

Saint Catherines Hospice Trust

# St Catherine's Hospice - Scarborough

## Inspection report

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## Ratings

Overall rating for this service

Outstanding 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Outstanding 

Is the service responsive?

Outstanding 

Is the service well-led?

Outstanding 

# Summary of findings

## Overall summary

This inspection took place on 13 and 14 April 2016 and was announced. The previous inspection was 8 May 2014. The hospice was part of the pilot to test the Care Quality Commission's new inspection methodology and so although they were rated this was not published.

St Catherine's Hospice Scarborough provides in-patient hospice care and a hospice at home service which are regulated by CQC and a day hospice which is not regulated. These are based on one site. The hospice holds condition specific clinics, has a social work team, a bereavement support service, therapy services, an education department, a fundraising department and a team of volunteers numbering around 600.

There is a hospice at home team who provide hospice care in the community to people. There is also a care homes team of clinical nurse specialists who work specifically with care homes in the area. MacMillan clinical nurse specialists who work with people in their own homes and neurology clinical nurse specialists who work with hospital teams and community services are employed by the hospice. A spiritual care co-ordinator supports people using hospice services across the area.

The exceptional care provided by the hospice is for people that live in the Scarborough, Whitby, Ryedale, Bridlington and Driffield areas of North Yorkshire. The service is a registered charity with a board of trustees. Day to day the service is run by a senior management team drawn from all departments within the hospice.

The service was extremely responsive and focused on providing a tailored service which people helped plan and develop. There were appropriate systems in place to ensure flexibility to people so that their care needs could be met either at home, the hospice or in the wider community. In addition the service provided excellent support to relatives and carers.

Excellent leadership and management was demonstrated at the service. The culture was open and inclusive which meant that people received a tailored service which was flexible to their needs.

The main site is a purpose built facility. The in-patient unit has 18 rooms which are en suite and have doors leading on to a patio and garden. There were 12 people using the service on the day we inspected. There is a day hospice and clinic areas. A separate area houses the education department. They are linked by a corridor which leads to the dining room and kitchens.

The provider has three locations registered with the Care Quality Commission. We found that there were areas that were common to all three services. For example, training, staff meetings and policies and procedures. For this reason some of the evidence we viewed was relevant to all three services.

There was a registered manager employed for this service who also managed the day hospices in Whitby and Ryedale. 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 beautiful environment was maintained by the hospice maintenance and gardening team. There were servicing agreements in place for mains services. The premises were extremely clean and tidy with appropriate adaptations in place for people who used the service. The gardens were extremely well maintained.

Staff recruitment processes were followed with the appropriate checks being carried out. There were a high number of staff on duty to meet people's needs in a meaningful way 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. Staff and volunteers received a thorough induction and regular training to ensure they had the knowledge and skills to deliver high quality care which they demonstrated throughout the inspection.

Staff followed risk assessments and guidance in management plans when providing care and support for people in order to maintain people's 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 and support available from the safeguarding champions. There was an embedded culture of learning from mistakes.

People brought their own medicines with them to the service and 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. They told us they were involved in all decisions about their care.

People were supported to receive a nutritious diet at the service. Their appetite was assessed through talking to them which led to staff being able to give the person the amount of food they would be able to eat. There was a choice of menu on the day we inspected and we sampled food in the dining room which was of a high quality. Patients and their families received the same food unless they had something specially prepared. Drinks and snacks were freely available. Patients and their families described the food in positive terms.

When people needed specialist healthcare support the day hospice made referrals to specialist services such as occupational therapy or the dietician. There was a helpline line for people who used services and their families to use twenty four hours a day which linked directly to the hospice where they could access advice and support. This gave people confidence when they were at home.

People told us that staff were caring and listened to them. 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. We heard examples of the excellent spiritual support provided to people.

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 and the staff who we spoke with displayed empathy in respect of people's needs. These characteristics were embedded in staff training.

People were able to make decisions about the care and support that they received and told us that staff at the service communicated well with them. Confidentiality was respected through safe storage of records and by the staff who offered privacy when having difficult or sensitive conversations demonstrating respect for people's privacy and dignity. People spoke with such thankfulness about the respect shown to them by staff giving examples of how staff had helped them retain their dignity.

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 in a mutually respectful way. There were regular team meetings. 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. They also took part in research projects as a means of improving their service and educating staff. The quality of the service was enhanced by these measures and this was reflected in feedback received by the service.

## 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 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 had their medicines managed safely.

### Is the service effective?

Good ●

The service was effective.

Staff told us they felt well supported. They had supervision individually or as a group and annual appraisals were undertaken. Staff received a thorough induction and regular training to ensure they had the knowledge and skills to deliver high quality care.

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 and people told us about the high quality of the food. There was a choice of menu and drinks and snacks provided.

When people needed specialist healthcare support the hospice made referrals to those services. There was a helpline for people who used services and their families to use twenty four hours a day which gave people and their families confidence when at home.

### Is the service caring?

Outstanding ☆

The service was very caring. People told us that staff were very caring and went the extra mile. Excellent support was provided to people and their relatives by a team of staff and volunteers.

People's spiritual needs were supported and respected.

People made decisions about the care and support that they received and told us that staff at the service communicated well with them. Care was extremely person centred.

Staff respected people's privacy and dignity.

### Is the service responsive?

The service was very responsive. The hospice provided flexible services to people where they could receive help with symptom control and management as in patients, in the day centre or at home.

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 services from clinical specialist nurses and allied healthcare professionals who worked at the hospice and in the community. The social work team gave practical support.

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

**Outstanding** 

### Is the service well-led?

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

There was a willingness by everyone connected with the hospice to improve and develop. Information was shared and communicated with staff, people and their relatives through a variety of means. High quality care and support was consistently provided.

The hospice presented annual quality accounts which looked at

**Outstanding** 

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.

