Saint Catherines Hospice Trust

St Catherines Day Hospice Ryedale

Inspection report

Malton Hospital
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 11 April 2016 and was announced. It was the first inspection for this service under their current registration. St Catherine's Day Hospice-Ryedale provides free day care to adults with a life limiting condition or a diagnosis of cancer that live in the Ryedale area of North Yorkshire. The service operates on Mondays between 9am and 3pm with capacity for up to eight people. There was one person using the service on the day we inspected. The service is based in a local hospital ward and so had little control over the décor or environment although these met the needs of people who used the service. People had access to consultants and medical care, nursing care, physiotherapy, occupational therapy, social workers and spiritual support to meet their needs.

There was a registered manager employed for this service who also managed the main site, a hospice at home service and another day hospice. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was very experienced after being employed by the hospice for many years.

The day to day running of this service was managed by a nursing sister employed by St Catherine's Hospice Trust. Staff followed risk assessments and guidance in risk management plans when providing care and support for people in order to maintain their safety.

Staff were able to describe what it meant to safeguard people and told us how they would report any suspected abuse. There were policies and procedures in place for staff to follow.

Staff recruitment processes were followed with the appropriate checks being carried out. There were sufficient staff on duty to meet people's needs and the service had a team of volunteers who provided additional support. The hospice had a bank of staff who they could contact if they needed additional staff. All staff received supervision individually or as a group and annual appraisals were undertaken. New staff received a thorough induction and regular training to ensure they had the knowledge and skills to deliver high quality care.

The safety of the environment was managed by the NHS. Staff working at the day hospice had plans in place if people needed to be evacuated in the event of a fire. They also had their transport checked, maintained and serviced regularly. The premises were clean and tidy with appropriate adaptations in place for people with a physical disability such as wide corridors and doors for wheelchair access and adapted toilets. There was equipment available to help staff but also to maintain people's independence such as care chairs which people could adjust themselves.

People brought their own medicines with them to the service. There were systems in place to ensure they were stored and administered safely.

Staff worked within the principles of the Mental Capacity Act where appropriate. People had choices about their care and their consent was sought by staff.

People were supported to receive a nutritious diet at the service which was provided by the NHS. There was a choice of menu on the day we inspected and drinks and snacks were freely available. When people needed to receive nutrition by other means they were supported by staff that were trained.

When people needed specialist healthcare support the day hospice made referrals to specialist services such as occupational therapy or the dietician. People and their families could access advice and support through a helpline line twenty four hours a day which linked directly to the hospice.

People told us that staff were caring, friendly and supportive. There was a spiritual care co-ordinator who was available to people who used the day hospice and their families. This support was across all faiths but specific religious leaders could be accessed through the co-ordinator if a person preferred.

The seven protected characteristics of the Equality Act 2010; age, disability, gender, marital status, race, religion and sexual orientation were adequately provided for within the service; the care records we saw evidenced this. The staff who we spoke with displayed empathy in respect of people's needs.

People were able to make decisions about the care and support that they received. They us that staff at the service communicated well with them. Confidentiality, privacy and dignity were respected through safe storage of records and by the staff who offered privacy when having difficult or sensitive conversations with people.

People helped develop their care plans which were person centred. This is when any treatment or care takes into account people's individual needs and preferences. The persons chosen place of care and place of death was clearly recorded where the person had chosen to share that information. People were given time and support to develop advanced care plans, advance directives and living wills if they wished. People received help with symptom control and management at the day hospice but could also enjoy socialising with others.

People were confident expressing any concerns to staff at the service and knew who to approach if they were not satisfied with the response.

Staff and volunteers shared similar values and worked closely with each other. There were regular team meetings for staff to share their views about the service. There was also a newsletter for staff and volunteers, a time out group for carers of people who used the service and a drop in group for newly bereaved relatives to provide support.

Accidents and incidents were clearly recorded. Where any mistakes were made these were discussed and reflected upon in order to make improvements.

The hospice presented annual quality accounts which looked at patient safety, clinical effectiveness and patient experience. They benchmarked their safety data against other hospices by engaging with a national initiative and audits were completed across the organisation providing a thorough and comprehensive system of quality assurance.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff used safe working practices and followed risk assessments and guidance in risk management plans when providing care and support for people.

Staff were able to describe what it meant to safeguard people and told us how they would report any suspected abuse.

Staff were recruited safely and there were sufficient staff on duty to meet people's needs.

