

## Harrogate District Hospice Care

# Harrogate District Hospice Care Limited

### Inspection report

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### Ratings

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

### Overall summary

The inspection took place on 2 July 2015 and was unannounced.

At our last inspection on 15 October 2013 the provider was meeting all the regulations that were assessed.

Harrogate District Hospice Care Limited provided care and support to more than 2,000 people every year through its hospice and community based services.

Services included specialised support at home, hospice care including day therapy and inpatient care, lymphoedema management, support for families and carers, and bereavement support. They are made available to people living in the Harrogate area who are at least 18 years old and there is no charge to people using the services.

# Summary of findings

This report follows an inspection visit to the 10 bedded inpatient unit known as Saint Michael's Hospice, which was carried out on 2 July 2015. People are referred to the hospice in agreement with their consultant or GP and may be admitted for care during the last weeks and days of their life, symptom control, assessment and / or respite care. The hospice is located in a large adapted building overlooking Crimple Valley in Harrogate. During their stay people have access to a team of health and social care professionals as well as bereavement counsellors, complementary therapists and chaplains.

There is a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that Harrogate District Hospice Care Limited provided outstanding care. Effective leadership, management and governance systems were used along with clear strategic planning to critically assess their performance and create a culture of continual improvement, to meet the changing needs of the population.

There was a visible management presence throughout the service, which promoted the hospice vision and values and ensured consistent best practice. Feedback from people using the service, health and social care professionals and visitors was wholly positive. Everyone spoke highly of the care that they or their relative received and people said that staff were highly sensitive to their needs and were compassionate. Hospice staff were extremely proactive in finding out and meeting people's emotional, spiritual and social needs as well as their physical needs. This meant people approaching end of life or with a life limiting conditions were actively supported to lead a full, active life. People were provided with as much information as they wanted and were encouraged to make their own decisions based on the best therapeutic options.

People spoke positively about all the staff and the catering team was singled out for particular mention. People who used the service and staff said that catering staff were always willing to make special efforts, to tempt

people's appetites with food that they might like or that had been requested. Everyone told us that the food was of an excellent quality and that mealtimes were a social occasion that everyone enjoyed.

There were examples of excellent partnership working and joint planning with commissioners and other providers, to ensure people received the best care. A joint initiative with the Harrogate Hospital Foundation Trust meant that people had the support of specialist care and advice whether they were in the hospice, in residential or nursing care, in hospital or at home. Staff were currently engaging with another care provider to review and better understand palliative care needs for people with a learning disability. This offered staff the opportunity to exchange professional ideas and promote best practice.

Volunteers were used extensively throughout the hospice and in the counselling and befriending services. Those services provided substantial practical care and emotional support during people's illness and during bereavement. People experiencing emotional distress or poor mental health could also access counselling and support services, which operated alongside the bereavement support service. The award of a social action end of life project grant meant that the home care service was set to expand still further and thus enable people living with any terminal illness to benefit.

An extensive range of educational development programmes, meetings and support was provided to external organisations. This benefitted people living in the Harrogate district area through the dissemination of best practice and enhanced communication between partner agencies. Health and social care professionals endorsed the training they had undertaken and were positive about the benefits to their own work.

Effective management arrangements were in place to safeguard people and to promote their wellbeing. Safe recruitment practice was followed for both paid staff and volunteers, which minimised the risk of appointing someone unsuitable. All staff and volunteers received training appropriate to their role within the hospice. Staff were knowledgeable and had the right skills, knowledge and experience to provide people with safe, consistent care. Clinical supervision and counselling promoted staff self-awareness, professional accountability and emotional wellbeing, which further enhanced patient care.

# Summary of findings

There was a high level of expertise in the way people's symptoms were managed and clinical care was delivered. Prescription charts were clear and the times medicines were administered conscientiously recorded and medicines due outside of normal medicine rounds were flagged to ensure they were not forgotten. Whilst practice issues regarding medicines management were discussed immediate action was taken once these matters were brought to the manager's attention. The governance arrangement around the management of medicines including controlled drugs was good. Incidents including medicines errors were logged and reviewed by the manager quarterly to look for trends and to learn from what had happened.

People's care plans gave a good overview of people's individual needs and the assistance they required. They contained detailed information to instruct staff what

action they should take to make sure people received appropriate care, treatment and specialist support. People were supported to attend healthcare appointments and hospice staff liaised with other healthcare professionals, to meet people's holistic care needs.

A high value was placed on dignity and respect and the wishes of the person who was ill. Staff were aware of the requirements of the Mental Capacity Act (MCA) 2005 and Deprivations of Liberty safeguards (DoLS) and had applied their knowledge appropriately to ensure people's rights and freedoms were upheld. Where people were unable to make complex decisions for themselves the service had considered the person's capacity under the MCA and had taken action to arrange meetings to make a decision within their best interests.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was safe. Processes were in place to protect people from the risk of abuse. Staff were aware of safeguarding adults procedures.

Risks were assessed and well managed. Safe recruitment practice was followed, which minimised the risk of appointing anyone unsuitable. Volunteers who worked with people also underwent stringent interview processes and Disclosure and Barring System checks.

Staff handled people's medicines safely and focused on effective symptom control. Issues around medicines management were dealt with promptly and efficiently.

Good



### Is the service effective?

The service was effective. People received high quality, compassionate care from a dedicated, committed staff team.

