

St Catherine's Hospice - Scarborough

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Outstanding 

Are services safe?	Good 
Are services effective?	Good 
Are services caring?	Outstanding 
Are services responsive?	Outstanding 
Are services well-led?	Good 

Overall summary

St Catherine's Hospice is operated by St Catherine's Hospice Trust. The hospice currently provides 14 inpatient beds and has the capacity to open up to 16 inpatient beds if the service demands. It also provides a well-being centre and other outpatient facilities. The hospice provides a hospice at home service (in

collaboration with Marie Curie) across the Scarborough and Filey region, specialist palliative care services which includes outpatients and in reach to the acute trust as well as support to local care homes. Outpatient services include a lymphoedema clinic, physiotherapy and occupational therapy services, complementary therapy

Summary of findings

and specialist palliative counselling services which includes a service for families. The hospice also provides a specialist palliative social work service, spiritual care, carer support, education for patients and families and an out of hours telephone support line.

The hospice provides care to adults only although children are included in any family counselling services where appropriate. The hospice cared for 2388 patients from February 2018 to January 2019; 681 were aged 18 to 65 years and 1,825 were over the age of 65. Fifteen children aged from four to 17 were seen through the counselling service offered to families.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 14 May 2019 and 4 June 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

We rated this service as **Outstanding** overall.

- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff completed and updated risk assessments for each patient, risk assessments considered patients who were deteriorating and in the last days or hours of their life. Risk assessments considered patients' capacity dignity and choice.
- Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and its wider network.
- The service provided care and treatment based on national guidance and evidence-based practice.

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients, communicating effectively with other agencies to ensure the best possible care and coordination across services.
- There was individual consultation with patients which ensured that food was appropriate to their individual needs and preferences, so it was appealing to the patient and they were not put off by too large portion sizes.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs to ensure person-centred care.
- Feedback from people who used the service, those who are close to them and stakeholders was continually positive about the way staff treated people. Patients said that staff went that extra mile and their care and support exceeded their expectations. Patient feedback regarding the emotional support from all staff groups and services was consistently, extremely positive.
- There were multiple examples of where staff had gone the extra mile to ensure person-focussed, exceptional care.
- Staff empowered patients and families to be partners in care, practically and emotionally. People's individual needs and preferences were central to the delivery of tailored services.
- The service was proactive in its approach to understanding the health needs of the local population and working with other providers in the local health economy to ensure the service was planned and delivered in a way that met those needs.
- Staff actively encouraged patients to give feedback and dealt with any concerns as far as possible as soon as they were raised. Staff at all levels in the organisation were engaged with improving services as the result of complaints.
- Leaders had the integrity, skills and abilities to run the service. They understood and managed the

Summary of findings

priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills. Staff felt supported and valued.

- The service had a vision and strategy that were focused on sustainability of services and aligned to local plans within the wider health economy.
- All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

However, we also found the following issues that the service provider needs to improve:

- The hospice had undertaken a mapping exercise of safeguarding training with the requirements in the adult and children's intercollegiate guidance. This had identified gaps in adult safeguarding training requirements at all levels and children's requirements at levels one and two. Work was underway to address the gaps but this needed to be implemented and embedded. Safeguarding policies / procedures needed updating with the training levels required for the different staff groups.
- There was an ongoing review of all policies and procedures to bring them up to date with current guidance and best practice and there were still some policies out of date.

- Resuscitation equipment had not always been checked as per the services protocols.
- There was no evidence of actions taken, when medicine fridge temperatures went outside of the required range
- Only 70% of junior registered nurses had received an appraisal in the last 12 months.
- Processes and systems in place regarding; trustee recruitment and oversight/ management of their performance or development needs, audit and performance target setting and monitoring, keeping policies and procedures up to date with current guidance and best practice and oversight of disclosure and barring certificates were not robust.
- There were gaps in information to committees and board to enable full oversight and governance of the service.
- The business continuity plan was a work in progress.

Following this inspection, we told the provider that it should make some improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Anne Ford

Deputy Chief Inspector of Hospitals (Northern Region)

Summary of findings

Our judgements about each of the main services

Service

**Hospice
services for
adults**

Rating

Outstanding



Summary of each main service

We rated the service as outstanding overall. Safe, effective and well-led were rated as good. Caring and Responsive were rated as outstanding.

Summary of findings

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Outstanding



Location name here

Services we looked at

Hospice services for adults

Summary of this inspection

Background to St Catherine's Hospice - Scarborough

St Catherine's Hospice is operated by St Catherine's Hospice Trust. The hospice opened at its current site in 2004. It is an independent hospice in Scarborough, North Yorkshire. The hospice primarily serves the communities of the Scarborough and Filey area. It also accepts patient referrals from outside this area.

The hospice provides inpatient beds, a hospice at home service, specialist palliative care services, outpatient services including a lymphoedema clinic, therapy and counselling services, a specialist palliative social work service and an out of hours telephone support line. The hospice provides care to adult patients and support to their families.

At the time of the inspection, a new manager had recently been appointed and was in the process of registering with the CQC to be the registered manager for the service. A registered manager is a person who has registered with the CQC to manage the service. They have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is run.

St Catherine's was previously inspected by CQC using an adult social care framework in 2016 and was rated as outstanding overall. It was rated as Good for Safe and Effective and outstanding for Caring, Responsive and Well-led.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector and a specialist advisor with expertise in end of life care. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Information about St Catherine's Hospice - Scarborough

The hospice had one inpatient unit which could take up to 18 patients. St Catherine's Hospice Trust is currently registered to provide the following regulated activities at St Catherine's Hospice - Scarborough:

- Diagnostic and Screening Procedures
- Personal Care
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

During the inspection, we visited the inpatient unit, spent time visiting patients with the hospice at home team and a clinical nurse specialist. We spoke with 15 staff including registered nurses, health care assistants, reception staff, medical staff, senior managers and one of the trustees. We spoke with two patients in the inpatient unit and two patients and their family members on home

visits. During our inspection, we observed patient care and interactions and reviewed nine sets of patient records. We also reviewed other information and data about the hospice and provided by the hospice to make our judgements.

There were no special reviews or investigations of the hospice ongoing by the CQC at any time during the 12 months before this inspection. We inspected the service using new methodology on 14 May 2019, our inspection was announced at short notice, to ensure that everyone we needed to speak with was available. We then carried out a follow-up inspection on 4 June 2019.

Activity

The hospice cared for 2388 patients from February 2018 to January 2019; 681 were aged 18 to 65 years and 1,825 were over the age of 65. Fifteen children aged from four to 17 were seen through the counselling service offered to

Summary of this inspection

families. The hospice provided its services to patients under NHS funding agreements. The hospice did not provide any privately funded services as the management team felt this would potentially create a conflict of interests.

The hospice employed a total of 154 staff this included; 10 medical staff employed by the hospice there were a further four trainees who worked under practising privileges. The hospice employed; registered nurses, healthcare assistants, clinical and non-clinical managers a range of allied health and social care professionals and a range of other support and administrative staff. There were 504 volunteers supporting St Catherine's hospice, shops and fundraising activities.

Track record on safety (from February 2018 to January 2019)

- Zero - Never events
- Zero - Serious incidents
- 63 - Clinical incidents; 36 no harm, 24 low harm and 5 near miss. (April 2018 to October 2018)

- Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- Zero incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of hospital acquired Clostridium difficile (c.diff)
- Zero incidences of hospital acquired E-Coli
- Eight - formal complaints
- 152 - written compliments

Services accredited by a national body:

- The service was working towards achieving ISO27001/13 accreditation with regard to information technology and information governance.

Services provided at the hospice under service level agreement:

- Health and safety management for all areas of the hospice trust was provided by another company under a service contract / agreement.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated safe as **Good** because:

Good



- The service provided mandatory training in key skills to all staff and the overall compliance rate was 89% at the 31 March 2019
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well.
- The design, maintenance and use of facilities, premises and equipment kept people safe.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- All staff had access to an electronic records system that they could all update.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and its wider network.
- The service used monitoring results to improve safety.

However, we also found the following issues that the service provider needs to improve:

- The hospice had undertaken a mapping exercise of safeguarding training with the requirements in the adult and children's intercollegiate guidance. This had identified gaps in adult safeguarding training requirements at all levels and children's requirements at levels one and two. Work was underway to address the gaps but this needed to be implemented. Safeguarding policies / procedures needed updating with the training levels required for the different staff groups.
- Resuscitation equipment had not always been checked as per the services protocols, gaps in the records indicated checks were not always made daily or weekly when they should have been.

Summary of this inspection

- There was no evidence of actions taken, when medicine fridge temperatures went outside of the required range

Are services effective?

We rated effective as **Good** because:

- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff gave patients enough food and drink to meet their needs and improve their health. There was individual consultation with patients which ensured that food was appropriate to their individual needs and preferences, so it was appealing to the patient and they were not put off by too large portion sizes.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and clinical supervision was available to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support to help them live well until they died.
- Staff supported patients to make informed decisions about their care and treatment.

However, we also found the following issues that the service provider needs to improve:

- Some policies such as the recruitment of volunteers' policy needed reviewing it did not have an issue or review date.
- Only 70% of junior staff nurses had received an appraisal in the last 12 months.

Good



Are services caring?