People brought their own medicines with them to the service and there were systems in place to ensure they were stored and administered safely.

Is the service effective?

Good

The service was effective. Staff told us they felt supported. They received induction, training and supervision to support them in their roles.

Staff worked within the principles of the Mental Capacity Act where appropriate. People had choices about their care and their consent was sought by staff.

People were supported to receive a nutritious diet at the service. Food was provided by the NHS and when people needed to receive nutrition by other means they were supported by staff that were trained. There was a choice of menu and drinks and snacks provided.

When people needed specialist healthcare support the day hospice made referrals to specialist services. There was a helpline line for people who used services and their families to use twenty four hours a day.

Is the service caring?

Good

The service was caring.

People told us that staff were caring, friendly and supportive. Peoples spiritual needs were supported.

People were involved in making decisions about the care and support that they received and told us that staff at the service communicated well with them.

Staff respected people's privacy and dignity. Confidentiality was respected through safe storage of records and by the staff who offered privacy when having difficult or sensitive conversations.

Is the service responsive?

Good

The service was responsive. The day hospice provided a flexible service to people where they could receive help with symptom control and management but could also enjoy socialising with others.

People told us that they would be confident expressing any concerns to staff at the service and knew who to approach if they were not satisfied with the response.

Excellent support was available for people who used the service from allied healthcare professionals who worked at the hospice and the social work team who gave practical support.

People were involved in developing their care plans which were person centred and clearly described the care and support needed.

Is the service well-led?

Good

The service was well led.There was a registered manager employed at the service who supported a senior sister with the day to day running of the day hospice. They both had extensive experience of working in hospice services.

Staff were supportive of people who used the service and of each other.

The service used a variety of means such as a staff newsletter, a time out group for carers of people who used the service and a drop in group for newly bereaved relatives to provide support. Where any mistakes were made these were discussed and reflected upon in order to make improvements.

The hospice presented annual quality accounts which looked at patient safety, clinical effectiveness and patient experience. They benchmarked their safety data against other hospices by

engaging with a national initiative and audits were completed across the organisation providing a thorough and comprehensive system of quality assurance.

St Catherines Day Hospice Ryedale

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 11 April 2016 and was announced. We gave the service 48 hours' notice of the inspection because it is a day service and we needed to be sure that there was anyone the service and if people were being supported there. This provider has three locations registered with the Care Quality Commission (CQC). We found that there were areas that were common to all three services. For example training programmes, quality assurance systems and policies and procedures were used across all three services. For this reason some of the evidence we viewed was relevant to all three services. Our individual findings for each service are discussed in separate reports.

The inspection team consisted of one inspector and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in adult social care settings and included experience of palliative and end of life care.

In order to plan our inspection we looked at statutory notifications we had received. Statutory notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. Before the inspection, the provider completed a Provider Information Return (PIR).This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used the information they had given us to help with our planning.

During the inspection we were shown around the day hospice by the nursing sister who was in charge. We looked at the communal areas and treatment rooms. We spoke with one person who used the service, one

care worker and one volunteer and had discussions with the registered manager and nursing sister in charge of the day hospice.

We pathway tracked three people care records on Systmone and observed practice throughout the day. Systmone is a clinical record system used to record patient care electronically in real time and make referrals to other healthcare professionals. We reviewed other records relating to the running of the day hospice such as some policies and procedures, safety checks and maintenance records and saw the comments made by people in a recent survey by the service. A lot of the records relating to the running of this service were kept at St Catherine's Hospice main site. We looked at the appropriate records that related to this service on 13 and 14 April 2016 when we inspected St Catherine's Hospice- Scarborough. We also looked at all policies and procedures, staff recruitment and training records relating to those staff on duty during the inspection, quality assurance systems including audits and the hospice trust business plan which referred to the day hospice.

Following the inspection we requested feedback from a social worker, a GP, a member of the respiratory team at Scarborough Hospital, an occupational therapist and district nurse.

Good

Is the service safe?

Our findings

People told us they had every confidence in the staff at the day hospice. One person said, "Yes" when asked if they felt safe with the carers and staff at the day hospice. A relative gave us an example of a member of staff keeping someone safe when their prescription was incorrect. They told us the member of staff had acted promptly to get the prescription changed.

We observed staff using safe practices. When operating a hoist they worked in pairs and checked throughout the manoeuvre on the person's position, comfort and safety demonstrating the care they took to provide safe moving and handling of people. Accidents and incidents were clearly recorded in people's records. There was a form for staff to complete where they could reflect upon the incident and learn from it in order to make improvements. We did not see any accidents recorded for people receiving care on the day of inspection.