Staff continually developed their skills, and focused on clinical practice and professional development, to enhance people's care and treatment. The provision of clinical supervision counselling promoted reflective practice and emotional wellbeing in the staff team and further enhanced the provision of high quality care.

Extensive training, professional meetings and ongoing advice and support was provided to staff working in the service, volunteers and external organisations, to ensure people received excellent care based on national guidance and best practice.

People commended the catering team and the quality of the food provided. Both staff and the people who used the service told us that the catering team made special efforts and went the extra mile to tempt people with food that they might like or that they had requested. They said mealtimes were a social occasion, which everyone enjoyed.

The hospice staff liaised closely with other health and social care professionals to ensure that people received high quality care and the healthcare treatment they required.

Good



### Is the service caring?

The service was caring. The feedback we received from a range of sources was entirely positive. People spoke highly about their care and they said staff were highly sensitive to their needs and were compassionate.

People's experiences were enriched by volunteers who offered a wide range of practical support and companionship. People using the service and their families had access to bereavement counselling and befriending services, to promote their emotional and psychological wellbeing.

People living in the community could also access bereavement counselling independently of other hospice services. This service operated alongside a counselling and support service, which offered counselling, befriending, support and social groups, to support people's emotional and psychological wellbeing in the community.

Outstanding



# Summary of findings

The hospice was proactive in addressing health inequalities and improving access to people living with life limiting or end of life conditions, in line with national directives. For example, the service was actively working with another provider to look at improved outcomes and access to hospice services for people with a learning disability living with palliative care needs.

People were involved in end of life planning, and their wishes were recorded and carried out. People were supported to access information through leaflets, in the supporter's magazine and on the website. Translators were made available to people whose first language was not English to make sure they were involved in decisions about their care.

People's privacy and dignity were respected. Visitors could visit at any time and could stay for as long as they wanted. People had access to counselling services, quiet spaces for reflection and visiting chaplains offered solace and support.

## Is the service responsive?

The service was responsive. People's care records were personalised to reflect their individual preferences and the support they required to meet their care needs. Care plans were used as a basis for quality, continuity of care and risk management.

People spoke positively about the service and were confident that their views and opinions would be listened to and acted upon.

People received consistent and coordinated care. Staff worked collaboratively with other palliative care providers to promote a responsive and effective delivery of services.

Good



## Is the service well-led?

The service was well led.

There was an experienced leadership team who communicated a clear vision and purpose about the strategic development of the service. Management systems were used to critically assess the service's performance both regionally and nationally and drive a culture of continual improvement.

People described a confident, innovative culture with a strong focus on best practice. There was a dedicated, committed staff team that ably demonstrated the vision and values of the organisation to put local people at the heart of how care was delivered and improve the lives of people affected by terminal illness.

Effective management systems were in place to promote people's safety and welfare. The hospice fostered good working relationships with partner organisations in order to give people access to high quality, person centred end of life care. Staff and volunteers were encouraged and supported to develop their practice to ensure people received flexible care that effectively met their care needs.

Good



# Harrogate District Hospice Care Limited

## 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 2 July 2015 and was unannounced.

The inspection team included an adult social care inspector, an expert by experience and two professional advisors. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had prior experience of developing hospice services. One of the specialist advisors was a pharmacist. The second specialist advisor was a registered nurse with experience of working as a senior commissioning manager within the NHS.

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 also reviewed the information we held about the service, such as notifications we had received from the registered manager. A notification is information about important events which the service is required to send us by law. We planned the inspection using this information.

We sent questionnaires out to three people who used the service and to seven relatives, one was completed and returned. Questionnaires were also sent to three community professionals and one was received. We contacted community healthcare professionals including a commissioning manager with the Clinical Commissioning Group (CCG), a Community Matron and Head of Community Nursing and a GP to ask for their view on the quality of the service. We also asked Healthwatch for feedback about the hospice. Healthwatch gathers the views and experience of people about their local services, and uses that information to help improve services and influence commissioning outcomes for people living in the area.

During our visit to the service we met and spoke with four inpatients, two people who attended the day hospice service, and with one relative. We looked at the care for three people who used the service in detail. This meant we spoke with staff and read people's care records to see how the people were supported. We met the medical director and interviewed the head of inpatient services (the manager), the deputy head of inpatient services (the deputy manager), the professional and clinical supervisor counsellor, the nursing sister on the inpatient unit and a nurse. We reviewed a range of records including care plans for three people; prescription charts for five people; quality assurance audits; recruitment files and staff training records for four staff; patient surveys; nutritional audit and minutes from the food and nutrition group; minutes from the Board of Trustees meetings and Clinical Governance Trustee Group meetings; the summary of clinical incidents; medicines audits; and the Statement of Purpose.

# Is the service safe?

## Our findings

Everyone we spoke with told us they felt safe in the hospice in every way. Although people told us they did not have any concerns they were confident that should they raise any issues these would be addressed. People looked clean, comfortable and very well cared for, as did the environment. One person said, "The staff are rigorous about my hygiene to make sure I do not get an infection." Another person said, "I feel very safe. Sometimes I have to wait when I ring the bell but that is mostly at night and staff always explain why." All people said the care they received in the hospice was better than any they had received in the hospital setting or could receive at home. There was good interaction going on between staff at all grades and roles and the people using the service and visitors. Staff were polite and professional.