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# St Catherine's Hospice - Scarborough

## **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 13 and 14 April 2016 and was announced. We gave the service 48 hours' notice of the inspection because some of the services run by the hospice took place in the community and we needed to arrange to accompany staff in the hospice at home team and arrange appointments to talk to other community teams.

The inspection team consisted of one inspector and two specialist advisors. One was a pharmacist and the second was a palliative care specialist. An expert by experience was part of the team. 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 information we held about the hospice. We looked at 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.

The registered manager showed us around the hospice in patient unit which is regulated by CQC and the day hospice and education unit which are not regulated by the registered manager. We looked at the communal areas, treatment and clinic rooms, laundry, kitchen and outside space. We spoke with five people



who used the service, all of whom received a regulated service from the in-patient unit or hospice at home team. We also spoke with a group of four carers of people who used the service, two relatives in the hospice and one relative by telephone. We spoke with the team leader, a registered nurse and three care workers who worked on the in-patient unit and two clinical nurse specialists (CNS) from the care homes team. We spoke with the catering manager, two occupational therapists, the head of patient and family care services, a social worker, and four volunteers. We also interviewed the medical director, two members of the education team and the spiritual care co-ordinator. We accompanied a registered nurse from the hospice at home team which is regulated by CQC on a visit to a person's home.

We pathway tracked three people's 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 hospice such as policies and procedures, safety checks and maintenance records and were shown feedback gathered from people in a recent survey by the service and other comments which had been collated.

We looked at seven staff recruitment files and training records relating to those staff. We also looked at quality assurance systems including audits and the hospice trust business plan.

Following the inspection we requested feedback from Healthwatch who had no current information about the service, and a social work team manager who said they had only received positive feedback about the hospice services.

# Is the service safe?

## Our findings

People told us they felt safe with the staff at the day hospice. One person said, "Yes I am safe." and a volunteer told us, "A hospice isn't for everyone, but people have said they feel safe, people don't get that and if they did they would feel happier about coming here." We observed that people were safe because staff worked using safe practices.

Risks to people's health were clearly identified and managed. We attended a community multi-disciplinary team (MDT) meeting. These were held once a week on separate days for both the in-patient unit and the community teams. People's needs were classified using the RAG system. This is a popular method of rating, based on red, amber and green colours used in a traffic light rating system to denote the level of risk and therefore prioritise accordingly. People who received a red or orange rating which was high or medium priority were discussed at every meeting.

At the meetings every department was represented to ensure that all staff working with the person were aware of any changes and could contribute to discussions about their care.

We saw that staff had completed risk assessments in relation to people's health and welfare which were recorded on SystmOne. SystmOne is a clinical record system used to record patient care electronically in real time and make referrals to other healthcare professionals. These corresponded with the discussions that were held at the MDT meetings which meant that staff were aware of the risks and risk management plans for people using the hospice services. For example, one person was identified as having a medical problem and their medicine had been changed which could affect their condition. The risks and the benefits of the treatment were clearly recorded on SystmOne.

Where there was a risk identified, people had a risk management plan in place which gave clear guidance to staff. We saw from people's records that risk assessments were reviewed regularly by the nurses as people's conditions could change quickly. We saw that there was clear planning when people came to the hospice as an inpatient. Where necessary there was increased use of volunteers or staff to support people's safety. An example of this was when a person had been admitted recently they had become very disorientated and wanted to walk around the hospice. Volunteers stayed with them or nearby to ensure they were safe without intruding or entering their personal space and therefore not restricting them in any way.

People's medicines were managed safely. They were supplied by the local hospital pharmacy where there was a service level agreement in place. In addition York Teaching Hospital confirmed that they had in place a MHRA Wholesale Dealer Authorisation and Home Office Licence for the supply of medicines to the hospice. This meant that medicines were supplied legally.

Medicines were stored in locked rooms or cupboards in people's rooms. The key codes for the medicine rooms were changed regularly. The keys to the cupboards were held by senior members of staff. The rooms had air conditioning to keep the rooms cool. Recording of medicines and their administration was of a high standard. We inspected ten medicine records and found the medicine charts were complete, legible and

accurate. We reviewed and checked the medicine records of two people who had their medicines stored in their rooms. Both of the people were aware of their medicines and one of them had discussed their medicine with the team leader that morning. One person told us, "The pharmacist visited to check my cupboard" demonstrating that checks of medicines were carried out for individuals who wished to keep their own medicines. Staff supported those people in administering their medicines. People received their medicine according to the prescription. One person who required medicines at a particular time in order to maintain good health had received them appropriately.

Controlled drug records were inspected and found to be correct matching stock levels. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. Stricter legal controls apply to controlled medicines to prevent them being misused, being obtained illegally or causing harm. Patients own controlled drugs were not used for administration. A separate record book was in place for recording receipt and administration of patients own controlled drugs where necessary. Controlled drugs were destroyed by two registered nurses in the presence of an authorised witness on site. No anomalies in the destruction records were noted.

If a medicine is used in a way that is different from that described in its licence, this is called 'unlicensed' or 'off-licence' use. There was one unlicensed medicine in use at this service which was treated as a controlled drug and therefore patient level records were available for its use. Patients were on syringe driver medication (unlicensed use). The hospice staff had a lot experience using combinations of medicines in syringe drivers to manage people's symptoms and had specific guidance to support them such as the palliative care formulary and the syringe driver handbook. The unlicensed medicines were administered safely.

There was evidence of learning from medicine errors. A calculation error had taken place in February 2016. The incident had been reported, investigated and action had been taken to prevent a repeat of the incident. Staff reflection had been undertaken. The error was reported to the accountable officer. All healthcare professionals have a statutory duty to report all complaints, concerns or untoward incidents involving controlled drugs to the controlled drugs accountable officer. These are then discussed at local area network meetings to share learning points with other Accountable Officers and identify areas of concern across the networks. Benchmarking of medication errors was undertaken with Hospice UK. In quarter one of 2016 the hospice had had less medicine errors than other hospices. The records and actions demonstrated that effective action was taken in managing medicine errors and in the prevention of further incidents.