In addition we saw that staff had completed risk assessments in relation to people's health and welfare. For example they were in place for falls, nutrition, skin integrity, and more specific areas relating to peoples conditions such as the risk of choking. Where there was an identified risk people had a risk management plan in place which gave clear guidance to staff about how to keep people safe. We saw from people's records that risk assessments were reviewed weekly as people's conditions could change quickly.

We saw one person was at risk of choking and the nursing sister had identified that this risk was increasing. They were planning a review with the person to discuss this and plan next steps. The day hospice provided an escort service on the mini bus for people who needed to travel to and from the day hospice to ensure they had support during the journey to maintain their health and safety.

Safety checks of the environment were completed. The day hospice was situated in a wing of a hospital ward and so NHS staff carried out maintenance of the building and equipment as part of the agreement. There was a fire risk assessment in place for the day hospice. Tests of the fire alarm were completed on a regular basis by hospital maintenance staff to make sure it was in safe working order. Fire exits were clearly identified and staff were aware of each person's needs for evacuation. The transport belonged to the hospice and we saw maintenance and servicing documents for the vehicle.

The registered provider helped people feel safe and supported by encouraging them to share any concerns they had in relation to their care at the day hospice. We spoke with the staff about safeguarding people and asked what action they would take if they witnessed anyone being harmed. Everyone we spoke with said they would report any safeguarding concerns to the sister or registered manager.

Staff were able to tell us about safeguarding procedures and demonstrated their knowledge of the management of any abuse. This included knowing who they should contact when making referrals. Staff told us that they had received training in safeguarding adults and there was a safeguarding champion within the service to support staff. Volunteers also received safeguarding training. The service had safeguarding and whistleblowing policies and staff told us that they would be confident enough to inform senior staff of

any concerns they had. There had been no safeguarding referrals made by this service in the last twelve months.

Safe recruitment procedures were in place. We looked at the files of the staff members who were on duty during the inspection. We saw they had completed an application form, which included information about their qualifications, experience and employment history. They had two written references in place, one of which was from the last employer, personal identification and evidence of a Disclosure and Barring Service check. This also applied to the team of volunteers who worked at the day hospice. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions and minimised the risk of unsuitable people being employed.

Checks of nursing qualifications had been carried out prior to nurses starting work at the day hospice and regularly thereafter. This ensured nursing staff were suitably qualified for their role. Nursing qualifications and registration details were checked with the Nursing and Midwifery Council (NMC). The NMC is the regulator for nursing and midwifery professions in the UK. The organisation maintains a register of all nurses, midwives and specialist community public health nurses eligible to practice within the UK.

Staff told us that the nurse in charge "Had her hand on the tiller." and that, "Everyone worked well together." We spoke to the nurse in charge about duty rotas and spoke with the team about staffing levels. The nurse in charge told us that they or another senior nurse would always be available when the day hospice was open. In addition there was a care worker and a team of volunteers. If more staff were needed the hospice had its own bank of staff to call upon. We observed and staff we spoke with during the inspection told us they thought there was sufficient staff on duty to meet people's needs. A person who used the service agreed with this and a relative said they were satisfied with staffing levels because, "We got an excellent service, one to one care."

The hospice trust employed their own team of doctors and allied healthcare professionals, such as physiotherapists and occupational therapists. These could be accessed when needed. In addition there was a social work team. This meant that people's health and social care needs were supported safely. In addition there was a lone working policy and procedure in place giving clear guidelines for staff. There was a risk assessment carried out where necessary in order to protect staff when visiting people at home or travelling alone with anyone.

We looked at the arrangements in place for managing accidents and incidents and preventing the risk of reoccurrence. The registered manager said that accidents and incidents were not common occurrences; however they had appropriate documentation in which to record them should they occur. Any incidents were recorded electronically in order to maintain records on Systmone. This is a centrally hosted clinical computer system used by a large number of healthcare providers to maintain real time records and to be able to provide seamless care by sharing information with healthcare professionals.

We looked at the systems in place for medicines management, taking account of the services medicines policies and procedures and current national guidance. We saw that people brought their own medication into the day hospice in the original containers. Where necessary nursing staff supported the person to take their medicine. There had been an incident the previous week recorded on Systmone by a community nurse where one person had needed to have medicine administered using equipment to deal with a medical emergency. The sister in charge had noted this and prepared equipment at the hospice in readiness just in case it was needed at the day hospice demonstrating recognition of the risk to the person.

