had the privacy they required.

Is the service responsive?

Good ●

The service was responsive.

Care and support plans were personalised and reflected people's individual requirements.

People and their relatives were involved in decisions regarding their care and support needs.

There was a support programme, manned 24 hours.

There was a complaints system in place and people were aware of this.

Is the service well-led?

The service was well led.

People and their relatives knew the registered manager and were able to see her when required.

People and their relatives were asked for, and gave, feedback which was acted on.

Quality monitoring systems were in place and were effective.

Good ●

Keech Hospice Care

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 29 and 30 June 2016 and was unannounced.

The inspection was carried out by two inspectors, a specialist advisor and a pharmacy inspector. The specialist advisor was a specialist in children's palliative care.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We checked the information we held about this service and the service provider. We also contacted the Local Authority. No concerns had been raised and the service met the regulations we inspected against at the last inspection which took place in July 2013.

During our inspection we observed how staff interacted with people who used the service.

We spoke with the CEO and registered manager, the manager, the quality and compliance manager, finance manager, head of human resources, one human resources staff, training and development manager, three volunteers and the chef manager. In the children's unit we spoke with three nurses, two health care assistants, two parents and one carer who was supporting a child. In the adults in patient unit we spoke with a senior sister, a sister, one staff nurse and one health care assistant and one person who was being discharged. We also spoke with the senior sister and one person in the palliative care centre (day service)

We reviewed three people's care records on the adult in patient unit, three people's records on the children's unit, five medication records, five staff files and records relating to the management of the service, such as quality audits.

Is the service safe?

Our findings

One parent of a child who used the service said, "I feel [name of child] is very safe here." Staff had a good understanding of the different types of abuse and how they would report it. One staff member said, "I would flag it up to the senior immediately." Another said, "We have an on-site social worker we can go to, a senior nurse on call, there are a lot of people we can report it to." Staff told us about the safeguarding training they had received and how they put it into practice and were able to tell us what they would report and how they would do so. Staff were aware of the provider's policies and procedures in relation to keeping people safe and felt that they would be supported to follow them. Staff told us they were aware of the provider's whistleblowing policy and would feel confident in using it.

All of the staff we spoke with had an in depth knowledge of safeguarding, what to look for, to listen for and how to respond appropriately to children. All staff were aware of the increased vulnerability of children and young people with complex needs. Routinely a body map was completed within hours of each admission to record any existing marks to assist with managing safeguarding responsibilities.

The children's unit was separated from the adults unit and accessed by a coded lock. This enabled staff to be aware of who was in the unit to keep children and young people safe.

Within people's care plans were risk assessments to protect people and promote their safety. Staff told us they were completed to enable people to be as independent as they were able, but to keep them safe. All appropriate risk assessments were in place, up to date and reviewed at each admission. Specific risk assessments had been comprehensively completed for both adult and children. These included seizures, pressure care and skin integrity and nutrition. They had been developed with input from the person or family. One parent we spoke with explained how they had been involved and told us they knew the risk assessments were in place. We saw they had been reviewed regularly and updated when required.

We saw that there was a business continuity plan which took in to account all areas of the hospice and what action could be taken in the event of an emergency situation. Records showed that the service was liaising with the local council to further develop the plans. This ensured that in the event of an emergency, people could still be cared for and supported effectively.

The registered manager told us, and we saw evidence that all safeguarding's had been investigated and reviewed in a robust manner. There had been a full overview and root cause analysis of the types of incidents to determine whether there were any particular causes or triggers. Areas for improvement were identified and action plans compiled so that action could be taken to address these.

We saw that there were plans in place to ensure all equipment was serviced according to the manufacturer's guidance. Records had been kept and stickers were in place on individual equipment stating last and next service dates.

We found that there was a sufficient amount of staff with differing skills levels on duty in all units. Staff told

us there was enough staff to provide the appropriate care and support to people and children who used the service. We checked the rotas for the month and found staffing levels were consistent.