There was a safeguarding policy in place that included information about the protection of adults and children. Information about the policy was displayed at points around the service and four staff were designated as safeguarding officers. These staff members met on a monthly basis to discuss and review cases, and liaised with the local authority safeguarding team. The staff we spoke with were familiar with safeguarding policies and procedures. Staff confirmed they had annual mandatory training on safeguarding, to ensure their knowledge and awareness of safeguarding issues was up to date.

Records demonstrated that people were assisted to make informed decisions about their care and supported appropriately where risk was involved. There was evidence of risk assessments for people, with family and carer involvement where appropriate. Health or social care professionals completed a referral form, which included details about existing or potential risks to ensure the safe transition of care.

Everyone described their care positively and described having their needs met. People felt fully engaged in their care planning including risk assessments, as much as they wished to be. Risk assessments described the actions staff were to take to reduce the possibility of harm without applying any unnecessary restrictions. For example, individual risk assessments included measures to minimise the risk of falls whilst encouraging people to walk independently. Assessments also considered the likelihood

of pressure ulcers developing or to ensure people were eating and drinking. This meant that risks could be identified and action taken to reduce the risks and keep people safe.

There was a policy on clinical governance. Data on falls, pressure ulcers and medicine incidents was collated nationally and used by the service to benchmark their performance. Records demonstrated that incidents and accidents were reviewed through the management reporting processes to board level. The sub trustee governance group meeting minutes provided evidence that learning points and improvements were discussed and agreed.

We spoke with a member of staff who was responsible for updating people's risk assessments and care plans. For one person, these were due to be updated on a weekly basis but they had last been reviewed on 20 June 2015. On exploring this further with the nurse, we were told that the service had been exceptionally busy and staff had prioritised people's safety and care at the weekend. They told us, and the manager confirmed that reviewing and updating risk assessment and care plans were re-scheduled to the following week.

Personal emergency evacuation plans (PEEP) were in place, taking into account people's mobility and moving and assisting needs. The purpose of a PEEP was to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. The provider told us in their PIR that they had purchased two high pressure relief mattresses one of which had an integral fire evacuation sledge which was an additional safety factor.

The service had a wide variety of equipment such as overhead tracking hoists, manual hoists, and assisted baths. General risk assessments covered the building and the environment including risks of using hoisting equipment and disposal of waste materials. Appropriate systems were in place for the maintenance of the building and keeping equipment clean and serviced. Staff training programmes ensured that staff were up to date with moving and handling procedures, so that people were assisted to mobilise safely.

Thirty contracted staff, mostly part-time, were employed on the inpatient unit with another seven staff in the day therapy unit. The service also operated its own bank staff of

## Is the service safe?

registered nurses and health care assistants. Although they had needed to use agency staff in the past six months the manager told us that three new starters had just joined or were about to join the registered nursing team. During our visit we observed that sufficient staff were available and they responded to people in a timely way. One person said, "I always feel I can press my buzzer and they [the staff] come quickly." Staff confirmed that they did not have to rush, and were always able to spend time with people.

The service had a recruitment policy, which provided a sound framework for the recruitment and selection of staff and volunteers. A range of checks were carried out including proof of identity, written references, and checks with the Disclosure and Barring Service (DBS). Further verification was undertaken for nurses through the Nursing and Midwifery Council (NMC). All staff had completed an application form and had been interviewed. The hospice used a large number of volunteers in the befriending and counselling services as well as in administrative and fundraising roles. Volunteers who worked alongside people using the service also went through a stringent recruitment process to assess their suitability.

Appropriate arrangements were in place for the safe storage, administration and disposal of medicines. Medicine stocks were supplied by Harrogate District Foundation Trust (HDFT) via a weekly technician topping up service. Medicines including Controlled Drugs (CDs) were checked with the order note when they were delivered. A clinical pharmacist visited every week day to carry out clinical checks on prescriptions. They also attended medicines review meetings, which took place on a three monthly basis. A medicines audit was carried out every three months by the pharmacist from HDFT who provided clinical advice and managed the supply of medicines to the hospice.

During our visit we spoke with the manager about issues relating to medicines management, which needed further clarification. This included arrangements for the disposal of medicines belonging to people admitted into the unit, which were returned to the hospital for disposal. We also asked the manager to check that the wall fixings for the Controlled Drugs (CDs) cupboards met legal requirements. Following our visit the manager confirmed that the hospital did not hold a waste carrier licence. Therefore an external

controlled waste agency had been contracted for disposing of people's medicines. Appropriate action had been taken to check wall fixings to ensure that medicine cupboards used to store CDs met the required standard.

Although the administration of creams was sometimes delegated to health care assistants we identified that the records of administration were made by nursing staff. The deputy manager confirmed that this matter was referred to the medicines review group to ensure that staff were trained in the changes to procedure. Individual medicine cabinets were being fitted into people's bedrooms to promote a person centred approach to the administration of medicines. In the meantime, people's dressings, prescribed creams and nutritional supplements were being held in locked cupboards.

There was a high level of expertise in the way clinical care was delivered. On admission people's medicines were reconciled with the referral letter before the prescription chart was written. Prescription charts were reviewed by a doctor and by a nurse before they were brought into use and both parties signed to say this had occurred. We saw that prescription charts were clear and contained the times medicines were administered and recorded. A red laminated card was used to highlight to staff any medicines prescribed outside of the normal medicine rounds. Medicines prescribed to be taken on an as required basis were constantly monitored and written in the evaluation daily to ensure that patients remained symptom free. We found that nursing staff were highly skilled in this area. For example, to ensure their effectiveness patches were checked twice daily to ensure that they were still in situ and had not lifted at the edge. Care records showed capacity assessments were completed with regard to consent and people's ability to administer their medicines independently.