The nurse in charge was a non-medical prescriber and records showed us that they had completed the appropriate training and competency checks. Non-medical prescribing is undertaken by a health professional who is not a doctor. It concerns any medicine prescribed for health conditions within the health professional's field of expertise. There was an audit of prescribers every six months by the hospice trust and the information was fed back to the medical director for a review of medicines prescribed.

One person received prescribed nutrition through a percutaneous endoscopic gastrostomy (PEG). This is when a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding. Staff were trained and competent in supporting a person to receive nutrition through a PEG tube according to their care plan.

Medicines were stored securely whilst the person was in the day hospice and the keys were held by the nurse in charge. Medicines requiring refrigeration were stored appropriately and records were maintained daily. Detailed care plans and risk assessments around the identification of pain and symptom control ensured medicines were prescribed and given in a person-centred way. This allowed staff to be clear about how people demonstrated pain and how they should respond to that. There were medicines policies and procedures in place which were regularly reviewed and up to date. There was no one using the service during the inspection that could not consent to staff supporting them in administering their medicines. However, staff were aware of the process to follow when someone did lack capacity.

Audits were completed annually using a nationally recognised tool and the results were benchmarked to determine how the hospice performed in medicines management against other hospices. Actions from audits were documented and discussed as part of the team meetings. We looked at the incident reporting system for medicines and found that lessons learnt from incidents were discussed in the executive and leadership team meetings and disseminated to staff through their team meetings for shared learning. In addition staff undertook further training if it was appropriate.

Good

Is the service effective?

Our findings

People told us that the staff knew what they were doing. One person said "Yes" when asked, "Do you feel that staff know what they're doing?" They also answered, "Yes" when asked if they thought staff were knowledgeable. A relative told us, "[Staff name] was great, smashing; on the ball. [Staff name] sorted what needed doing there and then." A volunteer told us about the nurse in charge, "I think she's excellent. She has the knowledge and skills and cares about these people." A member of staff said that she was, "Very supportive, on the ball and had a good manner with patients."

Staff were well trained and supported. Staff told us about the training they had completed and we saw their training records which confirmed this. They had completed training in first aid, manual handling, use of oxygen, fire safety, dementia, safeguarding, MCA equality and diversity and other subjects. This training was updated annually. In addition volunteers received training. One volunteer told us, "I completed training in health and safety, confidentiality and communication when I started." The day hospice held a volunteer training pack which covered moving and handling, safeguarding and complaints to support staff in giving additional training to volunteers.

Staff received a thorough induction. They spent one day at the main site with appointments made to visit every department in the hospice. In addition training was arranged for the next available date and this took place over two days. One member of staff told us, "I was impressed with the induction. I got a really good overview of the hospice service."

The management team at the hospice had accessed systems to support nurses in their revalidation. Revalidation is the process where registered nurses and midwives are required every three years to demonstrate to the Nursing and Midwifery Council (NMC) they remain fit to practice.

Doctors in training were managed by a medical director when on placement at the hospice. They were all linked to different university medical schools. This service was a teaching hospice for doctors and they had education meetings every week. Nurses were also invited to the education meetings. The medical director and senior medical staff observed junior doctors and gave on the spot feedback.

During the inspection staff told us they felt well supported. We saw that trained staff had access to one to one supervision and care workers also took part in group discussions. Supervision is a meeting between staff and senior workers. It gives staff an opportunity to discuss their work, training and development needs. A supervision log was completed outlining the focus of discussions. One member of staff said, "I was supervised more in the first few weeks." This demonstrated the support provided to new members of staff.

We saw records to confirm staff received an annual appraisal which included a review of performance and progress within a 12 month period. This process also identified any strengths or weaknesses and areas for growth.

In order to maintain best practice the service engaged with The National Association for hospice at home

services and day hospices, Hospice UK, Skills for Care and others. The hospice ran a forum for care providers in the area and invited a representative from Skills for Care to attend and outline training to support skills and knowledge in end of life care. This demonstrated a desire to develop local skills and knowledge to support their work.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people (aged 16 and over) who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. For people living in their own home, this would be authorised via an application to the Court of Protection. There were no Deprivation of Liberty Safeguards (DoLs) authorisations by the Court of Protection in place for people using this service. People were supported to make their own decisions and consent was sought when staff provided any care and support.