We rated caring as **Outstanding** because:

- People were truly respected and valued as individuals and were empowered as partners in their care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Outstanding



Summary of this inspection

- Feedback from people who used the service, those who are close to them and stakeholders was continually positive about the way staff treated people. Patients said that staff went that extra mile and their care and support exceeded their expectations.
- Staff prioritised the individual needs of patients by ensuring that they understood how they could help the patient and demonstrated innovative ways to meet their needs.
- Staff could provide multiple examples of where they had gone the extra mile to ensure person-focussed, exceptional care.
- Staff provided emotional support to patients, families and carers to minimise their distress. Staff recognised and respected the totality of people's needs. They always took people's personal, cultural, social and religious needs into account.
- The hospice provided emotional support to patients and their relatives through offering a range of psychological support options. Patient feedback regarding the emotional support from all staff groups and services was consistently, extremely positive.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who used the service, those close to them and staff were strong, caring and supportive. These relationships were highly valued by staff and promoted by leaders
- People who use services are active partners in their care. Staff are fully committed to working in partnership with people and making this a reality for each person. Staff always empower people who use the service to have a voice and to realise their potential. They show determination and creativity to overcome obstacles to delivering care. People's individual preferences and needs are always reflected in how care is delivered.
- People's emotional and social needs are highly valued by staff and are embedded in their care and treatment.

Are services responsive?

We rated responsive as **Outstanding** because:

- Services were tailored to meet the needs of diverse groups of people and were delivered in a way to ensure flexibility, choice and continuity of care.

Outstanding



Summary of this inspection

- People's individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care.
- The involvement of other organisations and the local community was integral to how services were planned and ensured that services met people's needs. There were innovative approaches to providing integrated person-centred pathways of care that involve other service providers, particularly for people at the end of their life including those with multiple and complex needs.
- There was a proactive approach to understanding the needs of diverse groups of people and to deliver care in a way that met those needs and promoted equality. This included people who were in vulnerable circumstances or who had complex needs.
- Patients could access the specialist palliative care services when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.
- There was active review of complaints and how they were managed and responded to, and improvements were made as a result across the services. People who used services were involved in the review.
- Staff actively encouraged patients to give feedback and dealt with any concerns as far as possible as soon as they were raised. Staff at all levels in the organisation were engaged with improving services as the result of complaints.

Are services well-led?

We rated well-led as **Good** because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.
- Staff felt supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Good



Summary of this inspection

- The service had a clear governance structure. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact.
- The service collected a variety of data and analysed it to understand performance in specific areas, make decisions and improvements.
- The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

However, we also found the following issues that the service provider needs to improve:

- We were not assured that the processes and systems in place regarding trustee recruitment, audit and performance monitoring and oversight of essential human resource information such as training data and currency of disclosure and barring certificates were robust.
- Key performance information presented to the board and committees tended to be around activity and lacked analysis to easily identify themes and trends or to monitor or benchmark performance. There were gaps in the information provided to committees and board needed for thorough governance.
- The business continuity plan was a work in progress.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospice services for adults	Good	Good	<div>☆</div> Outstanding	<div>☆</div> Outstanding	Good	<div>☆</div> Outstanding
Overall	Good	Good	<div>☆</div> Outstanding	<div>☆</div> Outstanding	Good	<div>☆</div> Outstanding



Hospice services for adults

Safe	Good
Effective	Good
Caring	Outstanding
Responsive	Outstanding
Well-led	Good

Are hospice services for adults safe?

Good



We rated safe as **good**.

Mandatory training

- The service provided mandatory training in key skills to all staff and the overall compliance rate was 89% at the 31 March 2019
- The mandatory training was comprehensive and met the needs of patients and staff.
- Mandatory training topics included the Mental Capacity Act and deprivation of liberty, safeguarding children and adults, moving and handling, complaints, infection prevention and control, equality and diversity, fire safety, cardio-pulmonary resuscitation and medicines management. The training was a mixture of e-learning and face-to-face sessions.
- The overall compliance rate for nursing and medical staff at the hospice was 89%.
- The hospice wanted to achieve 100% compliance with mandatory training. The training target was not met but compliance with most modules was over 85% with the exception of safeguarding children which was 72% and equality and diversity which was 77%.
- Managers monitored mandatory training however there was no systematic process in place to monitor compliance and this data did not appear in clinical governance committee or board minutes.

- Staff we spoke with said that they were up to date with their mandatory training and they received reminders when training was due or when training had expired.
- There was a structured induction process for staff to ensure they had the skills needed for their roles. All staff including bank staff were provided with induction and orientation to their work area, mandatory training and there were series of individualised competences for staff of different roles to work through.

Safeguarding

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We observed one member of staff appropriately making a safeguarding alert due to their concerns regarding how a patient's finances were being managed.
- Staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us they discussed any safeguarding cases at their monthly staff meeting and as part of their reflective / clinical supervision sessions.
- The service made appropriate alerts, notifications and raised concerns to safeguard their patients.
- The service had safeguarding procedures for children and vulnerable adults, which were accessible to staff on the shared intranet. While the procedures gave clear guidelines for what staff should do if they suspected abuse and where to access support and



Hospice services for adults

information the children's procedures were not in line with intercollegiate guidance: 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff' (March 2014) with regard to training.

- The safeguarding adult's procedure included information on level of training for staff in different roles; awareness level – for all staff including shop volunteers, alert level for all staff with patient contact and responder / referrer level for medical, nursing and other clinical staff. Training requirements needed to be in line with intercollegiate guidance 'Adult Safeguarding: Roles and Competencies for Health Care Staff: August 2018' and this was not clear.
- We saw evidence that managers had already mapped their current training to the intercollegiate guidance for adults and children and had identified the gaps and how they could meet the training requirements going forward.
- The service reported that 99% of staff involved in the care of adults had been trained to Safeguarding Vulnerable Adults Level 1 and 65% had been trained to Level 2.
- The overall training compliance for children's safeguarding training at 31 March 2018 was 72%. Managers told us the rate was low because of the gaps identified in the mapping exercise as they were looking at alternative ways of providing training. This exercise had now been completed so it was expected training compliance would soon increase.
- The service had a safeguarding lead for adults and children and staff knew who to go to if they needed advice or support. The service safeguarding lead was trained to level 3.
- The service reported that there was only one counsellor working directly with children and they were trained to level 3 in in safeguarding children.
- The service monitored and recorded which patients had appointed people with lasting powers of attorney which ensured all staff were aware who was able to make decisions on behalf of their patients and in what capacity.
- All clinical staff and other staff working in direct contact with patients were checked through the disclosure and barring service prior to being

appointed. The policy was that these checks were made again every five years. It was difficult to establish that all staff had current checks as the service was transitioning from a paper human resource system to an electronic one. However, the random staff files and IT records we looked at did show those staff members had checks that were in date. The managers will be able to have clear oversight of currency of disclosure and barring certificates when all staff records are on the new system.

- The hospice was unable to evidence safeguarding training and current checks for all the trustees on our first visit. Managers were sure these would have been completed on appointment but some may have been carried out more than five years ago. However, by our return visit all trustees had made new applications for the checks to be renewed and managers provided assurance that trustees were to complete safeguarding training on an annual basis in line with other staff.
- The hospice management team had recently decided to and had carried out disclosure and barring service checks for all volunteers working in the St Catherine's shops and had also provided safeguarding awareness sessions for these staff.

Cleanliness, infection control and hygiene

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- All ward areas were clean and had suitable furnishings which were clean and well-maintained.
- We found that areas we visited were visibly clean and tidy. We reviewed a recent patient led assessment of the care environment which had some minor issues noted for improvement.
- Cleaning records were up to date and demonstrated
- During the inspection, we observed that staff were compliant with hand hygiene policies, including 'bare below the elbows and personal protective equipment practices.



Hospice services for adults

- Facilities for hand hygiene were available throughout the service, staff and visitors we saw were compliant with use.
- Staff we spoke with said that they had access to personal protective equipment (PPE). We observed staff using gloves and aprons appropriately.
- Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Reusable equipment we reviewed such as commodes were clean, labelled as clean and ready for use and well maintained. Toilets in empty rooms were also labelled to provide assurance to patients that the area had been cleaned and was ready for use.
- All staff were expected to undertake training in infection prevention and control, compliance with training at the 31 March 2019 was 87%.
- All rooms were single occupancy so were available for patients requiring isolation.
- There was an annual programme of 16 infection, prevention and control audits in clinical and non-clinical areas. The consolidated audit report for 2018 - 2019 showed compliance levels in the majority of areas were above 90%. Compliance with hand hygiene, protective equipment and care of the deceased patient were all at 100%. Any areas of non-compliance were noted for improvement actions to be taken.
- Managers told us they had sought the advice and support of the local hospital domestic supervisory staff to help develop cleaning standards for the turnaround of beds and patient rooms.
- Between February 2018 and January 2019, the service had no instances of the following healthcare acquired infections Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive Staphylococcus aureus (MSSA), Escherichia coli (E-coli) or Clostridium Difficile (C. Diff).
- Patients could reach call bells and staff responded quickly when called.
- The service had enough suitable equipment to help them to safely care for patients. Community staff told us they could get a same day delivery for essential equipment and they were able to 'fast track' other equipment which would be received within a week.
- Staff disposed of clinical waste safely. We saw appropriate processes for segregation of waste, including colour coded waste and facilities for disposal of sharps. We saw that community staff used single use sharps bins.
- Resuscitation equipment was available for staff to use, this was stored behind a locked door, however all staff had electronic access fobs. Resuscitation equipment we checked was clean and ready for use. There was a checklist held separately from the equipment but there were gaps in the records that indicated equipment was not always checked as regularly as it should.
- The inpatient unit was secure with restricted access to authorised staff, patients and visitors.
- Staff we spoke with said that they had adequate stocks of equipment and we saw evidence of stock rotation. All storage areas were clean, well-organised and stock was stored off the floor. The hospice at home team had a process in place for ordering and control of stock.
- We reviewed five pieces of equipment and found they had all been safety tested within the last 12 months.
- All rooms were decorated and well maintained, rooms all had access to patio doors opening on to garden areas. They all had en-suite facilities and hoists, static or mobile to enable staff to move patients safely.
- Two separate bedrooms with en-suite facilities and a relative's lounge had been allocated for families and carers to use as required.

Environment and equipment

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- The service had suitable facilities to meet the needs of patients' families.

Assessing and responding to patient risk

- Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.