A member of staff told us, "We have a strong recruitment process in place, and always make sure that we have two references and the Disclosure and Barring Service (DBS) check back before anyone starts. If things come back in the DBS, we would make sure they were risk assessed and get another reference if that was appropriate." Staff we spoke with confirmed that these checks had taken place before they had started to work. We reviewed staff recruitment files and these contained copies of the application, interview notes and checks which had taken place including references, an up to date photograph and the DBS check.

One person who used the service said, "I worry about my medication and they explain it all." We found medicines were obtained and administered safely to people who used the service. The service used a local community pharmacy to supply their stock medicines and medicines for people at discharge. The provider was not using nationally required documentation for the prescribing of controlled drugs to people who were being discharged from the hospice. There was no concern that processes were unsafe and obtaining the correct documentation was addressed following our inspection. This service included a weekly visit from a pharmacist. They provided a medicines supply service to the hospice and medicines advice to staff or people. The hospice doctors prescribed medicines on treatment charts and the information was checked on admission with a variety of sources to ensure accuracy, and where possible, charts were checked by the visiting pharmacist. Medicines brought in by people who used the service were checked by nursing staff to ensure they were safe to use. We saw evidence that people who used the service were getting their medicines as prescribed. The hospice had doctors on site every day and a system in place to ensure advice could be obtained out of hours.

Medicines including controlled drugs were stored correctly and securely although we found that the refrigerators were not being effectively checked to ensure medicines would be stored at the required temperatures. This was addressed during our visit. Staff were able to describe the action they would take in the event of fridge failure.

Each unit held stocks of appropriate emergency medications that were in date and regularly checked. We saw evidence of regular audits relating to medicines security, storage and record keeping; actions plans had been produced and actions documented. Staff who administered medicines had their competency to do so reviewed annually, this included drug calculation exercises. Health care assistants who provided a 'second-check' function for medicines administration also attended medicines training annually. This ensured people received their medication from staff who were trained to administer them correctly.

We examined the medicines charts for five people and saw that allergies were recorded consistently, where medicines had been omitted reasons were clearly documented and there was clear guidance on the charts for administration of non-oral medicines. These included patches, insulin and intravenous infusions.

We found an open culture of reporting medicines incidents and all staff we spoke to were aware of how to document incidents. We saw that systems were in place to ensure they were fully investigated. The provider had joined Hospice UK and had instigated a process for grading incidents to gain a better understanding of areas for improvement. The Management of Medicines group that met bimonthly reviewed all incidents. We saw that actions from errors or incidents were documented with feedback and/or additional training for staff provided as necessary.

The service only offered self-administration of medicines within the day centre service where there were processes in place to assess a person's ability to administer their own medicines safely. On the children's in-

patient unit parents or carers often administered medicine and this was fully documented on the medicines charts. People were informed about their medicines by the doctors and nurses, we were told that when medicines were used outside their licence it was not always practical to discuss this with service users but a leaflet was being produced to facilitate this.

Is the service effective?

Our findings

People told us they thought the staff were very well trained. One person said, "They all know exactly what to do."

A member of staff said, "When there is any training a list goes up in the handover room. It tells us what it is and when it is." The human resources department told us that new staff attended a welcome meeting when they started, where they had to complete some of the provider's mandatory training, including fire safety and an on line assessment. They then completed the provider's induction programme which included shadowing more experienced staff. One of the human resources staff said, "We have tried to make the induction process more engaging and formed a working party to ensure the effectiveness of this. We did a survey amongst staff to gauge the effectiveness and to help develop the role of the mentor/ buddy."

Two new staff said they had been very well supported during their induction. Both explained they had been given a clinical skills booklet identifying all the required clinical skills required within the children's unit. These skills had been observed before being signed off by a dedicated and named mentor. This ensured that staff skills had been checked before they were allowed to use them on people.

We were told that an education group met three to four times a year with representation from across the hospice to discuss the effectiveness of all the training to ensure that this remained appropriate for all staff. A learning management system enabled staff to keep up to date with their training courses and for this to be reviewed by managers for the purpose of staff supervision and appraisal, as well as supporting them through the induction process. Training came in the form of e learning and face to face training and was designed to be engaging and contain both practical and theoretical information. Some staff had been employed to undertake apprenticeships.