People's nutritional needs were assessed and care plans recorded their food and fluid needs. The day hospice facilitated the provision of lunch for people who used the service which was provided by the hospital. The menu on the day we inspected was a choice of fish or meat with vegetables or a salad. The day hospice staff provided snacks for people such as biscuits and cake. Whenever it was someone's birthday or a special occasion the hospice catering department would provide cakes and edible treats for people. There was a separate dining room where people could sit to eat. This was accessible for people using wheelchairs.

People were assessed to determine their nutritional status. Where there was any risk of malnutrition or choking the staff at the day hospice would make a referral to the appropriate professionals. One person received their nutrition via a PEG tube. The dietician and speech and language therapist were involved in their care.

We saw that people could access any health or social care professional quickly when they attended the day hospice. The day hospice, hospital and GP surgeries in the area used Systmone which allowed quick access to appropriate support providing integrated care for people who received care from the hospice. Integrated Care is a way of coordinating health and social care services to make sure they are based closely around people's needs. It is aimed particularly at those with complex and long-term health problems. One person told us, "We had the Macmillan nurse come to see us towards the end of last year. My [spouse] said [they] sometimes felt a bit isolated and lonely. The Macmillan nurse suggested Malton Day Hospice. My [spouse] enjoyed it. It was immediate access to healthcare professionals."

Where people had pain or other symptoms that caused them distress these were managed. The service used a validated pain scale in order to identify how people demonstrated pain. This was monitored closely and if it was necessary people could be admitted to the main hospice in Scarborough for a short time to allow them to be supported by medical staff to get their symptoms under control and make them more comfortable.

The hospice had a patient advice line available to everyone who used the service to give specialist advice and support at all times of day or night. This was called Palcall. It linked to the in-patient unit at the main hospice site so that people could get instant advice. If a doctor was needed staff could access the GP services and arrange a call quickly. A relative told us, "We found the PALS (I think it is called this) liaison out of hours service at St. Catherine's Hospice very helpful. A few times when my [spouse] was particularly ill we

could ring the PALS in the middle of the night. That was brilliant. We could ring out of hours and someone would make a decision about whether we needed a Doctor. It was basic, general advice, if my [spouse] was sick or uncomfortable they gave good sensible advice. I was able to give them symptoms and I would get good advice back. If my [spouse] needed a Doctor they then sorted that out which was brilliant. I couldn't rate that highly enough."

Following the inspection we contacted external healthcare professionals to seek their views on the care and service provided. We received feedback from a heart failure nurse who told us, "I have nothing but praise for the Ryedale (Malton) Day Hospice. I refer patients at all stages of palliative "heart failure", as the trajectory of the disease is often long and difficult to predict. What we know in our area is that with good support, patients often stay out of acute care, and their quality of life improves." This demonstrated how the day hospice can assist in preventing admissions to the hospital or hospice through working together with other healthcare professionals. In addition they told us, "They shine by providing fast track referrals into OT [occupational therapy], Physio [physiotherapy], and then care at home often becomes safer; quicker. Also having a specialist doctor available can really help with tricky medication issues or symptoms that sometimes are beyond us and the GP."

Good

Is the service caring?

Our findings

People who used the service and their relatives told us that the staff were extremely caring. One person described staff as "Helpful and kind" and another said, "[Relative] likes it there. Staff and volunteers are very good." One person who we spoke with during the inspection told us their favourite thing about the day hospice was that it was, "Friendly and peaceful." They also said that the care they received was, "Brilliant."

Positive relationships were developed at the day hospice. We observed an interaction between a volunteer and a person who used the service which appeared relaxed, caring and friendly. The person who used the service told us that staff treated them politely and with respect. We saw staff chatting to one person about how things were at home and whether they were getting enough support.

There were people who used the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there. These are age, disability, gender, marital status, race, religion and sexual orientation. We saw that those diverse needs were adequately provided for within the service. The care records we saw evidenced this and the staff who we spoke with displayed empathy in respect of people's needs. We saw no evidence to suggest that anyone using the service was discriminated against and no one told us anything to contradict this.

People we spoke with during the inspection confirmed that they were involved in making decisions about the care and support that they received. They told us that staff at the service communicated well with them. One person said that staff explained the support they would be getting. They identified the staff member that spoke with them and said they communicated in a way that was easy to understand. They also told us that they had a support plan of which they were aware.