The medical director shared evidence of medicine reports and audits demonstrating active management of medicine use. They were proactive in driving changes in prescribing habits to reflect best practice and cost effectiveness.

Staff were trained in medicine management and in the community staff competency checking was very thorough. The staff had written questions and supervision around medicines. The competencies had been developed by St Christopher's hospice [Founded by Dame Cicely Saunders in 1967 and is widely regarded as the first modern hospice] and taken up by staff at St Catherine's.

Safety checks of the environment were completed to ensure peoples safety whilst using the hospice. The hospice had a team of maintenance workers and had servicing agreements with external companies in place where necessary. When staff required any maintenance to be carried out they completed a general maintenance request which went to the maintenance team. We saw evidence that repairs and renewals had been carried out following these requests. In addition, we saw evidence that electrical equipment had been

tested and gas checks carried out. Water temperatures had been tested and there were COSHH data sheets available for all chemicals on the premises. There were up to date servicing and maintenance documents for the mini bus used by hospice staff to transport people to and from the service.

A fire risk assessment had been completed in October 2015 and had clear links to regulations and guidance in written and pictorial format. There were clear procedures for evacuation displayed. Tests of the fire safety equipment were carried out regularly to make sure it was in safe working order. Fire exits were clearly identified and staff were aware of each person's needs in the event of an evacuation.

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. When asked if they felt safe with staff and volunteers at the day hospice one person told us, "Yes, definitely, they are trained."

Staff were able to tell us about safeguarding procedures and demonstrated their knowledge of the management of any abuse. Staff were fully informed of the different types of abuse, when to raise concerns and who they needed to escalate their concerns to. They said they would have no hesitation in reporting any incidents. There was a safeguarding champion within the service to support staff as well as alerter champions. Staff had training during their induction and on an annual basis to keep them updated about safeguarding matters. There had been no safeguarding referrals made by this service in the last twelve months.

Safe recruitment procedures were in place. We looked at staff recruitment files and saw that 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 and regularly thereafter, ensuring they 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.

There were sufficient staff on duty to meet people's needs. Throughout the day we saw that there were three registered nurses on the in-patient unit supported by three health care assistants. In addition there were volunteers working on reception, giving out food and drinks and helping in all areas of the hospice. There were four registered nurses working at night with one health care assistant. No one was rushed and when people asked for assistance it was provided immediately. These levels of staff meant that when people sought any assistance it was provided with very little delay. The hospice at home team worked in conjunction with Marie Curie. Marie Curie is a charity that supports people receiving palliative or end of life care. The hospice at home team had at least one nurse on duty and sometimes two supported by four to six health care assistants dependant on people's needs. At night the hospice supplied one nurse and one healthcare assistant. Alongside this Marie Curie provided one health care assistant for overnight planned care. There was an on-call rota during the night if staff needed support. The care homes team supported people who lived in local care homes. This helped to avoid unnecessary admissions to hospital.

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 they visited people at home or travelled alone with anyone.

The hospice trust employed their own team of doctors and allied healthcare professionals such as physiotherapists and occupational therapists who could be accessed when needed. In addition there was a social work team who worked closely with local authority social work teams to support people's needs. This meant that people's health and social care needs were supported safely by a team of staff.

We looked at the arrangements in place for managing accidents and incidents and preventing the risk of reoccurrence. Accidents and incidents involving people who used the service were recorded on Systmone in order to maintain current records. These were audited and reported upon in some cases. For instance the incidence of falls and pressure ulcers was audited, recorded and benchmarked against other hospices. Where it was necessary incidents and accidents were reported to the local authority and CQC. Near miss incidents were identified and themes collated and acted upon. Safety incidents were shared with the hospice clinical commissioning group (CCG) partners monthly. There had been nine serious injuries in 2015/16. These had been reported appropriately.

# Is the service effective?

## Our findings

People told us that staff knew what they were doing. One person said, "I can't praise it enough. I was very ill when I came in. They weren't expecting me to live; now they're talking about me going home. It's the difference between a two star hotel and a five star hotel, it's brilliant" and another said, "It's as near perfect as you can get, the care and everything is as near perfect as I could wish for, I couldn't speak too highly of the place."

Staff were well trained and supported by an education centre which was run for hospice staff and any other professionals who provided palliative or end of life care for people in the region. Staff told us about the training they had completed and we saw their training records which confirmed this. They had completed training in subjects which included moving and handling, use of oxygen, fire safety, dementia, safeguarding, MCA and DoLS, equality and diversity and other subjects. This training was updated annually. Volunteers also received training and each unit held a training pack to support volunteers. This covered moving and handling, safeguarding and complaints. Training helped keep people's knowledge and skills up to date.

All new staff received a thorough induction with two days of training in the hospice education department. They also spent one day at the main site with appointments made to visit each department. One care worker told us, "I was given an induction pack and had two days mandatory training. Everyone does the same." This was a training hospice and so had medical students, trainee GP's and student nurses on placement at the service. They were supported by York, Leeds and Hull universities. The student nurses had induction packs and were supervised by registered nurses. The doctors were managed by the medical director and attended weekly education meetings. Nurses were also invited to these meetings. They were supervised by senior doctors and given immediate feedback. Each junior doctor was expected to carry out an audit of one area within the hospice whilst they were training.