Hospice services for adults

- On admission to the inpatient unit staff held discussions with patients regarding expected and unexpected deterioration to establish patients' wishes and determine ceilings of care. Discussions and ceiling of care was clearly documented in the patient records we looked at. This information was included in the handover notes so all staff knew what to do in the event of an acute deterioration. In the event of an acute deterioration, depending on the category of the patient an initial assessment would be completed by a doctor and if it was appropriate the patient would be transferred to an acute hospital by a 999 ambulance.
- There was a clinical emergency procedure in place for patients who became acutely unwell when attending outpatient services or the well-being centre.
- Staff we spoke with were knowledgeable about when to escalate a deteriorating patient and knew how to implement procedures to ensure timely and appropriate treatment.
- Staff completed risk assessments for each patient and updated them when necessary. Risk assessments undertaken included falls, confusion, nutrition and pressure ulcers. We found that risk assessments and care plans were reviewed and updated weekly or sooner if the patient's condition changed significantly. Risk assessments were recorded on the patient's electronic record which could be accessed by all hospice nursing and medical staff and paper copies were left with the patient when receiving care in the community.
- We reviewed risk assessments in five sets of inpatient records, in all sets of notes we reviewed we found these were fully completed.
- Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be suffering with mental health problems.
- Staff shared key information to keep patients safe when handing over their care to others.
- Shift changes and handovers included all necessary key information to keep patients safe. Discussions included patients' capacity and identified patients who needed extra support with decision making and advance care planning. Referrals were discussed and rated Red, Amber or Green to enable staff to prioritise admissions to the hospice inpatient unit.
- Inpatient unit and hospice at home staff attended a safety huddle each morning to handover care. Staff identified patients of concern, patients requiring referral to other services, they discussed safety alerts and highlighted risks any other risks staff needed to be aware of.
- Managers told us they had discussed ligature risks within the hospice with a colleague from the local mental health trust following a national safety alert. Staff had arranged to visit the Cross Lane Hospital in June 2019 to learn about any safety improvements they could make at the hospice.
- The service used a cross-boundary 'do not attempt cardio-pulmonary resuscitation' (DNACPR) form which was recognised in the hospital and across primary care services. The registered nurses were trained to have these conversations with patients and relatives and the clinical nurse specialists or a doctor would revisit the patients' decisions and complete the appropriate documentation.
- Advance care plans were discussed and documented in the patient's electronic record.
- Community staff had an emergency folder for easy access to contacts and information they may need in an emergency situation.

Nurse staffing

- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.
- The service had enough nursing staff of all grades to keep patients safe.
- The service had benchmarked their inpatient unit staffing levels with other hospices in 2018 and 2019, to ensure that they were appropriate, staffing levels were checked daily at the safety huddle meeting. Any concerns were escalated following this meeting.



Hospice services for adults

- Managers used a staff care tool to rate staffing levels as red, amber or green and used the 'Mary Potter Hospice Nursing Acuity Tool – In Patient Unit' to review the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift.
- We reviewed the staff care system and found that the number of nurses and healthcare assistants matched the planned numbers for almost all the shifts over the previous two months.
- The clinical services manager could adjust staffing levels according to the needs of patients. Staff worked flexibly across the community and inpatient teams and any shortfalls were covered by staff movement, staff working additional hours and by using the hospice bank staff. Agency staff could be arranged but managers told us there was rarely a need for this.
- The clinical nurse specialist team had undertaken a bench marking exercise with other similar services in the Yorkshire region to look at caseload size, population and time of patients on the caseload. Caseload size was much larger than their peer group as was the time spent on caseload, there were similar ratios of staff to population size. Because of this benchmarking exercise the team were going to review how they were managing their caseloads to see if they could manage this differently.
- The hospice at home team recorded their visits on a shared calendar and could ring in to the centre if they needed to know where other staff were if they needed assistance from another member of the team. The team had an escalation plan if they were under pressure of workload and needed additional staff.
- The hospice had lone worker and bad weather plans in place for community staff. All staff logged in and out when they entered the building. night visits were always undertaken by two members of staff.
- The service had low vacancy and sickness rates among clinical staff. The only vacancies in February 2018 were for a part time pharmacist and a part time therapy support worker. The highest area for sickness was the inpatient unit whose rate was 3.6%, the hospital at home rate was 0.5%.
- The hospice had not used any agency staff to cover nursing or therapy shifts from February 2018 to January 2019. The hospice did not provide data for bank staff use as these were their own contracted staff.
- Managers limited their use of bank and agency staff and requested staff familiar with the service. The hospice at home staff told us the bank staff who worked with them worked regularly and were familiar with the service.
- Staff told us they received an induction when they started working for the hospice and had a local induction specifically for the hospice at home service. Bank and agency staff received an induction when they started working for any of the hospice teams.
- The leadership team acknowledged that it was challenging to recruit and retain staff due to a variety of factors and had identified some improvements that could be made to help them recruit and retain staff.
- The hospice provided placements for student nurses from the local university and were also training three nursing associates.
- We saw from staff files that the recruitment process was thorough and all the necessary safety checks were undertaken.

Medical staffing

- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- The service had enough medical staff to keep patients safe. The service had recently undertaken a safe staffing review in line with the Royal College of Physicians Guidance and was compliant with recommendations.
- The service always had two medical staff on-call providing 24 hour – seven day a week cover, there was always senior specialist palliative care advice available from a consultant on-call.
- Handover of information was both verbal and written and included ceilings of care.



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- The service had 0% vacancy and sickness rates for medical staff from February 2018 to January 2019. There had been no need for locum use as shifts were covered by substantive staff and specialists working under practising privileges when needed.
- The hospice supported medical training programmes in relation to palliative care. Medical trainees came from GP and acute medical training programmes and the hospice worked with the deanery and medical school to ensure placements were meeting the needs of the trainees.

Records

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.
- Patient notes were comprehensive and all staff could access them easily.
- When patients transferred to a new team, there were no delays in staff accessing their records
- Records were stored securely
- Hospice at home staff used both electronic and paper records as they left patient held records for patients' families and other care providers to refer to.
- Electronic records were available for all patients. We reviewed five sets of records during the inspection and saw that these were appropriately completed. Risk assessments, care plans and daily records were all documented and updated as they should be.
- We did not see a specific records audit in place but we did see that records were audited for specific purposes such as collecting outcome data and that any gaps or errors found were acted on.

Medicines

- The service used systems and processes to safely prescribe, administer, record and store medicines.
- Staff followed systems and processes when safely prescribing, administering, recording and storing

medicines. There was an accountable officer within the hospice and the local NHS trust provided advice and support, which was available 24 hours – seven days a week, and an independent review of processes through quarterly audits. The hospice was in the process of recruiting their own pharmacist.

- Staff stored and managed all medicines and prescribing documents in line with the provider's policy.
- Medicines including controlled drugs were stored correctly with access restricted to authorised staff; they were checked in line with the policy and there were no discrepancies in controlled drug registers. Controlled drugs were audited by the nurse in charge of the inpatient unit on a daily basis and the local trust pharmacist completed a quarterly audit.
- Medical gases we reviewed were all stored appropriately in designated holders.
- The temperature of fridges used to store medicines were recorded, however there was no evidence of actions taken, if the temperature went outside of the expected range.
- We reviewed two medicine administration charts and noted that medicines were prescribed and administered in line with national guidance.
- Staff received competency based training in medicines which was included hospice and care home regulations and competency was reassessed annually. Hospice at home healthcare assistants were trained to be able to counter sign for administration of medicines via a syringe driver.
- Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. Medical staff could access medicines information for patients newly transferred patients from the local NHS trust through remote access to the trust's electronic prescribing system to enable medicines reconciliation.
- An audit of medicine charts August to November 2018 showed 31 errors, the commonest error was 'not correctly crossing off medication'. Action was taken to alert medical staff of the results of the audit and



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highlight the need to ensure medicines were correctly crossed out if no longer needed or if the dose had had changed. This audit was to be repeated to monitor if improvements had been made.

- Other medicine audits were taken in the hospice at home service in April / May 2018, observational audits of controlled drug administration in February 2019 and no major issues were identified.
- We found that 11 of the reported incidents from April 2018 to October 2018 were in relation to controlled drugs but we were not made aware of any themes or actions taken with regard to these incidents.

Incidents

- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service had an incident reporting policy, this provided staff with information about reporting, escalation and investigating incidents. The 'Incident Management and Reporting Policy and Procedure' gave a clear direction for managing serious incidents, notifiable safety incidents and duty of candour.
- From February 2018 to January 2019 the service reported zero never events.
- From February 2018 to January 2019 the service reported zero serious incidents. the NHS England Serious Incident Framework 2015.
- From April 2018 to October 2018 the service reported 63 incidents. Of these 36 were no harm, 24 were low harm and 5 were a near miss.
- The largest categories of incidents were falls (34) and controlled drug related incidents (11) we saw that staff at the hospice had undertaken a review of falls to identify the most common causes and contributing factors. There were a number of factors to be considered for potential ways of reducing falls. The hospice had taken some actions to reduce the number of controlled drug errors

- Staff we spoke with said that there was a positive reporting culture in the service and learning from incidents was shared with staff through individual conversations, emails, team meetings and huddles.
- All staff we spoke with knew what incidents to report and how to report them. Staff gave us examples of incidents they had reported, including an incident that did not result in any patient harm but was an opportunity for learning. They were able to tell us how this incident had led to additional training regarding diabetes and self-medication of insulin at the end of life to incorporate a need to ensure family members were trained and able to continue administration of insulin if this was required.
- Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The Duty of Candour (DoC) is a legal duty to inform and apologise to patients if there have been mistakes in their care that has led to moderate or significant harm.
- Managers debriefed and supported staff after any serious incident. We were informed of a serious incident when staff had been offered support from others within the hospice and from partners in the hospice network.
- Managers investigated incidents thoroughly. Patients and their families were given the opportunity to be involved in these investigations if they wished.
- Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us about incidents they had reported about syringe drivers. They had received feedback from the incidents and were aware of any learning
- Feedback from incidents was shared in team meetings and improvements to patient care were looked at.
- There was evidence that changes had been made as a result of feedback. Following a recent serious incident, the service had shared learning from the incident through educational sessions, improved policies and protocols, simulations and improved access to required equipment. Staff we spoke with were aware of the incident and confirmed that these improvements had been shared.