The learning management system worked on a Red, Amber Green (RAG) rating to highlight to staff when their training was due to be refreshed and allowed managers to overview competencies of staff. Clinical staff could source additional palliative care training including; syringe driver training, IV and pain control. Documentation seen showed this had happened. Links had been forged two local hospitals so that training could be based upon best practice. We found that there was a rolling programme in place for all training. The My Care coordination Team (MCCT) also focused on educating other providers on best practice when managing end of life cases and avoiding unnecessary hospital admissions. Two healthcare assistants who worked in the adult in-patient unit had completed their Assistant Practitioner training and the provider had recently launched a programme of education specifically for healthcare assistants to assist them in achieving their palliative care competencies.

There was a nine month leadership programme underway for managers and a two day management training programme had been delivered to junior managers and senior staff nurses.

Staff told us they were very well supported by their line managers and mentors. One staff member said, "We are a very supportive team. We are able to speak with our mentor or anyone if we have any concerns." There

was a variety of support systems in place which staff were able to access when they required them. These included; one to one supervision, group supervision and external supervision. The service held a debriefing session for staff after a difficult situation. Staff also received an annual appraisal. We saw completed documentation which showed staff had been supported and had been given the opportunity to discuss any concerns with a more senior member of staff.

Volunteers we spoke with told us they received training appropriate to the role they carried out. One volunteer who assisted in the kitchen said, "I have recently done food hygiene and infection control." They told us it had been useful and they could access more training if they wanted. They also told us they were very well supported by all of the staff and management.

The service had links with other hospices in the area and was part of a UK wide network of hospices. This enabled them to keep up to date with best practice and sector specific guidance and to allow them to share information with the other hospices. Staff attended regular strategic network meetings and palliative multi-disciplinary team meetings. These meetings were used as an educational platform for professionals to learn from each other and disseminate best practice.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack 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. We checked whether the service was working within the principles of the MCA. Within care plans, we saw that people had assessments and best interest meetings when required. On the day of our inspection no one had a Deprivation of Liberty Safeguard (DoLS) in place.

All staff we spoke with on the children's unit were aware of the Children's Act. All described how they gained both formal and informal consent. We saw each time an intervention was planned the staff asked permission and or described this to the child before going ahead. The care plans documented consent from the parents to share information and consent to photography. Parental responsibility was established and documented at each admission.

Within the children's unit we found that there was clear and comprehensive documentation regarding children or young people who may have had a learning disability. The use of a document called 'All about me' and robust links with schools and colleges, enabled staff to feel supported in the provision of appropriate care to children. This process ensured that staff knew how to act if a child showed any behaviours which could challenge.

Some people who used the service had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) in place. These had been completed correctly in line with appropriate procedures. Documents we viewed showed the person or their representative had been involved in the discussion regarding these. Staff we spoke with knew who had them in place which meant that their decisions would be fully respected.

One person we spoke with said, "The meals are all good, we have a choice and we just ask if we want something else. If I want a hot drink, I get one. There is a fridge in my room where I can keep goodies and my drinks cold. Staff even ask if you want a cup or a mug for your hot drinks." The chef manager told us they used a weekly menu, but said that people could have whatever they wanted. They were aware of who

needed specialist diets and these were catered for accordingly. She went on to explain that every day she made a different flavoured smoothie with fresh fruit and cream for the people who used the service. These could be made with soya or lactose free milk if required. There was an on-site restaurant for staff, visitors and people to use. At lunch time we observed the children, parents and staff all eating together in the restaurant. This was a social occasion with lots of laughter and chatting.

Within the children's unit there were very clear care plans in regards to nutrition. Staff were aware of when children who were artificially fed required support. These regimes were documented in care plans which moved with the child and which were detailed at staff handovers. All staff underwent a competency assessment annually for giving differing types of artificial feed. For children who could eat orally there was plenty of choice at each mealtime

The care team were able to access the kitchen out of hours to prepare food and snacks as required should anyone want additional dietary intake. This also enabled staff to provide nutritional support in the event of unforeseen situations.