From our observations it was clear that people felt they mattered and that staff were supportive of them. We saw people responding to staff who showed genuine regard for them in their actions and conversations. One person found verbal communication difficult and staff took account of this in a caring and supportive way. They made sure that the person had a number of communication alternatives available in order that they had a voice allowing meaningful conversations to take place. Care at the day hospice was provided in line with the hospice values including 'to work in partnership.' We observed that care and support was provided with equal input from people who used the service.

Staff did an initial assessment when people first came to the day hospice where they collected information about people's preferences. We saw that staff knew people's histories when we observed their interactions and listened to their conversations. One relative said, "My [spouse] said she sometimes felt a bit isolated and lonely." They commented on the social aspects of the day hospice saying their spouse enjoyed it. People's relatives were welcome at the day hospice. One person told us, "I went in on a couple of occasions when my wife was too ill to go; [Name of staff] was very helpful and very supportive."

There was a chapel available at the main hospice and a spiritual care co-ordinator who was available to

people who used the day hospice and their families. This support was across all faiths but specific religious leaders could be accessed through the co-ordinator if people preferred.

Throughout our inspection staff were extremely caring and thoughtful in their approach to people who used the service. They provided reassuring touches, laughed and joked with people. A volunteer noticed that a person who could not communicate verbally was indicating they wanted their wrist support removing. They immediately asked a trained member of staff to remove the support.

We saw that staff respected people's privacy and dignity. Confidentiality was respected through safe storage of records and by the practices of staff. People had access to a quiet space if they wished to talk privately. Staff demonstrated a good understanding of the meaning of dignity and we observed the respect they showed people. One person told us that staff respected their privacy through the use of curtains. They told us that staff also explored with them what assistance they needed and what could be managed themselves to allow the person as much independence as possible.

Good

Is the service responsive?

Our findings

People at the service received person centred care. This is when any treatment or care takes into account people's individual needs and preferences. An assessment was undertaken when people came to the day hospice and the nurse in charge had conversations with the person about their condition. Advanced care planning was undertaken if the person wanted it to ensure that their wishes in relation to their care were recorded. "Advance care planning (ACP) is a voluntary process of discussion about future care between an individual and their care providers, irrespective of discipline. If the individual wishes, their family and friends may be included." (National Council for Palliative Care). The nurse in charge told us that one person had recently been sent home with their advanced care planning documentation. They told us that they wanted them to be able to discuss their wishes with their spouse. The documents were completed at home and returned to the day hospice when the person was ready to share their wishes. This allowed the person to have control.

Each person who attended the day hospice was supported to make advanced plans for their future care if they wished to do so. Staff showed knowledge and understanding about these discussions. We were told that they liked to discuss and record where possible the persons preferred place of care and preferred place of death. This was so that person could choose to be where they felt happiest or most comfortable at the end of their life and staff would respect that choice where they could. Discussions with people took place about advanced directives or living wills. We saw that one person had made an advanced directive about the care they wished to receive and when they would not wish to receive any further care. This was highlighted on Systmone and in written documentation to ensure that all professionals were aware of the existence of the Advanced directive. Where services were not using Systmone the nurse in charge spoke to them and asked them to note the decision on their records. This ensured that peoples wishes would be identified quickly.

When we looked at people's care plans they reflected their individual needs and wishes. They contained information about people's needs such as personal care, mobility and support needed with eating and drinking. They had more specific plans in place reflecting their physical and mental health as well as their diagnosis. These had associated risk assessments completed with clear management plans in place. People's care plans were reviewed weekly by the nurse in charge before they arrived at the day hospice. Because the information was current on Systmone they were able to do so. Where a GP was not using Systmone the nurse in charge would contact the surgery or appropriate professional to update them about people's care. This meant that people received the most appropriate support for their needs.

People were supported to maintain as much independence as possible. One person had difficulty communicating verbally. When they had started to attend the Day hospice they were seen by an occupational therapist who explored the need for equipment with them. They then worked with the person to access the appropriate equipment to make their life more comfortable and promote their independence. For instance the occupational therapist was looking at environmental control systems which would use eye movements to enable the person to control their environment. Whilst at the day hospice the staff ensured that people always had a means of communicating such as iPad, whiteboard, letters and pictures to point at

so that they could make their wishes known to staff.

In addition suitable equipment was used to meet the specific needs of people. For example, the day hospice had a care chair available for people with physical disabilities. They were able to adjust the chair themselves in order to care for themselves therefore encouraging the persons independence and dignity.