Safety Thermometer (or equivalent)



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- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.
- 'The service continually monitored safety performance' by monitoring pressure ulcers and falls and by using root cause analysis to identify if any of these incidents were preventable and what could be done to reduce the risk of these in the future.

Are hospice services for adults effective? (for example, treatment is effective)

Good



We rated effective as **good**.

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients in their care.
- People's physical, mental health and social needs were holistically assessed by the service and care and treatment was delivered in line with legislation, standards and evidence-based guidance.
- Patients had a clear personalised care plan that reflected their needs and was up to date. Staff delivered care to patients in the last days of life that met the 'five priorities of care of the dying person' in line with NICE guidance and quality standard for 'care of dying people in the last days of life'. Individual care plans took account of symptom control, psychological, social and spiritual support and we saw evidence of discussion with patients and relatives recorded in care plans. This gave us assurance that care plans were agreed and developed with the consent of the patient.
- The service monitored the review of National Institute of Clinical Excellence (NICE) guidance and Medicines and Healthcare products Regulatory Agency (MHRA) alerts.
- Anticipatory medicines for distress, agitation, seizures and pain were prescribed and given in line with NICE guidelines for care of the dying adult in the last days of life and palliative care for adults.
- Patient's visited by the hospice at home or clinical nurse specialist teams and attending the hospice in both the day therapy service and inpatient unit had the opportunity to develop an advance care plan.
- Opportunities to participate in benchmarking, peer review, and research were proactively pursued. The service worked closely with the local NHS research teams, when participating or planning research projects.
- The service was committed to participation in national research and innovation projects to benefit their patients. We saw that research projects were chosen with care to ensure the contribution and learning would be of benefit to palliative care patients and or their families. The hospice had taken part in a C change project to help develop and validate a patient-centred, classification for adult palliative care provision, with the aim of reliably reflecting the complex needs and concerns of patients and families, in order to enable the delivery of better quality and more efficient care in the last year of life. The hospice had also been involved in a delirium project over the past few years and results were due to be published soon. Two further projects were being considered by the hospice; a body image study and the 'Resolve' project regarding improving health status and symptom experience for people living with advanced cancer. Any proposed projects and ethical considerations were deliberated by the executive team and the governance and compliance committee before being agreed.
- Although the hospice was not registered to use the formal Gold Standards Framework, due to cost restraints the hospice has adopted its principles in the development of their model of support and education for the care homes and GPs. The hospice was also supporting GP practices to achieve local 'Daffodil Standards' which are similar to the Gold Standard Framework standards.



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- Community Specialist Teams attend Gold Standards Framework multidisciplinary team meetings for the GP practices they cover.
- At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.
- The hospice had started an incremental review of all policies and procedures in 2018 in partnership with an external provider. We saw that some policies such as the recruitment of volunteers' policy still needed reviewing as they did not have an issue or review date. Safeguarding procedures also needed to be updated with current guidance regarding staff training.
- When new protocols or guidelines were issued staff were expected to sign a declaration that they had read and understood them. The process for ensuring staff had read and understood policies also included a process for asking questions if anything was unclear.

Nutrition and hydration

- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.
- Staff made sure patients had support with nutrition and hydration to meet their needs.
- We saw that staff were available to provide support to patients that needed assistance with food as required.
- Staff fully and accurately completed patients' fluid and nutrition charts where needed.
- Staff used a modified screening tool to monitor patients at risk of malnutrition and risk assessments were completed for patients requiring thickeners in food or fluids.
- Specialist support from staff such as dieticians and speech and language therapists* was available for patients who needed it.
- Patients and relatives, we spoke with, spoke with genuine pleasure about the food and drink choices available in the service.
- A patient told us that a member of the catering team had been to see them to discuss their likes and dislikes and portion sizes. This had ensured that food presented was appealing to the patient and that they were not put off by too large portion sizes.
- Patients were able to choose to have lunch in a variety of places for example, own bedrooms, patient dining room, garden or general dining room if they wanted to eat with their relatives.
- Menus were seasonal and varied fortnightly and staff provided patients with assistance to choose from the menu daily. Menu forms were completed to give additional dietary needs such as level of texture modification needed, allergies, assistance needed or any other individual dietary needs. The hospice had a dysphagia working group consisting of clinical and catering staff who had helped trial and taste test (with patients) a range of modified texture diets.

Pain relief

- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.
- Patients received pain relief soon after requesting it.
- Staff prescribed, administered and recorded all pain relief accurately.
- We saw patients being offered pain relief on a regular basis, patients and relatives we spoke with said that pain relief was offered regularly and following administration staff checked that it had worked.
- Patients we spoke with said that staff responded quickly to their requests for pain relief, and that staff reviewed their pain relief if it was not working effectively.



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- One patient being cared for at home told us that the nurses visited regularly to 'get on top of pain management.'

Patient outcomes

- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieve good outcomes for patients.
- Information about the outcomes of patient care and treatment was routinely collected and monitored.
- Patients were reviewed regularly by multi-disciplinary teams regarding symptom management. The hospice used 'Outcome Assessment and Complexity Collaborative' (OACC) outcome measures to measure and improve care for patients and families
- The service managers told us they audited practice against national and regional standards of care in clinical and non-clinical areas and that this included collecting information on advance care planning, do not attempt cardio-pulmonary resuscitation and achieving eye donation. However, we did not see that this information or OACC measures were compared with peers or set standards.
- The service audited its own performance in 2018/2019 against the five priorities in the NICE guidance for the Care of the Dying Patient. The audit identified a need to improve some elements of care in relation to assessment and care planning particularly in relation to bowels and nutrition and the spiritual and cultural needs of patients and carers and the documentation of discussions of various aspects of care and treatment. The service had developed a number of recommendations and actions to improve achievement of the desired standards.
- Patient outcomes were recorded on System One and included; mental capacity assessment, preferred place of death and Karnofsky scores. The Karnofsky Performance Scale classifies patients as to their functional impairment. The score is used to compare effectiveness of different therapies and to assess the prognosis in individual patients. Each patient was given a Karnofsky score when they were discussed at the community and IPU multidisciplinary meeting. However, scores were not collated by the service or reported on in any other forum and therefore the service was not benchmarking these or the outcomes.
- The hospice was able to provide data on how many people had DNACPR forms in place, how many patients had care plans that set out their advance care preferences and the number of people who had an advanced decision / directive in place. This information was used to improve local practice.
- The service provided a care homes team who delivered training and support to nursing and residential homes in the locality. Part of the service involved devising a development plan for each home to accommodate team building and their specific training and development needs.
- Following input from the hospice team improved outcomes were seen in advanced decision making, DNACPR forms in place and advance care plans in care home patients. Of the patients with a recorded preferred place of death this was achieved in 100% of cases from April 2018 to October 2018.
- The hospice at home team had also achieved preferred place of death in over 90% of cases in April and May 2018 and in 100% of cases from June 2018 to October 2018.
- Audits of moving and handling in the community demonstrated actions taken and improvements in subsequent audits.
- The lymphoedema team had audited patient knowledge about their condition and how to care for their skin integrity, how to identify and care for minor wounds and how to spot signs of infection and when to seek clinical advice. The results of the audit had indicated that patient knowledge and self-care was better when knowledge / education was current but practices slipped over time. The findings of the audit had led to actions to improve education of patients by reinforcement at every contact, testing of knowledge and provision of an educational leaflet.
- We found that the service had audited falls from January to June 2018, the audit identified a few areas and actions to be taken to reduce the number of



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patient falls. Staff were looking at the possible actions from their findings to establish how actions may affect patients' self-care and how this may impact on a person's dignity and choice.

Competent staff

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice.
- Staff were encouraged to network and attend local, regional and national learning events and conferences to share and bring back examples of good practice and information about clinical developments / initiatives and any changes to or new best practice guidelines.
- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers made sure staff received any specialist training and the clinical supervision required for their role. Staff worked towards achieving and maintaining competence in end of life and specialist palliative care.
- Registered nurses in the hospice at home team and clinical nurse specialists had undertaken a course in 'Advanced palliative care'.
- Staff told us they worked to NHS north of England Clinical Network palliative care guidelines which they were all given and had signed to declare when they had read and understood them.
- Managers gave all new staff a full induction tailored to their role before they started work. Staff were assessed against established competency frameworks.
- Managers supported staff to develop through yearly, constructive appraisals and clinical supervision of their work.
- From February 2018 to January 2019 100% of doctors, senior staff nurses and clinical nurse specialists had received an appraisal in the last 12 months. Appraisal compliance for allied health professionals, health care

assistants and staff nurses were 90%, 88% and 70% respectively. Staff we spoke with told us their appraisals were up to date and they also received a mid-year review.

- Re-validation was monitored and staff were alerted as this approached the due date. All medical and nursing staff had their registration status checked and all held current professional registration.
- Staff told us that their competence / practice was intermittently observed through 'shadow visits' where they were accompanied by another member of staff who observed their practice and provided feedback.
- Counsellors, clinical nurse specialists and clinical educators supported staff learning and development, facilitated clinical supervision and reflective practice. Managers ensured staff had access to debriefing and counselling when appropriate, for example following a serious incident.
- Staff told us they received regular clinical supervision and they could discuss any topic they felt they needed to during these sessions. Staff told us they could also attend group reflective sessions at the hospice and that these were held six times a year. Social work staff were members of the National Association of Palliative Care Social Workers.
- Clinical nurse specialists aimed to have 1:1 supervision every two months to reflect on their practice.
- There was a strong focus on education, both internally for hospice staff and externally for other providers of care and the service saw their role in development and delivering education as fundamental to their role.
- Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.
- Staff we spoke with confirmed that they received opportunities to attend further courses and educational sessions relevant to their work.
- Staff who were trained to verify death renewed their competencies annually. Training competencies were based on NICE guidance.



