

## Katharine House Hospice

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### Inspection report

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20 May 2016

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### Ratings

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

# Summary of findings

## Overall summary

This inspection took place on the 11, 12 and 20 May 2016 and was unannounced.

Katharine House Hospice is registered to provide care and support to people in relation to symptom control, pain relief, assessment and end of life care.

Katharine House Hospice in-patient facility caters for up to 10 people, accommodated within two four bedded bays or an individual room. The hospice service provides specialist palliative care, advice and clinical support for adults with life limiting illness and their families. They deliver physical, psychological, social and spiritual care through teams of nurses, doctors, counsellors, chaplains and other professionals including therapists and social workers.

Katharine House Hospice provides a Hospice at Home Service, which provides palliative care within people's own homes, which is provided by health care assistants.

Katharine House Hospice has a day therapy service, which provides an opportunity for people to meet and take part in a range of activities. The day therapy service in addition provides facilities for counselling and bereavement support, chaplaincy services, occupational therapy physiotherapy and complementary therapies.

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

People told us that they felt safe at the service and that they had confidence in the staff. The service was committed to promoting people's safety across all levels of staff within the organisation and included advising the Board of Trustees of safeguarding concerns and ensuring staff at all levels, including volunteers and administration staff received training on protecting people from potential abuse or avoidable harm.

Risks to people were assessed and where potential risks had been identified these were minimised in consultation with the person. The provider promoted people and their relatives' safety by providing leaflets and opportunities to take part in groups where information could be shared to reduce risk, for example in falls prevention.

The provider had robust systems to monitor risk which was facilitated by staff within the service with specific roles, such as infection control and tissue viability that undertook audits and reported the outcome to the Board of Trustees, where recommendations were considered and acted upon. The provider had a system to ensure that the premises of the hospice and its equipment were maintained to ensure people's safety and any issues identified acted upon in a timely manner.

People's medication needs were discussed by health professionals to manage and support people's symptoms and pain management. And information in the form of a leaflet was provided to people, which included information when medicines were not being used for their usual indications. Medicines were regularly reviewed and audited to ensure they met people's needs. A community pharmacist and pharmacy technician provided a medicines supply service and medicines advice to staff or people using the service, to ensure people received their medicines in a safe and timely manner.

People and their relatives were confident in the knowledge and skills of the staff that provided their care and support. Staff told us that they had access to training which enabled them to understand the needs of people and provide effective care and support. Staff said that they received planned and proactive support that enabled them to deal with the difficulties and challenges in providing care to people and their relatives with life limiting conditions and who required end of life care.

There were effective systems in place for all those involved in people's support and care to share and communicate well, both within the hospice and community services, which included the hospice at home service. Regular meetings were held involving health and social care professionals to promote the effectiveness of people's care by working collaboratively.

The staff of the service supported people within the community through services which included the hospice at home service, which provided respite care to people and their relatives. Volunteers provided psychological and social support to ensure a positive and open relationship between the hospice services was maintained when people were at home and so that changes to people's needs could be identified and responded to.

People in some instances accessed the day therapy facility. People told us that the day therapy facility enabled them to meet with people in similar circumstances and found the service to provide social support. The day therapy facility included services for people and their relatives, to promote people's well-being and independence. These included complementary therapies and an environment where physiotherapist and occupational therapists could assess and support people.

The registered manager and staff were clear about their responsibilities around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and were dedicated in their approach to supporting people to make informed decisions about their care. People and their relatives told us they were fully informed about their care and support and were involved in all decisions as to their treatment.

All of the food was freshly prepared and the meals provided catered specialist diets where required. People within the in-patient unit and day therapy service spoke positively about the quality of the meals and how any individual requests for food and drink were met.

People and their relatives were consistently very positive about the caring and compassionate attitude of the staff. They told us they were satisfied with the care, which they said they would not in their view be able to manage without. We found staff to be very motivated and enthusiastic and demonstrated a commitment to providing the best quality and end of life care in a compassionate way. People's wishes for their final days were respected and staff told us how they continued to care for people following their death.