People confirmed that all of their treatment choices were discussed with them and that they received their medicines on time. There was a policy which allowed staff to respond to a range of minor symptoms, and the doses administered were recorded on the prescription chart. All staff involved with the administration of medicines had their competency assessed before they were allowed to administer medicines and this was updated yearly. Nurses completed an annual syringe driver competency check and had

## Is the service safe?

undertaken training on intravenous therapies, including blood transfusion. This meant that people could receive essential treatment without the disturbance of having to travel to hospital.

The governance around the management of CDs was good. There were two CD order books in use and the book number plus the requisition number were logged in the CD register. This was good practice. CDs in current use were checked on a daily basis. These were stored separately

from CDs not currently in use, which were checked weekly. The contents of the syringe drivers that were running at the time people died and waste CDs were disposed of according to local policy.

Incidents involving medicines were logged and reviewed by the manager quarterly to look for trends and to learn from what had happened. This also formed part of the information which was shared at a regional and at a national level so that lessons could be learned.

# Is the service effective?

## Our findings

Staff had the knowledge, skills and attitude to provide people with excellent care and treatment. A visitor confirmed, "They know exactly how to provide the right care for [my relative]." One person who described their experience to us said, "It is like a big family. The staff seem really happy and that makes a big difference." Other comments included, "They know my situation and know what I need," and, "Most definitely they know [about my care needs]."

There was an effective training and development strategy in place. Staff received training on palliative care; counselling skills when working with bereavement and loss; and end of life care in Parkinson's Disease. Full training was also provided to volunteers who worked alongside people in the in-patient unit, the day hospice, and in the counselling and befriending services. Examples included palliative care; safeguarding; infection control; confidentiality, and moving and handling. A specialist community team provided ongoing advice and support to GPs, volunteers and other professionals who supported people approaching end of life. This combined approach enabled people to manage their symptoms, keep their independence and live comfortably at home for longer.

The hospice also offered courses and training sessions for health and social care professionals. One example was a certificate in professional development offered in association with the University of Teesside. This award provided practising clinicians with evidence based, best practice knowledge and skills in palliative care. Study sessions gave professionals the opportunity to explore key issues involved in supporting people affected by terminal illness, bereavement and mental health. A healthcare professional told us, "The education provided by the hospice staff is very good and easily accessed." We also received positive feedback from another care provider who spoke highly of the training sessions. They said the tuition was "Inspiring" and had enhanced their ability to deliver high quality end of life care.

A preceptorship programme offered newly registered nurses training and development in specialist palliative care, and contributed towards service development. The aim of preceptorship for new registrants is to enhance the competence and confidence of nurses as autonomous professionals. Staff confirmed that they had supervision

sessions, staff meetings and annual appraisals. Records evidenced that discussions were held on a range of topics such as professional development; leadership; organisation; management and goals. This showed us that staff were being offered support in their role as well as identifying their individual training needs. When asked about how they felt about working at the service one nurse said, "I love it. It is very emotionally and physically challenging work, and we always expect the unexpected. We have a very supportive team and work well together." As part of their role the deputy head of inpatient services provided nurses with senior leadership, supervision and support on a daily basis. This ensured people received high quality care.

Members of the staff team could also access individual or group sessions with the clinical supervision counsellor. This allowed staff time to reflect on their clinical practice and professional development, build resilience and provided emotional care. One nurse told us that managers encouraged staff to avail themselves of this service. They said, "It [the clinical supervision] is clearly beneficial to both staff wellbeing and patient care."

The provider had developed effective working relationships with speech and language therapists and other specialists involved in assessing communication needs. This helped staff to communicate clearly using non-verbal communication, and active listening techniques to promote mutual understanding. The manager told us methods they used to assist people to communicate included picture boards, electronic communication and environmental controls. This evidence showed us that people were supported to communicate and to participate in their own care.

Care records included an assessment on people's capacity and consent to admission, a spiritual assessment and advanced care plan wishes and levels of intervention. We saw that records were signed by the person or their relative or representative, if they were unable to sign. One person who used the service said, "It is very personalised here. When you first come you sit down and discuss your condition and what you want to get out of it [the hospice]." The manager told us, and records confirmed that they also discussed people's rights to refuse treatment and consent to share information with other professionals.

The Deprivation of Liberty Safeguards (DoLS) form part of the Mental Capacity Act 2005 (MCA). They are intended to

## Is the service effective?

offer additional safeguards for people who lack capacity to ensure they do not have their freedom restricted more than is absolutely necessary and that any restriction is in their best interests. Staff were knowledgeable about the MCA and DoLS. Appropriate assessments had been carried out to determine whether any restrictions placed on a person amounted to a deprivation of their liberty. This had applied to three people in the past year, and staff followed the procedure to ensure people's right and freedoms were protected. Appropriate notifications had been submitted to all of the relevant agencies including the CQC and the Coroner, as needed.

The provider had a service level agreement for dietetic services who provided support to the catering team, nurses and volunteers. They addressed the identification of allergens in food, making this information available to people who used the service. Nutrition risk assessments were used to identify specific risks associated with people and these were reviewed on a weekly basis. Where people were identified as being at risk of malnutrition referrals had been made to the dietitian for specialist advice. Risk assessments were also in place for people at risk of choking and we saw that special equipment, cutlery and plates were made available to support nutritional intake. This ensured that people with complex feeding needs were appropriately supported and quality nutritional standards were met.