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- Staff told us there were special interest / link nurses across a range of topics which included; infection prevention and control, continence, wound care and dementia. The link nurses provided support and training updates to the rest of the staff.
- The manager of the counselling team was developing an educational module for staff regarding mental health to raise staff awareness, knowledge and confidence in dealing with patients with mental issues such as anxiety and depression.

Multidisciplinary working

- All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Staff were committed to working collaboratively and worked across health care disciplines and with other agencies when required to care for patients.
- There was a holistic approach to planning people's discharge, or referral to other services. Arrangements fully reflected individual circumstances and preferences.
- Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.
- There were established multi-disciplinary meetings for discussion of patients, including patients who had died or been discharged. Staff who attended the meetings included representatives from the acute and community hospice teams, therapists and counsellors, medical staff and social care. Patients' capacity or need for capacity assessment and advanced decisions including DNACPR were noted and discussed, best interest decisions and deprivation of liberty applications were initiated if needed.
- The multi-disciplinary team discussed patients current care, symptom management, treatment needs and initiated plans for patients' discharge where appropriate. The discussion was holistic covering the needs of the family and whether there were any financial needs the team could help with. Social team members were able to help with finances and facilitated patients and families with accessing benefits and grants and voluntary support for families and carers.
- The multi-disciplinary team also used the meeting to discuss deaths and reflect on practice or if anything could have been done differently. The medical director told us if there were any communications from coroners or other external bodies that required action, investigation or to share learning then this was shared through this forum.
- Staff we spoke with said that teams from all staff disciplines were supportive and they had positive working relationships.
- Medical staff described effective working relationships with GPs and colleagues in the Acute hospital and gave examples of how they worked together to provide the best possible patient experience and seamless transitions through the patient pathway.
- We observed that the inpatient hospice team and the hospice at home team worked effectively together. The hospice at home team provided its services in partnership with Marie Curie and worked closely with the community adult nursing services in the areas it covered.
- Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.
- Patients and relatives had access to specialist teams within the hospice such as social workers, counsellors, spiritual coordinators, occupational therapy, physiotherapy and lymphoedema (chronic swelling) teams.
- Staff in the service held daily huddles to pass on key information.

Seven-day services

- Key services were available seven days a week to support timely patient care.
- Consultants led daily ward rounds on all wards, including weekends.
- Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.
- Junior medical staff were available seven days a week, with out of hours access available to senior medical staff.



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- Access to senior nursing staff was available seven days a week, including out of hours to provide support and assistance to junior staff.
- Pharmacy services were available out of hours through the local NHS trust.

Health promotion

- Staff gave patients practical support to help them live well until they died.
- The service had relevant information promoting health and offering support.
- Staff assessed each patient and family's health needs when admitted and provided support for any individual or family needs identified.
- Display boards and leaflets were available on a variety of topics to enable patients and their families to live well and access appropriate avenues of support.
- Patients had access to the wellbeing centre, which offered services such as complementary therapy. Patients' relatives had access to counselling and bereavement support.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty, where necessary.
- The hospice had a trained mental capacity act and deprivation of liberty safeguards lead, who the staff could go to for advice and support when needed.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and they knew who to contact for advice.
- Consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing. Staff we spoke with said that they always obtained verbal consent, prior to carrying out care and treatment for. Patients, patients and relatives we spoke with confirmed this.
- When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.
- The Mental Capacity Act (MCA) 2005, is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over. Following a capacity assessment, where someone is judged not to have the capacity to make a specific decision, that decision can be taken for them, but it must be in their best interests. Staff we spoke with could give a clear explanation of capacity assessment and the importance of recognising how ill health could impact on patients' capacity. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.
- Registered nurses in the hospice at home team could undertake a 'mini mental capacity assessment' which they then asked the patients' GP to follow up.
- The Mental Capacity Act allows restraint and restrictions to be used but only if they are in a person's best interest. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are Deprivation of Liberty Safeguards (DoLS). Staff we spoke with were aware of the legislation around deprivation of liberty safeguards.
- Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff recorded on their system whenever patients who were subject to a Deprivation of Liberty Safeguards accessed their helpline services.
- Staff told us that advanced decisions to refuse treatment were also documented in patients' records where relevant.
- Staff could describe and knew how to access policy and get advice on Mental Capacity Act and Deprivation of Liberty Safeguards.



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- Compliance with Mental Capacity Act and deprivation of liberty safeguards training was 85% at 31 March 2019.

Are hospice services for adults caring?

Outstanding



We rated caring as **outstanding**.

Compassionate care

- People are truly respected and valued as individuals and are empowered as partners in their care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- People were respected and valued as individuals and were empowered as partners in their care.
- Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff always did their utmost to maintain dignity and privacy.
- There was a strong patient centred culture in the service. Care plans detailed patients' preferences and protected characteristics. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between patients and staff were strong, caring and supportive. These relationships were highly valued by staff and promoted by the leaders of the service.
- Staff used bespoke end of life documentation which helped them focus on priorities of care, which included bereavement follow up for families.
- Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. They understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs, always taking them into account.
- Patients and relatives, we spoke with said that staff had made them feel very welcome. They said, 'what the staff do is marvellous and they are worth their weight in gold.'
- Patients and relatives, we spoke with, all confirmed that staff were kind, caring, helpful and attentive. Patients also said that nothing was too much trouble for the staff and that no matter how busy staff were they were able to make time for them. Patients told us they received excellent support from the clinical nurse specialists and had provided them with emergency and helpline numbers and support group information for their families.
- Patients, relatives and staff we spoke with all said that support was provided to patients on an individual basis and in line with patients' individual needs, for example they shared stories about animals visiting the hospice, dogs and cats staying in the hospice and families being able to visit and stay over without restriction.
- One patient told us their wife and dog had been able to stay with them overnight during a previous admission to the hospice.
- Patients told us nurses and doctors responded quickly to any request they made for assistance or for review of symptoms / symptom management.
- One patient who had been attending the lymphoedema clinic wrote that from their first referral in 2013 the nurse had 'been kind, considerate, reassuring, informative, patient, sympathetic and knowledgeable when showing me how to care for my skin'. This was typical of the comments and written feedback received by the patients using not only the lymphoedema clinic but the other services.
- We overheard conversations between patients and staff and all were conducted with dignity, respect and warmth. We observed staff talking with patients in an extremely positive way throughout the inspection.
- Privacy and dignity were embedded into the culture of the service and staff used no entry signs when they were providing personal care or treatment, or when



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patients needed additional support. This provided patients with the appropriate time and space to receive care and it provided staff with dedicated time to deliver the care in a patient centred way.

- During the inspection, all patients we observed were comfortable, looked well cared for and had their privacy and dignity maintained. We saw that all staff were professional and courteous at all times and followed policy to keep patient care and treatment confidential.
- Staff told us they would be happy to have their families cared for at the hospice and they tried to ensure they made the unit as welcoming as possible to patients' families so they felt able to come as often as they wanted and to stay as long as they wished to spend time with their loved ones. One of the trustees told us that the staff's success at this was reflected in the high number of visitors to the unit.
- On hearing one patient's wish to be able to visit a theme park with their family before they died, staff had helped raise money and enabled them to do so. The patient and family told staff that they had a wonderful day and a special memory.
- Feedback from people who use the service, those who are close to them and stakeholders is continually positive about the way staff treat people. People think that staff go the extra mile and the care they receive exceeds their expectations
- Patient survey feedback, compliments and postcards consistently gave exceptional feedback about the staff and services at the hospice. The themes from the compliments were of staff going above and beyond, providing exemplary care and attention, care, dignity and respect given to patients and families and could not have had better care.
- Patients described the services as 'welcoming and friendly and staff put me at ease'. One patient described their initial assessment as 'thorough and most impressively a holistic approach to me, my life, and the problems I am experiencing.'
- Staff told us of a number of weddings and christenings they had facilitated at the hospice for patients in their care.

- Nursing staff were passionate about creating positive memories for patients and their families when staying at the inpatient unit. Staff encouraged families and patients to enjoy the gardens at the hospice and to have fun with technology such as an Alexa and virtual headsets. Virtual headsets were also used to offer patients new sights and experiences. Staff told us they offered patients the opportunity to create and keep moulds of hands as a keepsake for them and their relatives.

Emotional support

- People's emotional and social needs are highly valued by staff and are embedded in their care and treatment.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- The hospice ran a support group for carers and counsellors provided services for patients and families. The service provided psychological and spiritual support for patients and post bereavement counselling for their relatives. There was a counsellor who could provide specialised support to children and young people.
- Relatives could attend one to one bereavement sessions with a psychologist or bereavement support groups.
- Feedback from users of these services was consistently positive.
- The Wellbeing Centre offered a range of complementary therapies to support patients and their relatives including massage and aromatherapy.
- Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.
- Staff recognised and took into account patient's personal, social and emotional needs. The patients' needs were valued by staff and were embedded in their care and treatment.