The staff and the chef manager told us they were working with the local hospital about some recent training they had attended regarding different levels of pureed food. This would help them to determine the correct consistency for people, being mindful of their assessed needs. We were also told the provider had a nutrition group which comprised of a dietician, speech and language therapist, catering staff and clinical staff. The group reviewed the menus with a focus on sensitivities and allergies, cultural needs and accessibility of foods outside of normal mealtimes.

People told us they had access to additional health care and support. One person said, "They deal with all my needs, physical, emotional and spiritual." The service offered occupational therapy along with complementary therapies including; reflexology, massage, music therapy and art therapy. This meant that adults and children, where appropriate, had access to therapies that could help manage their symptoms. These therapies were accessible to everyone who used the hospice services as part of the holistic approach provided.

One person said, "They give you pain killers and look after you." They went on to tell us how they were constantly in pain before admission, but the doctors had got it under control quickly. There were doctors on site or on call at all times to enable people to be as pain free as possible.

The Consultant in paediatric palliative care provided an outpatient session one day each week to review and manage difficult symptoms. This enabled children and young people to be seen in a friendlier environment and for the Consultant to observe them while at rest and play. It also gave the staff chance to undertake specific observations for example, the manifestation and presentation of seizures in order for the consultant to more effectively manage these.

The children and young people's unit had a service agreement with Great Ormond Street Hospital (GOSH) specialist palliative care team for out of hours support and advice for symptom control. GOSH and the service's own Consultant were part of the Association of Paediatric Palliative Care (APPC) network and participated in the development of guidance and best practice in children's and young people's palliative care.

One person told us, "They tell you everything. Everything has been discussed with me to make sure I understand and agree. They involve my family as well." And, "I'll be sorry to leave here; this has been a real life saver. I've got the support I need and know when I leave there is an advice line which is good. I can come

to the day centre once I have left and socialise, that is what it is all about." Each person had a lead nurse named on a board in their room, but they told us they could speak to anyone.

Is the service caring?

Our findings

One person who used the service said, "The nurses are angels, they deserve halos. From the cleaners to the cooks, they all deserve a medal."

One person told us, "I requested my treatment here; it was nicer and more relaxed. I have the same staff and it was friendlier than in hospital." We observed skilled and caring interactions with all staff able to adapt their levels to each child and young person's age and ability, including those children who had their own methods of communicating, for example, Makaton or signing. Some staff had been trained in different communication methods to enable people to express their views if they were non-verbal. Additional services such as translation services could be accessed if necessary. All information leaflets stated they were available in other languages, large print or audio format.

Staff told us they had received training in play which had augmented their care. We observed staff using play to incorporate care interventions with success. Staff routinely bent down to meet a child's eye or got close to enable a young person to see better. Staff changed their intonation to sound playful with younger children and then were able to act in an age appropriate way with young people.

One parent we spoke with in the children's unit told us, "This is the first time in such a long time that [child's name] has been considered as a whole child and not just the parts of his condition." Another person who used the service told us that the staff knew them well, including their family members and what was important to them. Staff told us each children's or young person's bedroom was personally prepared prior to each stay from age and gender appropriate bedding to pictures on the walls and extras such as cushions, toys and books. This was to make the child feel more at home and the family feel confident that the team know their child well and it mattered how their room looked and felt.

Staff were noted to respond quickly to call bells or requests for assistance. Staff told us that as they knew the people they were providing care for and had regular handovers; they were able to respond quickly to a person's changing needs. As there were doctors on site, there would not be a delay in getting assistance.

The service had a multicultural spiritual space. There were individual cupboards storing many separate faith artefacts and information for a number of religions. The registered manager told us that they would contact any religious leader for anyone who requested them.

People told us they had been involved in the planning of their care and in making advanced decisions. In the children's unit we found each child or young person cared for had a Keech own resuscitation status form that was updated with the Consultant at least every 12 months and it was checked each time the child or young person was admitted. This form was used for the child and young person who were for active resuscitation and detailed the types of resuscitative interventions agreed with family and the child or young person if appropriate and the medical and nursing team at the service. In the notes we reviewed we saw that people, parents or young people had signed the consent and had been involved in making decisions about their advanced care. Staff we spoke with were aware of each individual person's wishes.