Staff told us, and we observed that the catering team discussed people's food preferences with them. A snack menu was made available between mealtimes or for people who preferred to eat smaller meals more regularly. The manager said that catering staff were always willing to make special efforts to ensure people had food of their choosing. For example, when a person who was used to eating 'game' was admitted, the catering team bought in partridge so their preferences were met.

The people we spoke with were all complimentary about the food provided. Comments included, "The food is fabulous. I've hardly any appetite but the chef is very caring, tempting my appetite with what he thinks I might like;" and, "The food is great. Special efforts have been made with Wimbledon being on with strawberry cream cakes." With regard to choice one person said, "The chef produces a menu but you can have something different if you wish. We get a lovely three course meal and it is a

social event. We all sit together, patients, volunteers and staff." Another person said, "The food is brilliant, amazing, loads of choice. I am a vegetarian and I still get a good range."

A nutrition group met twice yearly to consider people's feedback and consider further improvements. The results from the last nutrition survey in 2013 showed 94% of respondents rated their overall satisfaction with the food and beverage service as excellent. Records demonstrated the actions that had been taken in response to areas for improvement, which had been highlighted. For example, the dietitian was given dedicated time to spend on menu planning, texture of food and allergen advice throughout 2014. They had been allocated one day per month to spend on non-direct patient specific work to accommodate the next satisfaction audit and report. This showed us that the service was continuously looking at ways to make positive changes to enhance people's quality of life.

There was a calm, positive atmosphere throughout our visit and we saw that people's requests for assistance were answered promptly. People told us that the staff constantly checked to make sure they were pain free. We spoke with a visitor who confirmed, "They always make sure [my relative] is comfortable and their bell is always at hand, within reach." One person who used the service told us, "They consistently ensure my comfort." Another person said, "They try to make me comfortable. I always feel I can press my buzzer and they [the staff] come quickly." Daily notes showed us that people's care was reviewed to re-assess their symptoms and to confirm their current level of pain control was effective.

We asked people if they felt their health care needs were met. People's comments included, "Yes, there is an assessment of my health needs every week. If something needs doing or changing, it is organised;" " My health needs are dealt with most effectively;" and, "The staff know to get you in contact with all the services and therapies that you might need to ensure you're as good as you can be." People's records included details of appointments with and visits by healthcare and social care professionals. Examples included psychologists, chiropody, tissue viability nurse, stoma nurse, and lung specialist nurse and pain consultants. This demonstrated that people could access a wide range of healthcare professionals to meet their care needs and maintain their health.



# Is the service caring?

## Our findings

The feedback we received from people using the service, relatives and healthcare professionals was wholly positive. Everyone we spoke with told us that they, and their loved ones, were treated with dignity, respect and compassion. One person who was attending the day care centre told us, "It [the service] is focused on you. You are the number one priority and can talk to people in similar circumstances. There is respite for partners and that is so important."

When we asked people what the hospice did well their comments included, "Not being written off," and, "The staff just seem to know when you need them and know the limits of what they are wanted for." One person said, "I have not met one [staff member] who is not kind and compassionate. They are always respectful." Other comments included, "They are very caring and take their time doing things. Nothing is ever too much trouble," and, "I can honestly say I have received first class care."

The care planning process focused on the person's history, views and life choices. The staff said they used this information to support people in a way that met their individual wishes, beliefs and preferences. Records demonstrated that staff engaged people in decisions about their care and treatment, but if they did not want to express their wishes this was also respected. One person told us about the care they received in the following terms, "I would describe the care as warm. Everyone greets you. They are all courteous and not only do they have the medical skills you need, they also have the hospitality skills you find in a top class hotel."

People told us the staff also considered their relatives' needs and we saw evidence of this in people's care and treatment records. In their feedback one healthcare professional said, "Very high quality and compassionate care for people requiring palliative care, in particular providing care not just for the patient but for their family." One person told us, "They [the staff] are very kind and compassionate. They are very respectful and look after my family and friends too." One family member said their relative had received, "Wonderful care. Discussions have taken place with family involvement to help us plan properly. They [the staff] are so caring and have spent time with us, whatever time we need."

Healthwatch forwarded positive comments they had received from a volunteer with the community engagement programme who gave talks to groups about the hospice and its work. They said the feedback from audience members whose loved ones had spent their last days in the hospice had been uniformly positive. They told us that as part of their role as a trained counsellor they also spoke with people who used hospice services. In their feedback they stated people they met were "Eloquent in their praise for the quality of the care given and the love shown."

The hospice used whole population data to map the palliative care needs and end of life needs of people in the local community. This was being used proactively to ensure improved access to hospice care for everyone who could benefit. Staff participated in a range of multi-agency initiatives to improve access in line with national directives on inequalities in end of life care. One example was partnership working with another care provider of learning disability services to widen access to palliative care for people with a learning disability and life limiting or life threatening illnesses. This enabled staff to share information and promote best practice, and raised staff awareness of the palliative care needs of people with learning disabilities. The service also offered specialist help and support to any individuals affected by lymphoedema, whatever the cause. Lymphoedema is a chronic condition that causes swelling in the body's tissue. This helped people manage their symptoms and minimise the effect the condition had on their lives.