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- Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Three members of the hospice at home team had received additional training to be mental health mentors.
- We observed staff providing reassurance to patients through verbal communication and touch such as, holding hands for reassurance and comfort.
- Patients and relatives, we spoke with all said that they felt safe within the hospice and were glad they were being cared for within that environment.
- Patients and relatives, we spoke with said that they were never rushed, and staff “always had time to support them, give them a smile or have a little joke” with them.
- There were quiet spaces and gardens where patients and relatives could sit and relax.
- We saw that the staff and leaders were visible, and patients and relatives could speak with them whenever they wanted to.
- Staff we spoke with said that they supported patients with mental health conditions, addictions and homelessness in a non-judgmental way and provided support according to the patient need and risks that they presented with. Staff told us how they had supported one patient with their addiction and recovery and how this had subsequently led to this patient being able to be discharged.
- The service ensured they supported the emotional wellbeing of their staff by providing debriefing and the opportunity to speak with the service counsellors. The service was exploring how they may be able to better support staff by providing a regular drop in session.
- Staff empowered people who used the service to have a voice and people’s individual preferences were reflected in how care was delivered.
- Staff made sure patients and those close to them understood their care and treatment.
- We saw evidence in patient care records of patients and family involvement in advance decision making and plans of care. Patients and their relatives told us that staff answered questions about care and treatment openly and the information provided to them was clear. We observed the community nursing staff involving and engaging patients and their relatives in discussions about care planning.
- Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.
- Patients and their families could give feedback on the service and their treatment and staff supported them to do this.
- Staff supported patients to make informed and advanced decisions about their care. Patient feedback confirmed that staff had helped them to talk about their wishes and how staff had supported them with this.
- Patients and relatives, we spoke with shared with us examples of when staff had recognised and supported their relationships, by letting them stay at the hospice, enabling them to be involved with providing care for their loved ones or just by sitting quietly with them.
- There was a culture of inclusion in decision making and patients and relatives we spoke with said that they were involved in decisions made about their care and treatment.
- Patients we spoke with shared stories about the ways staff had supported them to make decisions, for example with housing needs.
- Patients we spoke with said that they were aware of who to approach if they had any issues regarding their care, and they felt able to ask questions.

Understanding and involvement of patients and those close to them

- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.
- People who used services were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person.



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- Patients we spoke with were aware of their discharge arrangements and actions required prior to discharge. A family meeting was held prior to discharge to ensure discharge plans were communicated and all of the patient's needs had been taken into consideration.
- It was evident that patients and their families had been provided with information to support them with accessing services, giving medicines and understanding the progression of illness.

Are hospice services for adults responsive to people's needs? (for example, to feedback?)

Outstanding



We rated responsive as **outstanding**.

Service delivery to meet the needs of local people

- Services were tailored to meet the needs of diverse groups of people and were delivered in a way to ensure flexibility, choice and continuity of care.
- The involvement of other organisations and the local community was integral to how services were planned and ensures that services meet people's needs. There were innovative approaches to providing integrated person-centred pathways of care that involve other service providers, particularly for people at the end of their life, particularly for those with multiple and complex needs.
- For example, staff told us how the lymphoedema clinic had been developed and how hard the hospice had worked to sustain this service despite a reduction in funding. The hospice had been determined to save this service as it was highly valued by patients and staff. The hospice had worked with partners and established there was no other means to provide this and had therefore decided to continue the service despite cost pressures.
- We found the senior management team worked with local commissioners, acute hospital teams, GP's and other providers to provide a service that met the needs of local people. The providers supported each other to provide the best possible service to patients at the end of their life across the whole pathway. For example, consultants from St Catherine's supported some clinics and ward rounds at the local hospital and in reach to the community hospitals at Malton and Whitby and the hospice education team provided training and support into care homes and to GPs.
- The service had diversified the services it had traditionally offered, in addition to cancer services St Catherine's was now able to offer services to patients with other end of life conditions for example; liver, neurological and lung conditions. Clinical nurse specialists had been developed through extra training to support improve their service for neurology, lymphoedema and other specialist palliative care patients.
- Senior medical staff held contracts with the local trust to facilitate cross-provider working and facilitation of specialist advice and support for patients in the community, hospital or hospice setting.
- The senior management team were clear about the services they needed to offer to local people and to other providers to improve the care of patients receiving end of life care not only in the hospice but also in the local community wherever care was provided. They were clear about where services need to develop further and were working with local commissioners, other providers and specialist teams to expand the current provision.
- Facilities and premises were appropriate for the services being delivered. The inpatient unit was designed to meet the needs of patients living with dementia.
- The service had systems to help care for patients in need of additional support or specialist intervention including counselling, mental health services and a variety of complementary therapies. Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health problems, learning disabilities and dementia.
- Staff from the hospice at home team told us they were involved in 'community working together meetings and joint operational meetings with colleagues from



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community nursing services and social care to discuss operational pressures and to plan how the services could best work together to ensure patients received the care and support they needed.

- The Hospice had started work to develop a single point of access and was undertaking a piece of work using the Strategic Health Asset Planning and Evaluation tool to look at local population needs as part of future service design.
- Based on the success of specialist neurology end of life provision a need for a similar service for Parkinson's was identified and set-up in collaboration with the Parkinson's team at the local acute trust.

Meeting people's individual needs

- People's individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care.
- There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that meets these needs and promotes equality. This includes people who are in vulnerable circumstances or who have complex needs.
- Patients could access assistance through the telephone helpline or attend the day services which included drop-in as well as more formal outpatient support.
- Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.
- We reviewed care plans and saw that services were coordinated with other agencies to provide care to patients with more complex needs. The hospice was in the process of looking into how care coordination could be improved following a complaint where a patient's family had experienced poor coordination.
- Staff could give examples of when they had referred patients to community mental health services, community nursing teams and other services.
- Staff supported patients living with dementia and learning disabilities by using 'This is me' documents, patient passports and memory boxes. Staff told us

that they had all attended a 'Dementia Friends' awareness session and had received training around; mental capacity, safeguarding, deprivation of liberty and dementia.

- Staff were able to meet the information and communication needs of patients with a disability or sensory loss. Occupational therapists were available to provide support with and provide communication aids and advanced communication systems if needed.
- Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had information leaflets available in languages spoken by the patients and local community. Translation services were available for patients whose first language was not English. Staff had access to communication aids to help patients become partners in their care and treatment.
- Patients were given a choice of food and drink to meet their cultural and religious preferences.
- The services provided reflected the needs of the population served, including patients with protected characteristics under the Equality Act and those in vulnerable circumstances. Reasonable adjustments were made so that patients with a disability could access services on an equal basis to others. For example, the unit, was accessible for patients with limited mobility and people who used a wheelchair.
- Patients received high quality individualised care, planned in a way which enabled patients to be supported appropriately and achieved good outcomes. The service used a Carer Support Needs Assessment Tool (CSNAT) to help ensure tailored support to families.
- Patients were able to attend the wellbeing centre if they felt able and could receive complementary therapies, have hair styled or sit and chat with other patients.
- Patients had access to physiotherapy, occupational therapy, counsellors and social workers to help meet any physical, social or emotional / mental health needs. Support could be accessed 24 hours a day, seven days a week through a telephone helpline. The



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helpline was manned by the hospice at home team so the staff were aware of any patient concerns or problems and could respond with a home visit or follow up telephone calls as needed.

- We saw that patients' mental health and emotional health needs were continually reassessed and referral to and access to appropriate support was immediate. We saw examples of when St Catherine's staff had helped patients access services and facilitated rehousing when their accommodation was unsuitable for their needs. Staff had accessed services and completed forms on their patient's behalf to ensure they were provided with suitable housing that could accommodate their needs and any equipment required to meet their care needs.
- Staff monitored and reviewed the changing needs of patients through regular 'comfort rounds' and frequent medical reviews.
- Equipment was available to provide distraction to patients and relatives, such as games, books, magazines and puzzle books. Patient rooms had TVs and access to Wi-Fi, the hospice had recently purchased an Alexa which we saw one patient enjoying and some virtual reality headsets which patients could use to experience and 'visit' places and things they had never seen.
- Patients were able to sit outside, have doors open to the bedroom or go out outdoor visits as they felt able.
- Staff were knowledgeable about how patients wanted to be cared for, and this was documented in communications and care plans about the patients.
- We heard discussions during handovers that planned for patients advancing conditions and included potential issues when they were being cared for at home. Staff discussed the possibility of needing a 'catastrophe bed' for a patient if the family and multi-disciplinary team were unable to meet the needs of the patient at home as their condition deteriorated.
- The inpatient team were aware of when a bed may be needed for a patient under the care of the hospice at home team and whether this would be needed for a brief admission, such as for a procedure, or pain control or whether this would be for ongoing care.

- Patients and relatives were able to access religious services and spiritual care, either individually or through collective worship in the onsite chapel.
- Staff told us that they would collect and return medicines for patients and their families if this was struggle for them even if this meant a trip of many miles.

Access and flow

- Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.
- From February 2018 to January 2019, 279 patients accessed the inpatient unit, 1320 accessed community services and 346 patients used day / clinical therapy services provided by the well-being centre and 212 attended consultant clinics or the lymphoedema clinic.
- The unit had 14 medical beds open and had recently opened two additional nurse-led beds, to facilitate discharge from hospital in the last days of life and improve achievement of preferred place of death. Managers told us they were operating at around 80% bed occupancy.
- Referrals into the inpatient unit largely came from GPs and the local hospitals.
- Managers monitored waiting times and the multidisciplinary team prioritised referrals for admission to make sure patients could access services when needed and received treatment within agreed timeframes.
- From April to October 2018 the average waiting time for an inpatient unit bed was 3 days
- From April to October 2018, 86% of patients admitted to a nurse led bed were admitted within 24 hours of referral.
- The reasons for patients suitable for a nurse led bed but not transferred was monitored to identify why the transfer had not taken place to identify any difficulties that could be avoided for future transfers.
- Attendance at the well-being centre was monitored and a project had been undertaken to understand the



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patients' reasons for not attending. As the most frequent reason was that patients had forgotten, a reminder process had been introduced for patients who attended at long intervals.