People and their relatives were supported by a range of individual and group services provided by the hospice staff and volunteers. People spoke of the benefits of these groups in providing practical information along with emotional support.

Staff respected people's spiritual needs and people told us they received the religious and spiritual support they wanted and needed. Relatives told us staff understood their emotional needs and focused on their wellbeing as well as the wellbeing of their family member. Bereavement support was available to people and their families and friends. This provided emotional and practical support to those who required it.

People were fully involved in assessing their care and treatment needs and their wishes and preferences were incorporated in planning how those needs were to be met. Regular reviews of people's care were held and people and their relatives were involved in discussions about their health to ensure their wishes were known. The hospice at home service worked in a range of individual ways to support people and their relatives when at home, this included support by telephone and social support provided by volunteers. In addition staff worked with health care professionals within the wider health community to provide care to enable people to remain within their own home as per their wishes.

The management structure showed clear lines of responsibility and authority for decision making and leadership in the operation and direction of the hospice and its services. The Board of Trustees and the management team demonstrated a strong commitment to providing people and those closest to them with a safe, high quality and caring service and promoted high standards. The service actively encouraged and provided a range of differing methods and opportunities for people who used the service and their relatives to provide feedback and comment about the service in order that they could influence the service and continue to drive improvement.

The service is open and transparent providing a range of information within the service and on its website, which includes the outcome of surveys and audits undertaken and their response to improving the service. There are systems in place to enable people to make comments and ask questions about Katharine House Hospice, which includes the use of social media.

Staff worked closely and in partnership with external health and social care professionals and other national organisations to improve the service within the hospice and health provision in the local community and nationally.

The Board of Trustees is committed to the development of the service and takes an active part and interest in all aspects of service provision through regular meetings, participation in audits and the reviewing of reports provided by managerial staff within the hospice.

## 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 had been trained to recognise and respond to any actual or potential abuse. The service had developed systems for reporting concerns and worked with health and social care professionals.

Potential risks to people were assessed and measures put into place to reduce risks. Where incidents occurred these were analysed and used as a learning tool to reduce future risks.

People's needs were met. They were supported and cared for by staff from a range of disciplines that had the appropriate skills and knowledge to meet their needs safely.

People were supported by staff in all aspects related to their medicines.

### Is the service effective?

Good ●

The service was effective.

People received support and care from a staff team who were trained to meet their needs. We found staff were encouraged to develop their knowledge and skills and at all levels within the service.

Staff were aware of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People were involved in making decisions about all aspects of their treatment and care.

People were supported to eat and drink and maintain a balanced diet. People were able to choose from a varied menu, which included a range of specialist drinks for those with a reduced appetite.

People's health needs were carefully monitored and shared with a range of health and social care professionals to ensure people's care, treatment and support was effective.

### Is the service caring?

Good ●

The service was caring.

People and their relatives told us that staff treated them with kindness, care, dignity and respect at all times. Staff were highly pro-active in their approach to care. They demonstrated compassion in every aspect of their work to make people feel valued and supported.

People's spiritual needs were recognised and if appropriate met by a chaplaincy team and counselling services

Staff supported the emotional wellbeing of people and their relatives with end of life care being provided with sensitivity, this included arrangements for the body of a person who had died to be cared for in a dignified way.

### **Is the service responsive?**

**Good** ●

The service was responsive.

The staff responded to people's physical, psychological, social and spiritual needs. People and their relatives were fully involved in assessing their needs and planning how their care should be provided, which included their wishes regarding their end of life care.

The provider had a positive approach to using complaints and concerns to improve the quality of the service and was monitored by The Board of Trustees and the management team.

### **Is the service well-led?**

**Good** ●

The service was well-led.

The service promoted a positive and open culture and provided a range of opportunities for people who used the service and their relatives to comment and influence the quality of the service provided. Information about services, which included practical information, was offered to people.

The Board of Trustees and managerial teams provided strong, effective leadership and provided a clear strategy for the long term development of the service.