Volunteers were used extensively throughout the hospice and in the bereavement, counselling and befriending services. They provided practical support and companionship that enabled people to live their lives as they wanted. For example, volunteers provided help with dog walking so people could preserve their energy whilst still enjoying the company of a beloved pet. The deputy head of inpatient services told us they assisted people to organise their daily activities, which made it easier to maintain a full and interesting life. During our visit we saw staff provided thoughtful touches, to support people with their independence and promote a sense of wellbeing. For example, people and their visitors could access kitchen facilities, which the catering team kept well stocked with refreshments and home baked biscuits.

Staff valued and protected people's privacy. They had private, en suite bedrooms and family members could visit



## Is the service caring?

and stay overnight if they wished. Separate facilities were also provided for visitors who wanted some time on their own for private reflection. One person told us, "There is a quiet room if you need or want privacy and all discussions we have are in private." Staff communicated with the people using the service, visitors and with each other in a caring and respectful manner throughout our visit. Discreet signs were used on doors to alert people for the need to be mindful to be quiet if treatment was in progress or if people wanted to be left undisturbed. People said, "I have as much privacy as I want," and "The staff are very discreet and always offer privacy." Staff spoke quietly and discreetly with people about their care options throughout our visit. Care records were handled carefully so as to preserve people's confidentiality.

The admission process was designed to put people at ease and set a positive tone for the rest of their stay. One of the nurses was allocated uninterrupted time to help people and their family settle into the inpatient unit. This meant that the staff could undertake the admission process in a timely, unhurried and individualised manner. An assessment was made on admission in relation to people's spirituality and people said their religious and faith needs were addressed.

We saw evidence that people with complex speech, language and communication needs were supported throughout the care planning process. For example, in one case where the person's first language was not English a trained interpreter was used to facilitate conversations with staff. This helped guarantee that the hospice services were explained properly and their views were understood and acted upon. Factsheets and leaflets displayed around the service were easy to understand and informative. Examples included 'eating with a dry mouth', patient support services and complementary therapies, and safeguarding. All of these could be customised to meet people's communication needs, to provide people with information about the hospice services.

People described their end of life planning and the support that this gave themselves and their family members. One person told us, "There has been positive support towards end of life. It is assisting me and hopefully, me being more

settled is helping the family." Another person told us that the hospice had helped them make their decisions and were reassured to know that the staff would support them. One person said, "The future is discussed and information is provided to help make end of life decisions." When we reviewed people's records we saw that important conversations were captured and recorded. This ensured that everyone was familiar with people's understanding and their expectations regarding their end of life care.

Hospice staff facilitated pre and post bereavement support for children, young people and adults through the Just B counselling service, which the service offers. People experiencing any type of bereavement could also access counselling independently through Just B. It operated alongside Talking Spaces, which offered counselling, befriending, support and social groups to help adults experiencing emotional distress or poor mental health. Counsellors worked with the British Association for Counselling and Psychotherapy (BACP) ethical framework for good practice in counselling. This meant that people could be confident their human rights and dignity would be upheld and protected.

People who used the service and staff mentioned the importance of providing a level of care that extended after death. We saw people had an advanced care planning assessment and end of life care plan. This meant that information was available to inform staff of the person's wishes at this important time to ensure that their final wishes could be met. The manager said and records confirmed that people's wishes were treated with the same respect and dignity in death as in life. For example, some people had express wishes regarding organ donation and the hospice ensured these wishes were respected wherever possible.

Special events provided the opportunity for people living in the area to visit the hospice and spend time with staff and volunteers in a welcoming and supportive atmosphere. Examples included the 'Say it with Sunflowers' open gardens in July 2015 and the 'Light up a Life' community remembrance event at Christmas time, which gave family, friends and staff the opportunity to join together to remember their loved ones.

# Is the service responsive?

## Our findings

People told us that the staff supported them to make decisions and made all the time needed to listen to them. Everyone we spoke with confirmed that the staff team was responsive to their individual needs. Comments included, "You can take all the time you need;" "All the information is provided to help your decision;" "You take it at your own pace;" and, "The staff listened and acted on my decisions."

Care plans were detailed and provided us with evidence that people received skilled, empathetic care, to enhance their wellbeing. Staff encouraged individuals to express their feelings and used relaxation techniques such as reading, music, breathing exercises and aromatherapy. One person told us, "They (the staff) meet more needs than I thought I had and I feel fully involved in planning my care. It is all discussed with the family too." Another person said, "The care is first class. I came in as end of life and we are now planning with a view to me getting home."

People told us that staff valued their opinions and that they were encouraged to express their views freely. One person told us, "The atmosphere is open to suggestions." Another person said, "People are encouraged to speak out all the time. It is just part of what goes on here." Feedback from healthcare professionals confirmed that the hospice services, managers and staff were held in high regard locally. Comments we received included, "An innovative and committed senior team," and "[The hospice] is very well respected by local primary care."

The people who were attending the day hospice confirmed that they could get in touch with staff at any time and would not hesitate to do so. In their written feedback a doctor reported that the hospice staff were always helpful when they telephoned for advice. They said, "The day hospice is highly valued by patients and I have had several who have asked to be referred back when they have new symptoms that require expert input from the team." This meant that people could be confident that the service was responsive to their changing needs and was supportive of them.

The staff team worked flexibly to provide consistent coordinated, person-centred care as people moved between services. The deputy head of inpatient care gave us an example of a recent admission when a person staying in the area became unwell. On their discharge hospice staff

escorted the person home, to offer pain relief and companionship. In addition, staff had arranged for appropriate local support services to be put in place for their return. This meant that the person received safe and consistent care both during their journey and after they arrived home.