The head of patient and family services managed staff from therapy teams, social workers and counsellors. They had links with regional universities and provided placements for students. They had input with the doctors through their loss, grief and bereavement programme and the spiritual care coordinator spoke to doctors at their lunchtime training sessions. They were the safeguarding lead for the service and provided some training at staff induction. They told us that one member of their staff was completing a PhD and as part of their research were looking at priorities for referrals. This demonstrated how the organisation supported development of staff and how that development benefited the 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.

During the inspection staff told us and we saw that trained staff had access to one to one supervision and care workers 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.

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.

Staff had the necessary skills to communicate with people in order to carry out their role. One member of staff told us, "I find out the best way a person communicates. If I am unsure I observe their body language. If they indicate that they mean 'no' I can always seek advice. I try and involve relatives in finding the best ways to communicate. If a person has dementia I like to sit and chat with them. If they want to walk I will walk with them. I like to find out about them." This demonstrated the skills which staff used in order to engage with people. If they needed support communicating with a person living with dementia there was a dementia champion working at the hospice. They had been trained in the subject and were able to advise staff on ways of assisting people to communicate their needs and wants. According to Hospice UK dementia care is an increasingly important strategic consideration for hospices. St Catherine's hospice had recognised the need for a champion in order to ensure that hospice care was extended to everyone affected by a diagnosis of dementia within the local community.

In order to maintain best practice within the service they engaged with The National Association for hospice at home services and day hospices, Hospice UK and Skills for Care amongst others. This demonstrated a desire to develop skills and knowledge through engagement with groups who promoted excellence in palliative and end of life care. This meant that people who used the service received care from people who had the most up to date knowledge and skills. For example Skills for Care were closely involved in the forum meeting held every two months at the service in order to promote training and support to staff as well as sourcing funding for specific learning. This benefited patients within the hospice and in the community because the staff working with them had up to date and relevant training.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. Collaborative work carried out by the hospice in conjunction with regional health and social care organisations had resulted in updated procedures reflecting up to date legislation and guidance. An audit had been completed by the medical and social work teams on how staff found the completion of paperwork. This had resulted in new procedures and improved paperwork. In addition the hospice had made it mandatory for doctors to have training on this subject. There was an MCA group which met every four to six weeks and there were plans in place for a trainee GP to carry out a further audit.

People's nutritional needs were assessed and care plans recorded their food and fluid needs. The hospice provided lunch for people. One person told us, "You can have anything you want. There is a choice of menu but if you want something different they'll get it for you. It's very good." Snacks and drinks were available throughout the day. There were kitchenettes where people could go to make their own drinks. Snacks were left in the fridges for people.

The hospice catering team were well trained and responded to people's needs. They provided nutritious meals for people who used the day hospice. They were delivered and served by volunteers on the inpatient



unit. There was also a dining room available which could be used by patients, their families and staff. The local environmental health officer had awarded the service a food safety rating of five. The food hygiene rating reflects the hygiene standards found at the time the business is inspected by a food safety officer. To get the top rating of '5', businesses must do well in all elements. One person said when asked what the food was like, "Fabulous. I think you can have what you want. Lunch, three courses, there's a vegetarian option, or any other thing if that doesn't suit. I had salad and they did it just how I wanted. They'll do something like egg and chips or scrambled egg. If you don't like it, they'll do something different. I've told my [spouse] he's sacked." Another person said, "The food is absolutely wonderful. It's too nice to leave any; very nicely presented." Their relative added that the food was of exceptional quality. Someone then came in with lunch for this person and asked if they would like them to return later. When they said "No", they made sure the lunch was left where they could reach it."

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.

We had a discussion with the catering manager during the inspection and they told us that a member of the catering staff visited everyone who was newly admitted on to the in-patient unit and discussed their likes and dislikes and any special dietary requirement. The catering team had a form they complete to identify appetite (which determined portion sizes), any food allergies, aids and support required to promote independence with feeding and the type of diet people required. The catering staff had access to a computer programme which could accurately provide information on the nutritional content of foods they provided and enable improved information around nutritional values. Where there were changes to people's diets, ward staff emailed the catering department, completed the lunch or tea time menu choices in the evening or spoke to a member of the catering team to ensure the change was managed. Specialised diets were detailed on diet sheets sent by dieticians to assist catering staff in providing healthy, nutritious meals to support people's health.

When a person had an identified food allergy one chef was designated to prepare and cook their food in a separate area of the kitchen using clean utensils to reduce any risk of contamination

We saw that people could access any health or social care professional quickly. The hospice, hospital and GP surgeries in the area used SystmOne which allowed quick access to appropriate support providing integrated care for people. 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, "I didn't realise how extensive the support is to go home. I had two occupational therapists and another staff member and his assistant, all in one day." She explained that they had arranged for a new chair. This demonstrated the way in which healthcare professionals worked together in order to meet people's needs.

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. Each person using hospice services had a named medical contact and on the in-patient unit they were cared for by a blue or a red team which worked at opposite ends of the unit. This ensured people knew who was caring for them.

If relatives wanted to stay overnight there were facilities for them to do so. There were relative's rooms and kitchenettes where they could have drinks or snacks. Meals were available in the dining room during the day and there were hot drinks dispensers for people to use. The hospice provided an emergency pack for



relatives if they had no toiletries with them. One relative told us, "At Scarborough when we arrived , when [Relative] was staying for a week staff made you feel at home and settled."

Following the inspection we contacted external healthcare professionals to seek their views on the care and service provided. We received feedback from a social work care team manager who told us that they worked with staff at the hospice particularly in carrying out assessments for people. They had received only positive comments from their team.

## Is the service caring?

### Our findings

People who used the service told us that the staff were extremely caring. One person said, "Fabulous, out of this world" and another said, "There's always someone there when you buzz your bell, always very friendly and caring. They ask about your family. Of course, mustn't forget the volunteers, they bring tea and fresh water, they're very good, very chatty, very pleasant." A third person told us, "They're understanding, caring. They try to see to every need that you've got. They make you feel important, cared for."