The management team was pro-active in seeking people's views about services provided and used information to develop the service to meet people's changing needs.

The provider worked with other healthcare professionals and

national organisations and participated in research projects to develop and influence care for people.

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# Katharine House Hospice

## 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 the 11 May 2016 and was unannounced and we returned on the 12 and 20 May 2016.

The inspection was carried out by one inspector, a member of the medicines team and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection team also included a specialist advisor. The specialist advisor had experience working as a nurse within the community and within the field of palliative care.

We reviewed information the provider had sent to us which included notifications of significant events that affect the health and safety of people who used the service.

We sought the views of health and social care professionals within the wider community who work in collaboration with the hospice and its staff.

We spoke with nine people who used the service and five relatives who were visiting.

We spoke with the Director of Care Services [registered manager], the Matron, the Chief Executive, PA to the registered manager, advanced nurse practitioner for day therapies, community services manager, occupational therapist, social worker, voluntary services officer, Sister of the in-patient unit, the medical director, head of human resources, the Chaplain and the facilities health and safety manager. We spoke with clinical staff, which included, nurses and health care assistants. We spoke with people who had lead responsibility for infection control and tissue viability.

We reviewed three people's care plans to see how their support was planned and delivered. We looked at a six people's medication records to check medicines were managed safely. We spent time observing staff

interacting with people and their relatives.

We also looked at the recruitment files of three members of staff, a range of policies and procedures, maintenance records of equipment and the building, quality assurance and clinical audits and the minutes of meetings.

## Is the service safe?

### Our findings

People we spoke with told us they felt safe and secure within the hospice and the hospice at home service as they had confidence in the staff.

Staff were aware of their responsibilities for protecting people against the risk of avoidable harm and abuse. A member of staff told us, "There is a safeguarding protocol in place" and went on to say that if they had any issues they would notify the nurse in charge. Safeguarding was included as an agenda item for multi-disciplinary team (MDT - a group of professionals from a range of specialist areas) meetings to remind staff to discuss any concerns. The provider had recently introduced training on safeguarding for volunteers and administrative staff, to further widen staff's ability to respond and protect people from avoidable harm and abuse.

Discussions with staff identified that the service had made referrals where concerns had been identified to the appropriate organisation. Examples of this included where a person had been identified as being vulnerable following the deterioration in health of their relative which alerted other services that the person may require additional support.

The provider followed a thorough recruitment and selection process to ensure staff recruited had the right skills and experience to meet the needs of people using the hospice services. This included carrying out a Disclosure and Barring Service (DBS) check and obtaining appropriate references. Staff we spoke with confirmed they were not able to start work until all the required checks had been completed and associated documentation received. Volunteers at the hospice also had checks carried out to ensure they were safe to work with people.

We found the Chief Executive and the registered manager had a pro-active approach to promoting people's safety which was discussed, shared and used to ensure the service was safe for people to use. Regular meetings were held to review the practices of the service in maintaining people's safety and reducing risk. We found the provider had acted on recommendations identified through an internal audit of people's falls. The audit of falls had identified people's safety could be improved by giving them advice and written information on the prevention of falls, both within the hospice and at home. Minutes of meetings with people and their relatives showed that fall prevention had been discussed at the carers support group and the well-being day.

The robust monitoring and reporting of pressure sore's enabled the provider to continually review the service and if required to develop strategies if improvements. We spoke with a nurse who told us they were the tissue viability link nurse. They said, "I collect the figures about who has developed pressure ulcers and do a quarterly report for the trustees and an annual report." When asked about the frequency of pressure ulcers, they told us, "Considering the contributory factors i.e. malnutrition, immobility, and disease progression, we don't get many." The report for the 12 month period, up until and including March 2016, which saw 190 people admitted to the in-patient unit, of these 9 people developed a pressure sore, which were as a result of the deterioration of their health and were unavoidable.