We spoke with one member of staff who told us that they acted as the 'link' nurse at the hospice. As such, they explained they liaised with the hospice's own specialist community nurses, community professionals and hospital based teams. They said this had resulted in improved communication with people using the service and between healthcare professionals. This meant that people's preferences could be identified at an early stage and key issues could be assessed and dealt with in a timely manner. From the care plans we reviewed it was evident that a full assessment of needs was undertaken before admission. Therefore people could be confident that staff could meet their specific requirements before they used hospice services.

Care plans gave an overview of individual needs. They contained information about people's likes, dislikes and interests. They detailed how people required assistance to better respond to the person's needs and enhance their life. In addition to the care plans, a genogram was completed for each person along with an overview of assistance with activities of daily living. A genogram was an evaluation tool, which hospice staff used to assess people's care needs within the context of their family, community support and spiritual needs. This information was then used to provide interventions both before death and during bereavement.

Staff were knowledgeable about people's individual care requirements and said they provided personalised care. Assessments were undertaken for people who were at risk of developing pressure ulcers. Care plans were up-to-date to inform staff about people's care and support needs in these cases. Re-positioning charts and body maps were in use with specialist pressure relieving equipment and preventative pressure relieving measures. Pain assessment body maps had been completed, to elicit information about the location of pain symptoms. We also saw the visual analogue score and non-verbal signs used to

## Is the service responsive?

measure pain, on re-positioning and before and after interventions. A Visual Analogue Scale (VAS) was a diagnostic tool that could be used to assess the severity of pain a person experienced.

A wide range of complementary therapies were used to reduce discomfort from pain. Examples included reflexology, reiki, acupuncture and massage. The service also facilitated people's access to spiritual and psychological support. People had an advanced care planning assessment and end of life care plan in place. Do Not Attempt Resuscitation (DNAR) forms were fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the health and social care professionals completing the form. This meant that information was available to inform staff and other healthcare professionals of the person's wishes at this important time to ensure that their final wishes could be met.

A weekly multi-disciplinary meeting considered the agreed plan of care and staff updated the care plan in a timely manner. The staff handover record showed that people's needs were discussed at handover, to ensure that essential information was communicated between staff. Information about people's health, moods, behaviour, appetites and the activities they had been engaged in were shared. This meant that staff were kept up-to-date with the changing needs of people who lived there. Daily accountability notes were concise and information was recorded regarding basic care provided, hygiene, continence, mobility, nutrition and medicines. These provided us with evidence that records were being maintained appropriately to show how people were cared for and supported.

The provider told us in the PIR that when people wanted to go home, then same day discharges could be achieved. A discharge liaison nurse worked with people using the service, families and carers to ensure a safe transition back into the community. On discharge a letter was posted or faxed to make sure that people's own GP was kept updated about their treatment plan. A summary of care needs was also provided to healthcare staff working in the community including copies of relevant paperwork and a medicines list.

The manager told us that they provided additional input in these cases, including support from the hospice occupational therapist and physiotherapist, list of useful contacts and associated telephone numbers, and small items of equipment. The manager told us that they also encouraged people's carers to communicate with the hospice in the event of any problems arising after discharge. The person's bed could also be held available over the first 24 hours to facilitate a return to the hospice, if agreed to be appropriate. This was further evidence that people were empowered to make choices and have as much control and independence as possible.

There was complaints policy in place and information about complaints was displayed in the service and on the website. In addition to the positive feedback we received, the service had 250 written compliments in the past year, and only one complaint. The manager explained that they tried to pick up on any minor frustrations that people expressed so that these could be dealt with promptly. They told us they were considering providing Dictaphones at key points to enable staff to make a quick record of any comments and suggestions for action. People could also access information and provide comments and feedback through the website.

People said they had not needed to make a complaint but they were confident that any issues they raised would be acted upon. One person said, "I do not have any (complaints) but I would feel comfortable to raise any concerns." Another person said, "I have not got any complaints and I do not anticipate any." Further comments we received included, "We are always being told to raise anything that we are not happy with" and, "I have expressed my views fairly forcibly. I am encouraged to do so and we have a bit of a joke about it. A frank exchange of views is good." Other people said, "I always say what I think or feel. The staff expect me to do that," and, "I would think everyone here can say what they want. It is actively encouraged." We reviewed the service's response to the complaint that had been made. We saw that the provider had investigated and responded to the complainant in a timely way. This provided us with evidence that people could be confident that action would be taken to address their concerns.

# Is the service well-led?

## Our findings

Everyone we interviewed expressed confidence in the care they received and in the management of the hospice services. We received numerous comments about the atmosphere, which people variously described as tranquil, calm and peaceful. One person said, "It is excellent, there is a 'good feeling' type of atmosphere. That comes from the top. It is very accommodating and supportive to friends and family." Another person said, "It is peaceful here. It has the ambience and feeling of a good quality hotel."

The management team fostered a culture of openness, respect and transparency. This was confirmed by one member of staff who said that senior managers and staff created a, "Positive and proactive culture." Another staff member described the service as, "Caring, always focused on patients, carers and families and well led by the management team."