Positive relationships were developed with people who used the services run by the hospice. We observed a volunteer waiting to meet and greet a new person in order to offer some much needed support for someone experiencing the hospice environment for the first time. Another volunteer told us, "The role of a patient care volunteer is to welcome them [people] to the hospice. You can be the first person they see if staff are busy. You go to the ambulance, take them to their room and wait with them if they're on their own and tell the relatives and patients what services there are and show them round. If people have no experience of the hospice they tell you their worries and you can feed that back to the nursing staff. The doctors aren't intimidating here but patients can forget to say things and we often pick up on things and feed back to staff. Everyone is so caring, that becomes the norm." One person who used the service told us, "It's beyond anything I could've imagined. Everyone is so nice and helpful" and a relative told us, "At Scarborough when we arrived, when [Relative] was staying for a week staff made you feel at home and settled. You can book in and have a meal with your relative which is good and they bent over backwards."

The hospice supported families and carers of people who used their services. We attended a carers group run by staff at the hospice for people whose relatives used hospice services. It was a supportive group attended by four people and facilitated by the spiritual care co-ordinator and the social worker. The people who attended provided support to each other and told us that it meant a lot to them to be able to attend the group. One person told us, "I am late for an appointment but I have come here instead as I would rather be here." The people that attended were able to discuss their concerns about their relatives with people who understood what they were experiencing providing them with a comforting, environment which supported their needs.

Staff were motivated to provide compassionate care. The hospice used a holistic assessment for each person who used the service. These not only incorporated the needs of the person using the service, but those of the people who were important to them allowing relatives and people of significance to the person to express their views and share their insights. In addition the hospice had separate relative's rooms or people could stay in the person's room according to their wishes. Relatives or family members were empowered by staff to contribute to the person's care if that is what the person wanted. This allowed the person using the hospice to receive extremely person centred care. One person who had shared their story on the hospice website had said they slept by their [relative's] bed. "Every time the nurses came into the room, they were checking my [Relative] but also checking we [family] were OK too," she said. "It made such a difference. We all felt so loved."

However, being a family caregiver at the end of a person's life requires support. The staff at the hospice

recognised this and gave as much or as little support as each person needed. The hospice further developed their carer services to include an annual series of training and support sessions for carers. This was called 'Caring for the Carer'. Another person who shared their story on the website said, "My Relative], [Name], has enjoyed taking part in a carers' course at the hospice where he learnt many valuable lessons in the hands of very knowledgeable and experienced people."

There were people who used the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010; 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 and understanding in respect of people's needs.

The hospice worked under the banner of Your community, Your hospice, Our care. Their documentation stated that in order to be able to provide 'Our care' they, "Put patients at the centre of everything we do." In the annual quality accounts we saw that one relative had been quoted as saying, "My [relative] only spent the last 10 hours of his life in the hospice but it gave him dignity and loving care in that time. I am very grateful for it and full of praise for the unstinting help given by the Clinical Nurse Specialist of the community team during the preceding months. The reassurance of the availability of Palcall was also a help throughout. I would like to thank you for the whole service and in particular that of the Community Clinical Nurse Specialist - He helped us both so much." Staff demonstrated the value of caring through their unstinting support of people and their families.

People we spoke with during the inspection confirmed that they were involved in making decisions about the care and support that they received. We observed people being asked what they wanted to eat and drink. There was strong evidence in multi-disciplinary team (MDT) discussions of person centred care and respecting individual's decision making. One example involved a person with a neurological condition who refused intervention for a particular condition. It was made clear in the discussions that the person had full mental capacity and had been informed of the risks associated with refusing care therefore being able to make an informed decision. One person told us, "They explain things to you; not just the good things."

We saw evidence of clear discussions with a newly admitted patient who had not tolerated an oral diet for five weeks. The patient was not keen on alternate feeding and did not feel it would be in their best interest. Clear communication was documented that they may not get completely free of the symptoms but the goal would be to manage their symptoms rather than gain total relief. Staff suggested alternative means of support with the person to maintain their comfort to which they agreed.

It was clear that people felt cared for and that they mattered to staff. One person told us, "The kindness, everyone's so kind, nothing's too much trouble, they're all prepared to go the second mile."

People's privacy and dignity was respected. We were told that a volunteer from the hospice had been awarded a top honour by the Prime Minister for their efforts, "In bringing dignity and comfort" to patients. A person who used the hospice service told us, "[Staff] are very sensitive." They said it was nothing specific that they had done but, "Just anything I ask they've done, open a window, or reach me something." Another person told us, "The girls were here when I had a bath they took my clothes off but then covered me with a towel so I could go to the bath with pride and the same when I came out of the bath." Confidentiality was respected through safe storage of records and by the practices of staff. Staff demonstrated a good understanding of the meaning of dignity and we observed the respect they showed people.

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 well, particularly when they were attending the day hospice. This was because people had often been involved with the hospice using different departments and staff had got to know them over time. One person told us that they had recently been on the in-patient unit and had access to Palcall. They told us, "I can't praise the staff here at the day hospice and main hospice enough. That's the beauty of coming here; everyone is so nice to you."

A patient admitted for respite care was recorded to have required significant supervision due to anxiety and restlessness increasing the risk of falls at night. Reassurance had been given by staff and the reason for admission was explained which appeared to reduce their distress allowing them to remember why they were there and reducing the risk to their well being. As they remained anxious on waking staff helped them to phone their relative which reassured them. The staff used their excellent knowledge of this person in order to support them when they were distressed.

People's spiritual needs were considered by staff at the hospice. 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. There was currently a good on-going engagement process with people who used the service, families and staff to determine how the chapel should be developed into a spiritual space for all faiths. In addition the spiritual care coordinator had organised a presentation showing how other hospices had carried out this exercise. They had rearranged the chapel to make it more inviting to everyone who may need to spend some quiet time in a spiritual space. Specific religious leaders could be accessed through the coordinator if people preferred. They told us that nurses and care workers often instigated their involvement with people through chatting. They highlighted an example of one care worker who, "Made it easy to pick up with people."