The registered manager told us they had access to an advocacy service if anyone was admitted who required their use. At the time of our inspection no one was using the services of an advocate.

The service ran a number of support groups for people who used the service and their family members. These included; weekly carer support, monthly sibling support, monthly bereavement support and monthly peer support. Family members were also able to access services including; art, music, complimentary therapies and bereavement support as individuals if they preferred one to one support.

Bereavement services were available to all family members after a loved one's death. Condolence letters were sent at set times with a reminder that support could be accessed whenever the family member wished. When a child approached the end of life, or when an adult had a child who needed support bereavement staff would work with the child's school and their friends and class mates. This could be out of class on one to one support or group sessions involving the whole class. There was also a community based bereavement support group which met monthly in a local community church. This was for anyone in the community, not only those who had been involved with the hospice.

Two annual remembrance services were held, one for adults and another for children. The families of all past users of the service were invited. Family members were encouraged to reflect on their loved ones, and special activities were organised such as releasing balloons or planting flowers in memory.

Staff we spoke with were able to tell us how they kept people's information confidential. One said, "We sign a confidentiality agreement when we start." They went on to tell us that the computers were all password protected, and paperwork was kept locked at the nurse's station.

People told us they were given the privacy they wanted. People's privacy and dignity was promoted by staff that ensured that doors were closed when people were being attended to. We observed that they knocked on people's doors before entering and respected people's choices. Rooms had easy access to outside space and we found that the gardens were well maintained, providing a pleasant view and the ability for people to have some fresh air and quiet time. There were lots of areas around the service where people could go alone or with visitors to have privacy. One person we spoke with told us all staff treated them with dignity and respect.

People were encouraged to be as independent as possible. This included staff enabling people to do what they could for themselves but with support where required, attending the day unit or even receiving care and support whilst staying at home.

The staff we spoke with told us that they respected each other in the team, everyone had a role and everyone was important. We observed positive staff interaction and support for each other. They told us they had support from each other and could speak to management or mentors if they needed after a difficult shift.

Visitors were welcomed at any time. We observed visitors at all times during our inspection. The service had facilities for relatives to stay at the service to be close to their loved ones. There were two self-contained flats allowing for whole families to stay and be supported. On the ground floor was a lounge with TV for families to relax. These enabled families to stay close to their loved ones.

One family's thank you letter following the child's end of life care and death at the service wrote: 'You all made [child's name] last days and hours the very best we could have hoped for; you are all amazing.' The Meadow suite could be personalised for each child laying at rest. The staff team or the family could

personalise the rooms or they could work together. We saw evidence documented that for one small child a Thomas the Tank Engine video had been set up in the suite and was continually played throughout the time this child lay at rest on the family's request. The service also had chilled cots for small babies; all of these could be used at the service or could be loaned for use at home for families that would like their child to lie at rest at home for a short period. The registered manager told us they had been used in people's homes which had helped bereaved parents as they had their baby with them at home in a familiar surrounding.

The Pasque room in the adult service was where adults who had dies could rest in a chilled environment so that their families could continue to visit should they wish to do so. The service told us they took care of the child's or the person's body until the family were ready for them to be taken to the undertaker.

The service would also accept referrals from ante natal services where it was expected that a new born would die at birth or shortly after. These families were offered the full hospice service and access to post bereavement care from staff. Staff worked closely with local ante natal services to support families of unborn children with palliative illnesses. There was a pathway in place to enable swift transfer to the hospice after the birth of a child if this was what the parents wished.

Is the service responsive?

Our findings

People told us that their care was personalised and individualised to them. One person said, "I'll be sorry to leave here; this has been a real life saver. I've got the support I need and know when I leave there is an advice line which is good. I can come to the day centre once I have left and socialise, that is what it is all about. They deal with all my needs, physical, emotional and spiritual." Holistic nurse led assessment of needs had been completed to determine a plan of care to support people's goals. For example, pain management or to return home. We found that a regular review of goals had taken place and could be extended to accommodate people's wishes and needs. People were supported in the way they wanted to be. Care plans contained as much of people's life history as well as medical history to assist staff in providing personalised care.