- The hospice at home team accepted referrals from community nurses, GPs and hospitals. Referrals were also sometimes picked up by the team through a call to the helpline. The team facilitated discharges from the hospice inpatient unit and helped 'fast track' packages of care in conjunction with their social care colleagues, Marie Curie and community nursing service.
- The service would be increasing its operational inpatient beds from 14 to 16, in the coming months, these two additional beds were nurse-led with the intention this would increase the availability of beds to allow dying patients access to their preferred place of death. The beds were ring fenced for hospital patients who were in the last days of life.
- Multidisciplinary, multi-provider decision making was evident in the approach to prioritising patients for access to the inpatient unit.
- Managers and staff worked to make sure patients did not stay longer than they needed to.
- Managers monitored that patient moves between services were kept to a minimum.
- The service moved patients only when there was a clear medical reason or in their best interest.
- Staff supported patients when they were referred or transferred between services.
- Managers and staff worked to make sure that they started discharge planning as early as possible.
- Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff were proactive and communicated well with other services to prevent delayed discharges.
- The hospice had set up a single point of access working group to improve / streamline access to the service.
- Patients could self-refer to counselling and well-being services.

- From November 2018 to January 2019 the average waiting time to access palliative care counselling services was 4.6 days.
- From November 2018 to January 2019 the average waiting time to access the bereavement support service was 0.8 days.
- The service had worked with local partners to develop a care home proactive planning tool, the aim of this tool was to improve communication, better coordinate care, improve the utilisation of resources and decrease unwanted interventions and hospital admissions. The planning tool was based on the gold frameworks for improving end of life care.

Learning from complaints and concerns

- There was active review of complaints and how they were managed and responded to, and improvements were made as a result across the services. People who use services were involved in the review.
- Staff actively encouraged patients to give feedback and dealt with any concerns as far as possible as soon as they were raised. Staff at all levels in the organisation were engaged with improving services as the result of complaints
- The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.
- From February 2018 to January 2019 the service had received eight complaints. Two of the formal complaints were upheld. Seven of the complaints were responded to within the target of 10 working days and the other complaint took 13 days. The complaint exceeding the target response time received an explanation of why the investigation and response were delayed.
- There were no recurrent themes in the clinical complaints but had highlighted areas of where communication could be improved. The hospice shared the learning and points for improvement with all relevant staff.
- We reviewed two complaints files and found; these had been investigated thoroughly, learning had been identified and managers had acted to make improvements to how services were delivered. Some



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of the actions taken to improve communication and care coordination included changing from a telephone assessment, when patients were referred to another practitioner, to a face to face handover in the patient's home. Community meetings had also been implemented to bring together all practitioners involved in a patient's care on a weekly basis. Documentation of discussions with patients and families was also highlighted as an area for staff to improve. We saw from our review of files that staff and the patients' families had contributed to understanding how things could be improved.

- Managers shared feedback from complaints with staff and learning was used to improve the service. They promoted learning from complaints by engaging staff in the process and by asking for ideas from the team of what they could learn from the complaint. Complaints were also discussed as part of team meetings.
- Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.
- Patients, relatives and carers knew how to complain or raise concerns. Patients and their relatives were supported and encouraged to voice concerns where appropriate. Patients were given a leaflet explaining how they can provide feedback or make a complaint as part of their welcome pack. The service clearly displayed information about how to raise a concern in patient areas.

From February 2018 to January 2019 the service had received 152 written compliments.

Are hospice services for adults well-led?

Good



We rated well-led as **good**.

Leadership

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.
- The service was led by a senior management team of chief executive, a medical director, a business, people and income director and a clinical services director. The senior management team was supported by a board of trustees. The management team and the trustees were visible in the hospice and took time to talk to staff groups and be involved in walkabouts and assessments of the environment.
- We spoke with one of the trustees who told us the board was well informed and able to challenge the leadership team in committees and at board meetings. They felt they had good oversight of the successes and challenges of the organisation and if any of the trustees raised an issue then the management team would respond quickly and appropriately.
- Each of the clinical departments such as the nursing services, the therapy services, patient and family support services and the education and training services were led by an appropriately qualified and experienced member of staff. The inpatient team lead post was vacant at the time of the inspection and was being covered by the lead from the hospice at home team.
- We found that the service operational managers and the senior management team were knowledgeable and approachable. They had a good understanding of the opportunities, risks and challenges the hospice faced.
- The clinical services director was newly appointed in December 2018 and was still learning and developing the scope and function of her role.
- Staff told us the senior managers were visible and approachable and they felt supported. Team leaders had dedicated time for management and support of staff.



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- Leaders within the service went out of their way to ensure that they were visible and approachable. The leadership team included an executive team and a board of trustees, staff we spoke with said they were supportive and knowledgeable.
- The leadership team prioritised person-centred, safe, high quality, compassionate care and respected and valued the opinion and contribution of staff, patients and service users.

Vision and strategy

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.
- The service had a vision to be the leading provider of Specialist Palliative and End of Life Care in the area, working in collaboration with others to deliver safe quality person centred services
- Staff we spoke with and observed clearly shared the hospice ethos of prioritising person-centred care.
- The service had a clear strategy which included the elements of; clinical excellence, empowered people, innovation and improvement, systems and processes, financial sustainability and
- The strategy recognised that integration of services and working with partners was integral to success.
- The hospice had a set a of values and expected behaviours regarding person centred care, quality, team work and integrity. We saw that staff worked in a way that upheld these values. The management team intended to do further work around embedding values and expected behaviours into appraisals and performance review.
- The service planned to develop the estate of the hospice to make the wellbeing services accessible to patients across a wider area and to make services more accessible to hard to reach groups.

Culture

- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The

service promoted and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

- Staff we talked with described the culture as professional, positive and supportive of training and professional development. Staff said they felt valued by their colleagues and the service and they loved working at the hospice.
- The senior management team were proud of staff and the care they delivered. We observed an open culture with an emphasis on providing an excellent, bespoke service based on the individual needs of patients and their families.
- Leaders of the service were keen to make St Catherine's a great place to work and were disappointed with the most recent staff survey results. Managers demonstrated they had listened to what staff had told them through the survey and were acting to improve the areas of concern.
- One of the areas they wanted to improve was staff engagement with service improvement so they could contribute more to service design and inform where cost savings could be made due to financial pressures, without compromising patient care. The leadership team wanted staff to feel they had a voice in decision making.
- Leaders and staff acknowledged that there had been a lot of change and restructuring at the hospice over the last 18 months and that this had caused some unrest and negativity. This was in addition to a lack of pay rise over a period of three years due to financial constraints and had affected morale. Staff we spoke with felt morale was improving and the service was moving forward. Staff told us that managers actively encouraged staff to seek support if they were struggling.
- The management team were trying out different ways in which staff could voice their opinions more easily and be more involved in service improvement by using a problem solving / decision making approach. This had been tried at the leadership meeting and it



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was intended to roll out this method to departmental staff meetings. It was hoped this approach would give staff a sense of shared responsibility and a way in which to influence service improvements.

- Pay awards had been carefully considered and granted as this was deemed to be an important factor in recruiting and retaining staff.
- Staff we spoke with said they felt able to raise concerns if required and were complimentary about the culture and communication in the service. The hospice had recently appointed two freedom to speak up guardians to support any staff who may want to raise a concern.
- Staff we spoke with felt the working conditions were good and that St Catherine's was a very caring place to work, for staff and for patients.
- Staff said they would be happy to have their loved ones cared for at the hospice.

Governance

- The service had a clear governance structure. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- There were effective structures, processes and systems of accountability to support the delivery of the service strategic intent and good quality, sustainable services. However, we were not assured that the processes and systems in place regarding trustee recruitment, audit and performance monitoring and oversight of essential human resource information such as training data and currency of disclosure and barring certificates were robust. There were gaps in the information provided to committees and the board to facilitate thorough governance and oversight.
- There was a clear governance and committee structure and governance and performance management policy and arrangements were regularly reviewed. The structure enabled the flow of information from frontline to senior managers and trustees. However, although there was some key performance data in the board and committee papers

the information set reported was incomplete, for example training compliance was not reported and incident and complaint data showed little no statistical analysis or monitoring over time.

- The board and committee meetings discussed information regarding clinical and operational issues and projects, policy ratification, considered research projects and looked at data regarding clinical and operational performance/ activity.
- The service monitored service quality and safeguarded high standards of care. However, data collected was not always collated or used to benchmark the service's performance. Performance information tended to be heavily reliant on activity and did not appear to be target orientated.
- The service undertook a number of relevant audits and quality assurance checks. However, there was no systematic programme of regular audits and although results from these were reviewed to identify if any areas improvements could be made and actions were taken where needed there was little evidence of monitoring performance over time or benchmarking against other providers or set standards.
- The service worked well with referring and partner organisations to improve care outcomes.
- There were good systems and processes in place for maintenance of equipment and there were appropriate policies and procedures in place, however some of these needed updating.
- The oversight of staff training, competence and maintaining professional registration was disjointed but improving as paper records were transferred on to the new electronic system.
- There were established systems in place for shared learning and peer review.
- Staff, managers and trustees we spoke with were clear about their roles and responsibilities and how they fitted into the organisational structure.
- Trustees had a clear role and this was based on the charity commission's guidance 'The Essential Trustee' (2012). The hospice used a skills matrix to ensure that each of the board governance sub-committees had trustees with the appropriate skills and knowledge to



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provide appropriate governance and challenge.

Trustees told us they felt able to challenge the hospice executive team and that they were very responsive to any challenges or concerns.