The nurse in charge told us that the aim was" To aim for comfort" for the person. We saw that people had symptom control aids in addition to medicines. One person had a neck collar which gave support and a cough assist machine. The cough assist machine helps to clear secretions from the lungs by mimicking the cough cycle. The machine brings a large volume of air gradually into the persons airways when they inhale. Once their lungs have expanded, the device will quickly reverse the flow to push the secretions out. In addition the person used a suction machine to clear secretions from the mouth. This was helpful in preventing infection.

When one person needed a hoist at home, the care worker from the day hospice visited the house and assisted in arranging the bedroom where it would be used to ensure safety and efficiency. They then visited the domiciliary care agency (DCA) who were providing this persons care at home to show them the sling that was to be used. They instructed the staff at the DCA in its use to ensure that they were competent before they visited the person at home. This proactive and inclusive approach was witnessed throughout our inspection. It was clear that the staff wanted to provide the best care possible for people who used the service.

The heart failure nurse said, "The Day Hospice helps my patients with support, socially and symptom management. Often it's just a matter of the carers getting some respite, because they too are on this difficult journey."

When people arrived at the day hospice they were asked about their interests and hobbies. One person told us they were asked what they wanted to do whilst at the day hospice. We observed one person playing dominoes with staff. The person had privacy if they wished but also had access to one to one support throughout the day if they wanted it. A volunteer told us, "I meet and greet people and take part in activities with people." As the day hospice was only open one day a week, there was very little time for outings but people who used the service were included in invitations to the wider events organised by the hospice trust. We saw feedback from people who had responded to a recent survey. One person said, "The staff go that extra mile to keep us entertained, amused and relaxed." They also said, "The volunteers keep everyone entertained. I look forward each week for a boost to my wellbeing and quality of life."

Attending the day hospice allowed people to problem solve because they had access to professionals who may be able to offer solutions. This had a positive impact on their lives at home. If people needed spiritual support the nurse in charge was able to access the spiritual care co-ordinator who was based in Scarborough. They provided a listening ear and bridged the gap between informal chats and formal counselling. They were also available for staff and volunteer support.

If the person needed practical support or advice there was a social work team available and they regularly visited the day hospices. They could make referrals to the local authority social work teams if necessary. The social work manager was actively involved in the running of carers groups and people's relatives could attend those groups which were run in different areas on a rotating basis to ensure access for people. They told us about other services available which included bereavement support that provided support to families after death. They told us how counselling was available to people who used the service and their relatives.

Until recently complementary therapies such as aromatherapy had been available but this was no longer the case. We asked the registered manager about this as the hospice information advertised aromatherapy as a service they provided. They told us that unfortunately staff had left the service recently and there had been some difficulty in recruiting to the posts. The chief executive told us there had been an issue this year with funding the posts and this would be reviewed at the start of 2017. One person who used the service told us that they had received massages and we saw from their care records that these had benefited them. A member of staff told us, "Patients have lost something which was so important and beneficial." The Cancer Research website highlights that research into the effects of aromatherapy and massage has found that it may be a helpful complementary therapy for people with cancer and other types of illness in relieving symptoms or side effects or to help people to feel better emotionally. Massage can alleviate many symptoms in patients with long term conditions. The leadership team had identified that there was a need and were doing all they could to respond to benefit the people who used the service.

St Catherine's Hospice had a website which provided information about the day hospice, the facilities and different types of support offered. One of the things they provided was respite for relatives who were the main carers. One person told us, "I asked if [relative] could come again soon. The day hospice is for real and helped me to get things done and have a break.

We saw that information was provided to people about the service complaints procedure when they came to the day hospice. In addition there were contact details on the website and the compliments, comments and complaints leaflet. We asked one person if they would know who to approach if they had a complaint. They told us they would approach staff initially but if they were not satisfied with the response they would then approach the registered manager.

There was a complaints policy and procedure for staff to follow. The leaflet provided to people who used the service highlighted the timescales in which people could expect a response. As no complaints had been received by the service we could not test whether or not they had been met. However people were confident their complaint would be dealt with appropriately. The nurse in charge assured us that any complaints would be taken very seriously and acted upon.

Good

Is the service well-led?

Our findings

There was a clear management structure at the hospice. There was a registered manager at this service who had extensive experience of running the service having worked there for many years. There had been a new chief executive appointed during the last eighteen months and they were registered with CQC as the nominated individual for the service. There was a board of trustees who visited the hospice services introducing the 'board to ward' concept which was linked to the business plan. In addition the chief executive had been involved in working with some of the teams at the hospice. The staff we spoke with were aware of the roles of the management team and told us they appreciated these initiatives.