Thorough assessments were carried out when people moved to the in-patient unit to identify those at greatest risk. Risk assessments were developed to enable staff to minimise risk and promote safety. Annual audits were carried out to establish whether the standard assessment for pressure area care had been carried out within six hours of a person's admission. Reports showed that majority of these were carried out within the six hour period, and where the initial assessment had not taken place then an explanation was provided. Reasons for assessments not being carried out within the initial six hours included, people being independent and reporting no problems and where information prior to admission had been received.

We found risk assessments were regularly reviewed and updated as people's needs changed. Nursing staff used a nationally recognised tool for checking the condition of people's skin; this consisted of a number of checks staff carried out regularly when a person was at risk of developing a pressure ulcer due to deterioration in their health.

The facilities health and safety manager provided us with documentation recording how the service and its equipment were maintained. A planned cycle of maintenance and audits ensures any issues of concern were documented and an action plan developed to address any shortfalls identified. The manager responsible told us how they used information provided by other agencies, such as NHS alerts to promote people's safety. They provided an example of where information had been shared that people were at risk of trapping their limbs within a named design of bed, this had been acted upon by the provider by ensuring adaptations were made to the beds as per the instructions of the NHS alert to ensure people's safety.

We spoke with an occupational therapist (O.T.) who told us they assessed the needs of people with regards to the provision of equipment in order to promote people's safety, both within the in-patient unit, day therapy service and in their own home. The O.T. carried out visits to people's homes prior to their discharge to identify whether any equipment was required or changes made to the person's home to promote their care in a safe manner.

Staff of the hospice at home service work collaboratively with other services in providing care to people and their relatives within their own home. This means they are not in all instances primarily responsible for assessing potential risk to people using the service and the mitigation of risk. For example, where people require equipment to support their mobility, this may be assessed and provided by other health care professionals, external to the hospice. Staff followed the risk assessments and used any equipment identified to promote people's safety. They liaised with health care professionals should they identified any additional risks in order that these could be addressed.

We found there to be sufficient staff to meet people's needs. People we spoke with told us that if they required staff assistance it was provided. People's comments included, "I ring the buzzer at night and they come immediately." We found there were three nurses and three health care assistants providing care to the seven people within the in-patient unit. Our observations found that there were sufficient staff to meet people's needs and that staff were available to offer assistance in a timely manner. For example call bells were answered promptly. Staff told us that staffing levels were good. One staff member said, "We've always got enough staff, not just to care, but to spend time with relatives and have time to provide support."

Volunteers were an important part of people's care and the role of 'care volunteer' had been developed to spend time with people accessing the in-patient unit. The role of these volunteers was to spend time with people, talking with them, taking them into the garden or in some instances sitting with people to keep them company.

The registered manager told us that staffing levels on the in-patient unit were based on an assessment of

people's needs and would be increased if a need was identified. The matron and ward sister had the authority to increase staffing numbers if it was required. They had a dedicated budget to facilitate this.

People told us they received their medicines as prescribed and on time. They said they had ample opportunities to discuss their treatment and that staff would always answer any question they had about their medicines or find the most appropriate person to help.

We found medicines were obtained and administered safely to people who used the service. The hospice used a local community pharmacy to supply their medicines. This service included a clinical pharmacist visiting once weekly and a pharmacy technician visiting twice weekly. They provided a good clinical and medicines supply service to the hospice which included stock management and medicines advice to staff or those using the service. Medicines charts were checked by the pharmacist as soon after a person had been admitted as possible.

We observed a nurse administering medicines and found that medicines were given to people in a caring, dignified manner. Accurate records were made following medicine administration. There were sufficient staff to ensure people were given enough time to make an informed decision about the medicines they required.

The medicine fridge temperature was checked daily however, we found that the thermometer was not being reset daily and this meant we could not be assured that medicines were being held at the correct temperature to keep them safe and effective. This was addressed by the Nursing Sister as soon as it was identified as a concern. Staff were able to describe the action they would take in the event of fridge failure.

Arrangements were in place to enable people to self-administer their own medicines after an appropriate assessment.

Controlled Drugs were held securely and appropriate records were kept. We saw evidence of regular audits relating to their security and storage and we observed a robust process for disposal of unwanted and out of date controlled drugs.