- However, there was not a thorough process in place for the recruitment and oversight of trustees' performance or development needs. All trustees had been in post for several years and although the hospice had historically interviewed trustees and carried out a review of CVs, disclosure and barring checks and director checks the service had not advertised posts or requested references. There was a process in place for regularly checking for any conflict of interests but there was not a process in place to identify and support trustee development needs or review performance. We discussed this with managers during the first day of our inspection and the management team took immediate action to develop new processes for recruiting trustees in line with fit and proper persons requirements and for oversight of performance and development needs. Recruitment processes were developed and were to be implemented with the next vacancy in a few months' time, all disclosure and barring checks were reapplied for and a process for performance review and board development was developed, by the time the inspection was completed.
- We reviewed the paper personnel files of five clinical staff members and found they contained evidence that staff had gone through an appropriate recruitment process. Not all records held disclosure and barring certificates or numbers but when the staff members were checked against the staff care IT record the information had been recorded there.
- The hospice was in the process of transferring human resource information onto the new staff care IT system. The management team had found that when a key member of staff was off duty they could not access all of the information they needed therefore, a robust system was not fully embedded for the oversight of human resource information.
- When all information is added to the staff care system this will enable clear oversight of all human resource information such as disclosure and barring service checks, professional registration, appraisals and training and development.

Managing risks, issues and performance

- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. However the service had not completed their business continuity plan.
- The service leaders had a good understanding of the risks and challenges the hospice faced.
- The service recognised risk in a number of ways such as through environmental risk assessments, clinical risk assessments, through staff discussions, from training and from external sources such as national risk alerts, health and safety requirements, legislation and regulatory requirements and from national clinical guidance and published clinical audits and reports.
- The managers used the information from incident reports, audit results, review of new guidance and complaints to inform their interpretation and mitigation of identified risks.
- The service had a risk register in place and used a nationally recognised tool to assess and rate risks. We saw from the risk register that the service had identified relevant risks and had taken mitigating actions or put plans in place to minimise them. We found that risks were reviewed regularly and new ones were added when they were discovered.
- The service and the individual staff each had appropriate indemnity and insurance in place.
- There were systems and processes in place in to monitor and manage performance of staff and of the services provided.
- There were policies and procedures in place to help staff reduce risks such as health and safety and control of substances hazardous to health.
- The management team were in the process of developing a business continuity plan that would incorporate all of the departments.

Managing information

- The service collected a variety of data and analysed it to understand performance in specific areas, make



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decisions and improvements. However, key performance information presented to the board and committees tended to be around activity and lacked analysis to easily identify themes and trends or to monitor or benchmark performance. There were gaps in the information provided from ward to board.

- The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- Staff had access to technology to help document patient care needs and outcomes, this included an electronic system, mobile computers and electronic care records. The IT system enabled sharing of records with community teams and general practice (where GPs were on the same system) which facilitated joined up care.
- All IT systems were protected by security measures, all staff including bank staff had individual log on details and access to patient information was restricted depending on staff role.
- The service was registered with the Information Commissioner's Office and the Medical Director was the nominated Caldicott guardian for the service.

Engagement

- Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.
- The service undertook formal patient and service user surveys and actively sought to make improvements on the feedback received. The service collected patient feedback through a number of mechanisms, feedback leaflets, postcard audits, compliment letters, social media platforms.
- The inpatient unit had patient questionnaires in the welcome packs and suggestion boxes were in the public areas.
- Managers told us that staff and volunteers actively encouraged patients and families to share their experience or give feedback verbally or in writing and to become involved with fundraising or marketing if

they wanted to. The Clinical Services Director visited clinical areas regularly to ask patients and families about the care they were receiving and to give them the opportunity to raise any concerns directly.

- Patient surveys regarding the bereavement support service and the palliative care counselling service indicated that 95% of service users would recommend the services. Five percent of the bereavement service users (3) did not answer this question. One of the patients who used the palliative care counselling service said they would not recommend the service.
- The children and young person's survey showed that 10 of 11 would recommend the service, all received information about what to expect and all attendees found the service helped.
- The service shared patient feedback from social media with staff and other patients using an electronic screen in the main entrance of the inpatient unit, this also provided information about the executive team, trustees and key staff, patients might meet. The hospice also publicised patient feedback on their website.
- We saw a board in the hospice at home office which displayed patient experience feedback for staff to view.
- The hospice at home staff kept a folder of patient stories that could be used for reflection. The stories illustrated what happened, what went well and any issues or anything that could be improved on. Staff could use these as examples of practice and reflection for re-validation purposes.
- We saw that the bereavement drop in service had undertaken a piece of work for service users to evaluate the effectiveness of the service and make suggestions for improvements.
- The service offered many volunteering opportunities and valued the time, experience and support that the volunteers brought to the service.
- As the hospice was a charitable organisation it greatly valued and relied on the support of volunteers and fund raisers in addition to commissioners for ongoing provision of services.



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- The hospice was planning to increase public and patient involvement in service improvements by increasing the collection and collation of the views of patients, families, careers and volunteers. The service logged and reviewed all comments left with service to identify any areas for improvement and ideas for development.
 - The hospice gave a number of improvements made as a result of patient and public involvement and patient feedback. One example was of working with a patient to review and improve disabled toilet access. This work resulted in the installation of a fully electronic door in the education and well-being centre which was subsequently signed off as complete by the patient involved. Other examples were of improvements made to The Wellbeing Centre and the proposed development of a single point of referral.
 - The management team produced a regular newsletter for all hospice staff. The newsletter provided updates of activities and developments in the service, welcomes and goodbyes to new staff and those leaving the service. There was also information regarding the work of the trustees and information about an upcoming fundraising event.
 - Staff were able to access wellbeing services provided at the hospice, such as counselling.
 - The management team had recently introduced a 'briefing in a minute' to help improve staff awareness of alerts, issues and developments within the service.
 - Staff were recognised through 'Time to Shine' which encouraged staff and patients to nominate and celebrate staff achievement and good practice. Positive feedback from patients and staff was uploaded on the hospice website to be shared.
 - The clinical nurse specialists displayed a colourful notice board of the 'great stuff' they were doing to develop services and training, to celebrate success and highlight examples of great care.
- Learning, continuous improvement and innovation**
- All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.
 - We saw that the manager and staff valued and shared learning and wanted to continually improve their service. The service was keen to learn from others and fostered good relationships with its peers and professional networks.
 - The service was committed to participation in national research and innovation projects to benefit their patients. We saw that research projects were chosen with care to ensure the contribution and learning would be of benefit to palliative care patients and or their families. The hospice had taken part in a C change project and a delirium project over the past few years and results were due to be published in the near future. Two further projects were being considered by the hospice; a body image study and a 'Resolve' project.
 - Staff told us the hospice was a progressive service and senior managers were supportive and encouraging of innovation and ideas. For example, the hospice had a dysphagia working group consisting of clinical and catering staff who had helped trial and taste test (with patients) a range of modified texture diets to meet the International Dysphagic Diet Standardisation Initiative. The group had also led on training for the use of thickened fluids to all clinical staff. The hospice also provided an education booklet to patients and families to reinforce important information regarding swallowing and texture modification.
 - Due to the geographical challenge of providing services, bereavement and counselling staff had introduced video-conferencing with patients and families if this was appropriate. The service loaned iPads to patients who needed them to be able to have long distance, face to face conversations with staff.
 - The management team planned to promote more flexibility of skills, learning and understanding across teams through internal staff rotation and secondment opportunities. The hospice was piloting co-location of the hospice at home and inpatient unit staff overnight at the time of our inspection. It was hoped this would allow more effective working of clinical teams.
 - There were plans to use the OACC clinical outcome scores in more clinical situations to illustrate objectively the clinical assessment of patients.



Hospice services for adults

- The management team planned to expand the use of volunteers into clinical areas and to develop the scope, delivery and access to services provided by the Wellbeing Centre.

Outstanding practice and areas for improvement

Outstanding practice

- Patient survey feedback, compliments and postcards consistently gave exceptional feedback about the staff and services at the hospice. The themes from the compliments were of staff going above and beyond, providing exemplary care and attention, care, dignity and respect given to patients and families and could not have had better care. The comment from one patient typified the care given 'thorough and most impressively a holistic approach to me, my life, and the problems I am experiencing.'
- The service took a proactive approach to understanding the needs of the local population and worked in a proactive manner with partners such as the acute trust, community services, Marie-Curie, care homes and social agencies to provide the services needed and improve end of life care across services. For example, 'the hospice had demonstrated improvements in preferred place of death and advanced decisions and care plans for patients residing in care homes through its care home education service.'
- The hospice used engagement with staff, volunteers and patients to shape the services provided. Staff and patient feedback were collected in multiple ways and staff could provide many examples of services being planned and improved as a result of feedback and from focussed audits or projects. For example, working with a patient to review and improve disabled toilet access, working with patients to improve the way services were provided by The Wellbeing Centre and work that was ongoing to develop a single point of referral.

Areas for improvement

Action the provider **SHOULD** take to improve

- Continue its work reviewing safeguarding training provision and updating of adult and children's policies / procedures to reflect current intercollegiate guidance. Implement the new training to enable staff to comply with intercollegiate requirements. (Regulation 13)
- Complete its review and update of all policies and procedure. (Regulation 17)
- Complete its review of staff records and transfer to the new electronic human resource system and as part of this review ensure that all staff, including trustees, hold a current disclosure and barring service certificate, in line with hospice policy. (Regulation 18)
- Implement monitoring of regular (daily / weekly) checks of resuscitation equipment and fridge temperatures including actions taken if outside of range. (Regulation 12)
- Work towards improving the appraisal rate for junior staff nurses.
- Complete the service business continuity plan.
- Implement and or embed robust processes and systems for;
 - providing the committees and board with a full set of agreed data on a regular basis to ensure complete oversight and governance from ward to board.
 - trustee recruitment and oversight/ management of their performance or development needs to meet the requirements of fit and proper person (Regulation 5)
 - a planned, comprehensive audit programme
 - performance target setting and monitoring against all relevant indicators such as training compliance.
 - keeping policies and procedures up to date with current guidance and best practice
 - keeping and renewing staff disclosure and barring service certificates when they are due. (Regulation 17)

Outstanding practice and areas for improvement

- Consider how patient outcome information or OACC measures can be compared with peers or set standards.