The service had an additional advanced care plan which could be left with the person to complete with assistance from family or staff. This was to assist people with making informed choices about their advanced care plan and future wishes. Staff told us this was a useful document as it often opened up difficult discussions between people who used the service and their families. A senior sister told us that they always advised people to bring in any documentation they already had in place regarding advanced decisions, living wills and lasting power of attorneys. This ensured that the service could act accordingly following the person's wishes. In the children's unit the End Of Life Care (EOLC) pathway detailed step by step how to respond as care needs increased and the child or young person and family's choices. This care plan included a section entitled 'Those little extras that make all the difference' this allowed for such things as a favourite toy to be identified or music, video and what should go into the casket with the child or young person. There was also an End of Life Care Plan used for adults in the in-patient unit. This covered all aspects of care leading up to their death, including information and bereavement needs of the family.

All staff members in the children's unit had undergone symptom control training which include traditional symptom management and also play interventions. For pain assessment the service used three main pain assessment tools, each providing a useful assessment according to the child or young person's ability to verbally communicate and age. They also had a very useful tool for those unable to communicate verbally. The Face Legs Activity Cry Consolability (FLACC) pain scale. We saw evidence of this tool in two care notes and a pain assessment in all notes reviewed. These tools enabled staff to quickly identify changes in pain levels and act accordingly to relieve the pain.

Trained volunteers were employed within the children's area to facilitate or augment play. We observed one volunteer on different occasions reading actively to different children. The All about Me document detailed individually for each child or young person descriptions of what makes them happy or sad and how to respond to these situations. We saw the care team in action using skills and interactions that they had developed for individual children and young people. The service maintained proactive communication with each child or young person's school or college as appropriate. Wherever possible the child or young person was transported to and from school or if required the child or young person's own teacher could go into the service to assess and or teach.

People were encouraged to maintain relationships with friends and family. One of the bedrooms in the children's unit had two beds and is a much larger room, this allowed for siblings to stay together, particularly if both are affected by the same condition, or a well sibling staying with a sibling receiving care and treatment. The service offered different types of support to enable relationships to be maintained including; Toys and Tots a service for under five years old who are not able to access mainstream nursery.

A play specialist worked with children in the children's unit and in the community to deliver specialised play activities tailored to the clinical needs and preferences of the individual child. Children who had difficulty communicating were enabled to use play as an alternative mode of communication and expression.

The provision of both a children's lounge and young people's lounge met the needs of the diverse age groups and needs of those who used the service. The young people's lounge had been developed with input from young people who used the service. It included a surround sound cinema and a pool table. There were a variety of quiet and active areas, along with outdoor spaces for both younger and older children to utilise.

The service had an on-site social worker who was available to help people and their families with the day to day issues of life, for example; assistance with benefits, travel and support. They ensured the correct care package was in place prior to discharge and continued to support the person and their family after discharge when extra help may be required. We saw that a translator had been booked to be at the service for the admission of a child who's family did not speak English. Later in the day we saw they had been involved in the admission process and the child's mother smiled and put up her thumbs to show they were happy. This ensured the child and parents were aware of what was happening. There was a professional interpretation service accessible at all times to ensure communication with the person was precise.

People we spoke with told us staff had all the time they needed, they said, "If I just need to talk I can do, they will stay with me as long as I want them to. Sometimes in the night it can feel lonely, but if you press your buzzer they are here immediately." A staff member said, "I feel I have the right amount of time to really get to know the child or young person and their families, so I can care for them as individuals." Another said, "I am able to give time to each person and their family, including bereaved families, as much time as they need depending on the situation." This showed that the care was centred on the person and was not time bound.

The provider had a complaints policy in place. This was displayed. Throughout the service were complaints forms and boxes to enable anyone to write a complaint and post it at any time. We saw that when people had complained they had been offered a meeting to resolve the issue which was followed up by written feedback. There had not been any recent complaints.

Regular surveys were completed to gain people's feedback of the service. We found they had been analysed to make sure that pertinent points were taken to drive future improvement if required. There had been no negative comments in the results we saw. Some positive feedback comments included; "Thank you is really not enough." "It was an honour and a privilege for my father to receive such wonderful and compassionate care." "You and everyone he came into contact with at Keech enriched his last days." "The care was great and the politeness of staff was amazing."