The spiritual care co-ordinator told us about one person whose great grandchild had been baptised. They were too ill to attend and so the next day the spiritual care co-ordinator who is also a lay preacher carried out a blessing in the hospice. Another patient wanted to renew their wedding vows and so they worked together to plan and carry out the service. The person has now asked if the spiritual co-ordinator will lead their funeral. One person told us, "I have appreciated the Chaplain [Spiritual Care Coordinator] visiting. [They] have been very helpful and encouraging."

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. They worked hard to ensure that people had a good death. For example, the National End of Life Care Strategy for England [18] defines 'a good death' as being treated as an individual, with dignity and respect; being without pain and other symptoms; being in familiar surroundings; being in the company of close family and/or friends. We saw that St Catherine's hospice aspired to meet these criteria in all cases.

People received high quality bereavement support. Support was provided pre and post death through the hospice palliative counselling and bereavement support service. In a recent retrospective quality audit carried out by an external body a case from St Catherine's Hospice had been presented for audit. The audit found that there had been excellent liaison with other external healthcare agencies and made positive comment about the care offered to the persons family post bereavement. Carers were supported up to the point of their relative's death and were invited to attend four counselling sessions afterwards. One person told their story on the hospice website and said, The hospice has given me such joy and fulfilment over the last two years. I have spent hours weeping bucket loads of tears with my hospice counsellor so that I can go out into the world with a smile on my face and make everyone believe that I am fit as a fiddle!

When people were at the end of their life staff in the in-patient unit encouraged families to stay with them for

as long as they wished. A member of staff told us, "People can stay as long as they wish. We would offer to let them to stay with us overnight, particularly if someone was elderly, so that they are not going back to an empty house." Three months after the death of a person on the in-patient staff wrote to their families inviting them to telephone staff if they needed help or support. The hospice website states, "What we offer is time. Time for people. Time for talking. Time to be heard. Time for understanding." Our observations of practice and people's feedback confirmed this was true.

## Is the service responsive?

### Our findings

Staff were passionate about providing people with compassionate palliative and end of life care that reflected their preferences. 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 initial and on-going 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). One person told us, "I've been looking at my support plan with staff here; I may go home for a day or two, that would be a goal."

Each person who used hospice services was supported to make advanced plans for their future care if they wished to do so. Staff showed knowledge and understanding about these discussions. It was recognised not all patients were ready for such discussions and this was clearly respected. We were told that staff liked to discuss and record where possible the persons preferred place of care and preferred place of death. This was so that the 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. We saw that in most cases these decisions were recorded in their records. Discussions with people took place about advanced directives or living wills.

One person whose relative had a life limiting neurological condition spoke on the hospice website about the positive impact of their relative having respite stays at the hospice. They said, "He was sitting out in the hospice grounds one summer's evening with his dog at his feet when a nurse brought him a lager for him to enjoy just as he would at home. Just how fantastic was that? It was something the nurse knew he loved to do, sit outside in the evening with the dog and his can. It makes such a difference to be able to talk to somebody who knows the illness and really understands. We know my [Relatives] illness is life-limiting. We just want to cram in as much as we can and that's what Saint Catherine's is helping us to do."

The hospice was responsive to the needs of people who were in hospital by developing an innovative service offering an alternative place of death to hospital in the last weeks or days of life. This was through the use of a nurse led bed service which was in constant use. There were currently four nurse led beds available for people who had no reversible conditions and symptom control was uncomplicated. Patients were admitted to these beds from the local hospital and could be transferred at any time of day. They may not have had any previous involvement with professionals working at the hospice, therefore giving the hospice an opportunity to provide high quality end of life care to a wider population. Working collaboratively with the local hospital, the project has been successful in reducing the number of patients at the end of life who die in hospital. The service offered people in hospital, the option of receiving excellent end of life care in the hospice environment increasing the choice available to people and reducing the number of people who died in hospital.

In addition the hospice had according to the provider information return (PIR) 'responded to the needs of

people with non-malignant disease as highlighted as a need nationally and locally through the development of heart failure, neurology and Parkinson's services'. We saw that the hospice had a respite bed which was used on a rota basis for neurology patients. This was because those people often had a longer prognosis and in order to support families to continue to provide care the respite bed provided them with a break. In addition the respite break gave an opportunity for staff to determine if there was a need for referral to access appropriate benefits or to assess and treat any symptoms the person may be experiencing. Some people are discharged to nursing homes or to their own homes. The hospice at home team and care homes team ensured the provision of care to be extended into the community. A nurse on the in patient unit told us, "Patients like to know we are still involved and that we are not abandoning them."

It had been recognised by the hospice that some individuals preferred place of care and death was at home but they had acute episodes of ill health which led to frequent hospital admissions towards the end of their life. In response a new service had been established called Hospice at Home. The service was provided from the hospice in partnership with Marie Curie providing a 24 hour seven day a week service to respond to such situations and to avoid unnecessary admissions to hospital. Staff worked collaboratively with district nurses, doctors and other health professionals to fill service gaps and provide a seamless service for individuals nearing the end of their life.

A care homes team had already been being established and was the only such team operating in the region. This was staffed by clinical nurse specialists who supported people who lived in care homes at the end of their life in order to allow them to be at home at the end of their life if they wished. They also provided training for care homes staff promoting high standards in palliative and end of life care. This improved the skills of care home staff in the area which encouraged better outcomes for people. The CNS's could access hospice services for people. One CNS told us, "I accessed a lymphedema nurse for a person in the last four weeks of their life who then accessed equipment for them." They told us that doctors from the hospice could do home visits and they could access clinics and the day hospice if people needed those services. They were also proactive in accessing advocacy for those people who had no family. In each care home they encouraged at least one member of staff to complete training as a palliative care link worker. They had access to the care homes team at any time which meant that people would be supported by well trained staff who were able to respond quickly to any symptoms or concerns through their link with the hospice.