During the inspection the registered manager was visible in the day hospice and we saw they related well to staff. One member of staff told us that the registered manager "Pops in all the time." They said they were approachable and they would be confident questioning practice or raising any matters with them.

On a day to day basis the day hospice was run by a senior nursing sister. They had also worked at the hospice for a number of years and had a wealth of experience. They had trained as a non-medical prescriber. A relative told us, "You get the impression that the service is so good because [sister in charge] is good. If something is wrong, [sister] gets it sorted quickly. It's great."

During the inspection it was clear to us that staff and volunteers worked closely together and shared similar values. They were motivated, enthusiastic, kind and supportive of people who used the service and of each other. One member of staff said, "[Sister in charge] was on leave last week and I forgot my Systmone card. I emailed the person who was covering and they provided me with a card within half an hour. Everyone is so helpful."

Regular team meetings were held where staff were kept up to date with developments and could have discussions about the running of the service.

The hospice had clear links with the community through their charity shop in the town. Local businesses had taken part in fund raising events for the hospice. In addition any events organised by the hospice included invitations to people who used the day hospice and their families. However one person whose relative used the service told us, "The service at Malton Hospice was great. It almost seemed underused. It didn't seem to have a proper home, as if they're camped out in a ward. Our experience was very, very positive." Although the day hospice benefited from the hospital facilities some members of the public held the hospice in such high regard that they believed the hospice should have their own premises. However, the hospice trust was dependant on grant funding and charitable donations and the hospital support was welcomed by them.

The hospice was adept at communicating with staff, people who used the service, their families and other professionals. They used a variety of means such as a staff newsletter, a time out group for carers of people who used the service and a drop in group for newly bereaved relatives to provide support. Where mistakes were made these were discussed and reflected upon in order to make improvements. An example was with

medicine errors. There was a document staff were asked to complete which assisted them in reflecting upon the situation. These reflections were then discussed as part of a learning process. Notifications were made to CQC where necessary meeting the services legal obligations.

The executive and leadership team had undertaken a strategic day as part of their strategic review to clarify the direction of the hospice and develop a plan for the next three years. An annual review was planned following this for 2017 to review achievements.

St Catherine's Hospice monitored the quality of care that was provided across the organisation via its Clinical Strategy and Governance Committee. They presented annual quality accounts which looked at patient safety, clinical effectiveness and patient experience. They benchmarked their safety data against other hospices by engaging with a national initiative through Hospice UK. They collected data and provided this on a quarterly basis which allowed for comparison of their rates of falls, pressure ulcers and medication incidents with the other participating hospices. They compared favourably. The hospice used methods of measuring outcomes of health care and looked specifically at the work undertaken by the Outcome Assessment and Complexity Collaborative (OACC) team at King's College.

St Catherine's Hospice Trust had participated in a number of research projects. They were one of eight national sites involved in a national C Change research project led by Kings College London. This is research which looks at the complexity of each person's care and how much time is spent with patients. Patients using the day hospice were involved in this research and their consent was sought before they took part.

Audits had identified areas for improvement in areas such as MCA and DoLs. In response to this the social work manager had led a project whereby the policies and procedures for MCA and DoLs had been updated, carried out two baseline audits, developed documentation and ensured that all staff received mandatory training looking at documentation and using a case study. There were meetings held to discuss progress every four to six weeks. In addition a leaflet had been developed which was available for people and their families to explain when decisions could or would be made in a person's best interests. These measures helped drive continuous improvement within the service.

The hospice engaged with and had representation with a number of organisations. They were represented on groups such as the palliative and end of life care partnership board for Scarborough, Ryedale and York, end of life steering group for the East Riding of Yorkshire and Hospice UK and National Association for hospice at home services and day hospices which kept staff abreast of changes in palliative and end of life care and developed their knowledge. They engaged with Hospice UK through project auditing and benchmarking in areas such as pressure ulcers, falls and medicine errors. The NHS through five CCG areas supported the service through grant funding and commissioning of services which provided approximately 34% of the hospice funding. The hospice relied upon charitable donations through their shops and through regular fundraising by the hospice and people in the community. The efforts of the fundraising team and individual members of the public allowed people to receive a free service supporting them with palliative and end of life care.