Positive feedback had also been received from a number of professionals. This included; complimenting how an admission had been carried out and how supportive two particular members of staff had been.

Is the service well-led?

Our findings

Staff told us that they were involved in the development of the service. On the wall at the nurse's station was an easy to read 'Strategy at a Glance 2015-2020' document and the nurses told us that they did feel included in the strategic devolvement of the service. There had recently been some changes in the senior management team, but staff had been involved and told us they were pleased with the changes.

There were strong links with the local community, the registered manager told us the local community carried out a lot of fund raising for them. The service had a number of charity shops within the area which were staffed by volunteers. The registered manager told us that any events they held at the service were supported by people from the community.

Staff told us they were able to question practice if they felt they wanted to, no one was felt to be blamed if errors occurred and everything was used as learning. If a staff member had been named in a complaint a reflection session had been held with the staff member. This showed they were supported through the complaint. As a result staff were aware of their roles and responsibilities and knew who to report to. This enabled the smooth running of the service as staff followed the correct reporting system. We saw in documentation that staff had been supported to report any issues they had or to report any errors they found.

The management team were aware of the day to day activities in the service as they were available and worked in the service. Throughout our inspection we observed staff and managers discussing the service and the provision of care to adults and children. This showed staff were comfortable with the management. The registered manager told us they had an open door policy and anyone could ask to speak with them at any time. Staff we spoke with confirmed this.

There were a number of ways which information was available for staff and people who used the service. A large variety of information leaflets were available including; facilities at the service, assistance with transport, specialist holiday resorts and local support groups. The service produced a quarterly magazine for everyone and a monthly newspaper for staff and volunteers which contained news from the service and they had a website with information to help people. The Chief Executive Officer (CEO) sent out a weekly blog email to all staff which gave news and photographs of anything that had happened the previous week and plans for the coming week. Staff we spoke with told us they liked the blog.

There was a manager in post who was registered with CQC. Information held by the CQC showed that we had received all required notifications. A notification is information about important events which the service is required to send us by law in a timely way.

The service had in place an employee assistance programme which provided practical information, resources and confidential counselling for staff and their families. The service had recently been involved in a project called 'well-being at work' in collaboration with a local university. Staff were given the opportunity to take part in an interview to have a discussion about well-being at work to assist with identifying potential

adjustments in the workplace to enhance staff well-being. Staff we spoke with were aware of both schemes.

The quality and compliance manager told us the service carried out a large number of quality audits including; infection control, accidents and incidents and medication. A small team regularly carried out a site wide inspection looking for safety hazards and speaking with staff to ask if they had any concerns about the work place. Any concerns found were raised with managers to address. These were used to develop the quarterly quality report. This had been produced and presented to the board of trustees, the senior management team, the audit and risk committee and commissioners. Individual reports had been produced for the lead of that area, for example clinical audits to the clinical lead. The quarterly quality report was used to develop the service if any shortfalls had been found. Action plans were developed and completed and reported on in the next quarterly report. Robust records had been kept in every area of the service. These records were used to feed into the quality assurance processes.

Regular trustee visits had taken place. Two of the hospice's trustees walked around the hospice speaking with staff and people using the service to gauge general opinions. Finding from visits were fed back to the trustee board and put into a report.

The registered manager told us they worked closely with Hospice UK and used them for benchmarking. One staff member said, "We are looking to have a holistic approach to share good practice." They had participated in exercises including; falls and medication incidents. This enabled the service to compare themselves with other hospices and the national benchmarks produced. It also gave them the opportunity to keep up to date with best practice.

Following the inspection, the provider sent us additional information. The provider told us, "Keech was instrumental in establishing three local Multi-Disciplinary Team (MDT) meetings for patients with non-malignant diseases, (respiratory, rare neurological and heart failure) in their local region. The MDT's were originally scoped and launched by Keech staff in partnership with local acute trust and community staff. Initially the meetings were chaired by Keech staff but now that they have matured they are chaired by consultants with Keech attending as a regular member.