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 risk management plans in place. People's care plans were reviewed regularly by nursing staff and medical staff. 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. There was clear documented evidence on SystmOne of discussions with people and their relatives where appropriate about treatment and the person's prognosis. One person told us, "They've incorporated my thinking all the time. They've been very sensitive to what I want [In care plans]."

Specific conditions were supported by staff at the hospice. The complexities of neurological patients were supported by two neurology specialist nurses employed by the hospice. They worked across CCG boundaries supporting patients in Yorkshire and the Humber areas. Quality of life and respecting individual wishes was very much at the forefront of their discussions at the community MDT. However, due to the nature of neurological conditions it was not always easy to identify clearly individual preferences for care and treatment which also led them to reflect on whether or not people retained capacity to make decisions.

Where it was decided that people may not have retained the capacity to make decisions staff used the principles of the Mental Capacity Act to make decisions in their best interests. The staff demonstrated a clear person centred approach to people's care and support. This was evidenced when they were highly commended at the BMJ (British Medical Journal) Awards in 2015.

Staff at the hospice were well trained and skilled in recognising when someone was in the last days of life. They were trained in recognising signs and symptoms as part of their on-going training. In the community if 'just in case' medicines also known as anticipatory medicines were not already prescribed staff would make sure that was done to ensure that the person suffered no adverse symptoms. They were given to people to be kept in their home 'just in case' they needed them. This meant they could be given a medicine to help relieve pain or other symptoms if they needed it, especially during the night. Staff were trained to set up syringe drivers in order to administer these medicines and care workers in the community were trained to recognise that the syringe driver was working properly. A syringe driver helps reduce symptoms by delivering a steady flow of injected medication continuously under the skin. In the in-patient unit these medicines could be prescribed and administered when needed.

If a person using the hospice was living with dementia, staff were supported to care for them by the dementia champion. They had a special interest in this subject and had helped the staff to make sure the hospice was dementia friendly as far as possible. There was signage throughout the building and long wide corridors to walk around. All the rooms led into a central courtyard area that was secure. There were empathy dolls [dolls to stimulate caring feelings and start conversations] available and twiddle muffs [knitted muffs with attached items for people to twiddle]. All of these items could be loaned by families to help in their care of the person. They were also there for staff to use to interact with people living with dementia and to use as a distraction technique. There was an education board in the in-patient unit with useful information for staff and families about the condition.

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. They told us that attending the hospice 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. 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. 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. Staff had left the service and there had been difficulty with recruitment. The leadership team had identified that there was a need for massage and were doing all they could to respond to benefit the people who used the service.

We spoke to two occupational therapists who worked at the hospice. They told us their referrals came from neurology specialist nurses, MDT meetings and day and the in-patient unit. Meaningful and purposeful intervention was provided with organised visits to people's homes in preparation for discharge. They checked that people could access areas of their home safely and made recommendations for ramps and support bars in the home. They also supported people in the in-patient unit. One person told us, "I said



yesterday that I don't like the chair, I can't get comfortable in it. I knew they were short staffed so I said I would go back to bed before the staff meeting, but they said, "You don't have to, we can get someone out of the meeting to hoist if necessary." I didn't want to be a nuisance. When I say that, they say "You're not a nuisance." I told one staff member I didn't like the chair and it was passed quickly to the senior, so they do listen and pass on info. One of the physios [physiotherapist] and the occupational therapist has said they'll organize another chair hopefully by lunch today." We spoke to a nurse who told us that a different chair had been provided alleviating their discomfort.

People knew how to complain. There were contact details on their website telling people who to contact and they were given the compliments, comments and complaints leaflet when they came into the hospice. We asked one person if they would know who to approach if they had a complaint. They told us, "I would complain to nurse in charge." There was a complaints policy and procedure for staff to follow. The leaflet provided to people who used the service highlighted the timescales within they should expect a response. One person told us, "I was so poorly when I came in; I wasn't aware, but my husband may have been told. There is information on complaints and comments in the book in the room. My husband's read it."

There had been three complaints received by the service in the last twelve months. They had been dealt with in line with the service policy and procedure. The complaints had been reviewed but no themes identified. None of the complaints were serious and were all resolved in the appropriate time scales. In comparison the hospice had received 112 compliments about their service. We saw some of the comments collected in a recent survey. One person said, "It has been a wonderful experience."

## Is the service well-led?

### Our findings

Exceptional management and leadership was demonstrated at St Catherine's hospice. Our discussions throughout the inspection demonstrated that there was an open culture with staff empowering people to plan and be involved in the high quality care provided at this service. This meant that people continuously had a say in how they wanted their care to be delivered.

The strong and positive management approach resulted in people receiving a tailored inclusive service which focused on them receiving outstanding individualised care.

The vision of the hospice was, "To be the provider of choice for excellent palliative and end of life care, which meets patient need and for which we have the skills and resources to make a difference." The way in which the service had responded to people's needs in the development of their services to ensure that as many people as possible in the area received high quality care at the end of their lives demonstrated that the vision was embedded in the culture of the service. Staff were passionate about their roles when they spoke to us and during the inspection people were unanimous in their positive comments about working at the service and were very keen to tell us about their area of work. A person who had used the services at the hospice and completed a survey said, "It has been a wonderful experience. Everyone has been wonderful." Those comments encompassed what we heard throughout the two days of inspection.