There were clear strategic plans in place for the continual development of hospice services. The Chief Executive held regular meetings to keep people informed about the strategic planning. Information was also made available on the provider's website and in the supporter's magazine. In the past year there had been an increase in community support services with 10% more people able to access hospice services. Specialist advice and support was provided to people living in care homes (16%), hospital (35%) and in people's own homes (41%), along with care and treatment provided in the hospice itself (8%). The service had also extended the psychological and emotional support they offered to adults, children and young people.

The government's Office for Civil Society and the Better Care Fund had awarded the hospice a grant. This will be used to expand the home care service and thus enable more people living with any terminal illness to benefit. It was one of only seven social action end of life projects in the country to be chosen to receive this award. The scheme will be used to provide valuable research evidence about the provision of end of life care in a largely rural area. The University of Lancaster and the Institute for Volunteering are responsible for the evaluation of the programme.

The governance and management structure provided clear lines of accountability for decision making. Senior staff had completed management and leadership training, which focused on staff development and quality within a hospice

setting. A healthcare professional told us, "The management of the hospice both the senior clinicians and the executive team are very professional and well organised." The service held a fortnightly communication meeting that gave staff and volunteers the opportunity to contribute to the running of the service. This was also used to communicate key information to ensure standards of care were maintained and improved.

Everyone we spoke with confirmed that the manager was approachable. One staff member said, "I can speak to her every time I am on shift if I need to." The professional supervision counsellor told us their work was fully supported by the leadership team who had recognised the benefits to their workforce and for patient care. Staff also met with their named line manager every 6-8 weeks, which enabled them to discuss their progress and training needs.

The manager told us that services were shaped and continued to be developed by those who use or would use them. For example, plans were in place to extend and develop their community based end of life care support through the provision of a personal care service at home. A separate manager had already been appointed and was registered with CQC to oversee the implementation of this scheme. This showed us that the service was proactive and responded positively to local needs in accordance with the Department of Health (DH) guidance on end of life care.

The Director of Clinical Quality and Effectiveness assessed and guided care quality at all levels and departments. This appointment was a joint initiative with two other hospices to develop the quality of patient service and drive continual improvement. A patient and client group met quarterly and people were asked to complete surveys to provide feedback about the hospice services. For example, a recent survey showed that 95% of people felt that they had been offered the bereavement support they needed.

Clear reporting procedures and monitoring arrangements were followed in the event of serious accidents and incidents relating to people's care. Records showed that incidents were analysed and the results communicated to staff along with any required actions. Appropriate notifications were submitted to CQC including one notification under the statutory duty of candour, which providers were required to meet from 1 April 2015. We identified that the provider had acted appropriately following a notifiable incident in the service to ensure that

## Is the service well-led?

the person and their family were kept informed and supported as well as offering a full apology. This showed us that the service was promoting a culture that encouraged candour, openness and honesty.

Staff from the service worked in close partnership with key organisations such as clinical commissioning groups and other care providers. This work supported service development and made sure people received joined up, co-ordinated care. The hospice had a line management responsibility for clinical nurse specialists who visited people in hospital, care homes and in their own homes. This team which was a joint initiative with Harrogate Hospital Foundation Trust ensured people had access to specialist support when needed. There were established links with the local hospital, universities, regional and national organisations to evaluate systems and drive continual improvement. For example, plans were underway to allow the hospice access to the patient Information system with Harrogate Foundation Hospital Trust to improve the process of clinical specimen test requests and retrieval of results and consultation notes.

All the staff we spoke with described a confident, innovative culture with a strong focus on best practice. This culture was well supported by a board of trustees who displayed a range of diverse skills and backgrounds. Minutes of board meetings demonstrated that participants had a good understanding of their role and were accountable for the strategic direction of the service. The appointment of a consultant in palliative care as medical director in 2014 provided the leadership team with a strong clinical perspective in decision making. Sub committees were used extensively to support the work of the board in overseeing the work of the hospice. We saw that these groups had clear lines of accountability and specific responsibilities for clinical governance. Trustees and managers were given the opportunity to spend time to concentrate on strategic planning, board development, and team building.

Staff participated in external groups where they could share professional ideas and discuss new legislation and

best practice. Senior staff belonged to regional palliative and end of life care groups, which meant they were in a good position to influence local and regional end of life care strategy. The service was also a signatory to a national group to share lessons and improve standards for volunteers, who comprised the largest proportion of people working for the organisation (Volunteers outnumbered paid staff by a ratio of six to one). All volunteers received full training before they started work and the hospice team provided ongoing support and supervision. This meant that the organisation had taken responsibility for its volunteers and their wellbeing. We saw from awards displayed that the voluntary service was recognised by the Harrogate and District Volunteer awards held locally.

The service offered health and social care professionals a wide range of training opportunities to promote and provide high quality palliative care. In addition to the courses offered the hospice could deliver bespoke training sessions on palliative care, bereavement support and emotional wellbeing. They also held conferences designed to develop insights into key aspects of providing specialist care. One example looked at how the community supported people who were bereaved through suicide. Other training was aimed at frontline staff from statutory, voluntary and private organisations who may come into contact with people who had experienced rape or serious assault. This served to equip frontline workers with the knowledge and confidence to respond and support people presenting with a range of life experiences in an appropriate and effective manner.

Effective management systems were in place to monitor the quality and safety of people's care. Progress was assessed against a series of measures structured around national directives on end of life standards. This enabled the service to measure progress against agreed standards, monitor quality in a systematic way and share best practice. Where improvements were needed, we saw that action plans with agreed timescales were put in place.