There was a clear management structure with a board of trustees and an executive and leadership group contributing to the day to day management of the hospice. The registered manager was in charge of patient services. The registered manager 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. The staff told us, "Even the chief exec [executive] came on to the unit and they knew all our names within the first week. They shadowed staff. I thought that was good as they don't always know how hard we work. It is like a big family."

During the inspection the registered manager was visible throughout the hospice and we saw they related well to staff. One member of staff told us that the registered manager was, "Supportive and cared about staff." A second person said, "When I thought I would have to leave work as I couldn't manage full time hours the registered manager told me they would rather keep me part time than lose me. That gave me confidence."

On a day to day basis the in-patient unit at the hospice was run by two team leaders. They had also worked at the hospice for a number of years and had a wealth of experience. The hospice at home and care home teams were managed by experienced members of staff as was patient and family care services. All of these managers were well qualified in their area of work and so understood the needs of the people they worked with clearly. They could also understand the issues staff faced day to day and were more able to give meaningful support. For people who used the service this resulted in a relevant and consistent service because the managers understood what they needed.

During the inspection it was clear to us that staff and volunteers worked closely together and had shared values with the hospice. People who used the service described them as very caring and said they were interested in what they had to say. The medical director told us, "This is a very positive place to work. There is a willingness to embrace new ideas and be open about things. It has allowed us to touch more people."

The care homes team contributed to best practice in palliative and end of life care in the region through their support of people in care homes, education of staff and support of community doctors and other healthcare professionals. The initiative being the only one of its kind in the region. They responded to the 'Every Moment Counts narrative' by working to make the last stage of life for people as good as possible. They did this through working with people, their carers and care home staff to have honest conversations, give timely support whilst meeting people's physical, spiritual and practical needs. Every Moment Counts sets out how good, coordinated or integrated care looks to people near the end of life and is written from their point of view. One clinical nurse specialist told us, "This work is so important in making sure that staff in care homes are able to give good quality care to people at the end of their lives. We are able to support them in this with our expertise." Their work was important throughout the area because it reached out into the community and provided an extension of the care provided within the hospice. Many more people would like to die at home than currently do so and community initiatives such as the care homes team have allowed people living in care homes to be able to make that choice. In addition, the involvement of the care homes team removed the need for unnecessary hospital admissions and promoted partnership working as they supported GP's and district nurses. One GP had said in feedback quoted in the hospice quality accounts, "I'm a GP and one of [Hospice] Clinical Nurse Specialist's (CNS) gave me the help I needed to keep two dying patients in their residential home, and allowed them to die as comfortably as possible. The CNS helped me with the syringe driver prescriptions and helped liaise with the DN's. I felt happy these patients would be well cared for over the weekend with the CNS on-call."

Regular team meetings were held where staff were kept up to date with developments and could have discussions about the running of the service. We saw minutes of the meetings where staff had discussed training and projects that the hospice was involved with. There were also weekly multi-disciplinary team meetings for the in-patient unit and community teams where people's care was discussed. This gave staff opportunities to share their views, experiences and contribute to the way their team worked.

Fund raising was integral at the hospice as much of their funding was secured in this way. The hospice had clear links with the community through their charity shops around the town. Local businesses had taken part in fund raising events for the hospice. In addition events were organised by the hospice fund raising team. Some of the events such as the sunflower appeal gave people an opportunity to remember loved ones. By giving a donation a sunflower was planted in the hospice garden in their memory. In addition the hospice held an annual service of remembrance for members of the community to attend at a local church in the area.

The hospice was skilled in 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. 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. This had involved staff at the hospice and feedback from people who used the service. An annual review was planned following this in 2017 to review achievements.

Saint Catherine's Hospice monitored the quality of care that is 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. The endorsement of this by the Scarborough and Ryedale Clinical Commissioning Group (SRCCG) said, "St Catherine's Hospice continues to drive high quality patient centred care across all their services and commit to the five priorities of care; being treated as an individual, being treated with dignity and respect, being without pain and other symptoms, being in familiar surroundings and being in the company of close family and/or friends. It has been a pleasure to work with them and we very much look forward to working with them in the future."

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. The data for quarter one showed that they compared favourably which meant that people who used this service developed less pressure ulcers, had less falls and fewer medicine incidents than at other hospices. 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 hospice were involved in this research and their consent was sought before they took part. The aim was to discover the best ways to ensure that patient level palliative care funding matched that of the person's needs. In addition the hospice had been involved in a pharmacovigilance study. Pharmacovigilance contributes to the safety of medicines and serves as an indicator of the standards of clinical care practised. These research projects and studies benefited both people who used the service and staff because the results were used to improve patient safety and care, which was part of the strategy for continuous improvement embraced by the hospice.

Audits had identified areas for improvement in areas such as MCA and DoLS. In response to this the social work manager had jointly with medical staff developed 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 was currently looking for people who had used services as patients, carers or family members to be involved in evaluating, planning and developing their future services. They would work with a small group of staff to look at the areas that could be developed in the future which would benefit people and their families. The hospice had begun to use descriptive patient stories as part of their patient and family feedback. Some of these narratives giving the persons perspective, are on the hospice website.

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. They engaged with Hospice UK through in patient safety auditing and benchmarking in areas such as pressure ulcers, falls and medicine errors. The NHS through four CCG areas supported the service through grant funding and commissioning of services.

The hospice demonstrated partnership working through their facilitation of a care homes forum every two months along with Skills for Care where staff from care homes were invited to listen to speakers and contribute to their learning through short teaching sessions. This was part of an area wide continuous improvement process locally. In addition the hospice staff attended regional groups for infection control, rehabilitation, education and bereavement counselling to keep abreast of good practice and network with other professionals.

The staff at the hospice worked closely with local doctors, district nurses, specialist nurses and allied professionals. We spoke to several health and social care professionals and all of them had only positive comments. One social work team leader told us, "What can I say. My team has never had a bad word to say about the hospice."