The service held stocks of appropriate emergency medications that were in date and regularly checked by the pharmacy technician and nurses.

Medicines were prescribed for people by the doctors who were present on the unit during day; the service also employed nurse prescribers. Arrangements were in place to access medical advice and medicines out of hours if necessary. On admission people's own medicines were assessed to ensure they were safe to use. Nurses and doctors closely liaised with GPs and hospital teams to ensure they had the most accurate information regarding people's medicines. Discussions with the ward Sister evidenced a good process to ensure medicine could be given safely on people's admission to the in-patient unit.

Staff who administered medicines had their competency to do so which was reviewed annually. We saw that new members of staff had a competency assessment which included a drug calculation exercise prior to taking part in medicines administration activities. Health care assistants who had received training in supporting nursing staff with medicine administration had their competency assessed. Staff we spoke with told us their six week period of training had been comprehensive. They told us their training focused on the storage and safe administration of medicines along with information as to side effects.

We examined the medicines charts for six people and saw that allergies were recorded consistently. The

directions for treatment included sufficient detail to ensure medicines applied to people's skin would be applied as the prescriber intended and charts were in place to record the checking of the sites of medicated patches. Patches are often used where people are unable to take medicines orally and can be used for pain and symptom management. Staff monitored people's patches to ensure that were still in place which was documented, to ensure people were receiving their medicine.

We found an open culture of reporting medicines incidents and arrangements were in place to ensure they were documented and fully investigated. The Director of Care Services showed us a recent programme of education events she had delivered to the clinical teams to promote a safety conscious culture. She described the processes involved in incident investigation and was able to demonstrate these having been used effectively with two incidents over the previous two months. The outcome of investigations into these incidents had identified specific training for staff and had reviewed how medicine was stored to prevent re-occurrence.

Arrangements for supplying medicines for people to take home were safe. The hospice's doctors prescribed and checked these and an information sheet detailing their medicines was given to people when they were discharged. This information was also faxed to the person's GP.

The hospice had produced an information leaflet on medicines that was given to people when they were admitted and was visible on the unit. This leaflet explained that medicines used in the hospice may need to be given outside of their licensed use and invites people to discuss any concerns with a healthcare professional. Medicines within the UK are licenced for specific conditions to be administered in a specific way. Where medicines are not used in this was then the person prescribing the medicine must advise the person of this. The leaflet provided by the hospice was particularly good in providing information to people about the licensing process for medicine and why medicine were sometimes used for other reasons. In addition the leaflet provided examples of the type of medicines that maybe used and why.

## Is the service effective?

### Our findings

People and relatives we spoke with shared their views as to the knowledge and skill of the staff. Their comments included. "The staff are well trained. They all know what they are doing." Whilst a second person said, "The staff are good at listening. If I have an idea that they think is not the right path for me they will listen but tell me what they think."

Nurses and health care assistants spoke to us about the support they received from managerial staff and through their training. Their comments included. "[Person's name] is my line manager; she is supportive towards my professional development." A member of staff talked to us about the degree they were undertaking. They told us they were given some study leave to attend the course, but did some work in their own time. A second member of staff told us they were a 'care champion' and this involved supporting volunteers on their first day to get familiar with the environment, introducing them to people using the service and to their role. We spoke to one of the volunteers, who told us they had been assisting in the hospice for the last six years.

The provider ensured staff were supported within the hospice service and we spoke with staff about the support available to them. They told us about 'clinical supervision', which took place weekly and provided them with an opportunity to meet collectively or individually to talk about things which affected them. Staff were able to give us examples as to how this had helped them to come to terms with difficult experiences and their reaction to these. For example one staff member told us about a time when they provided support to young people within the in-patient unit. They told us why they found this difficult and how the management and other services in the hospice which included the Chaplain supported them to deal with their issues.

People received care from a multi-disciplinary staff team who were qualified, supported and trained to meet their needs. There was 24 hour medical and nursing support provided within the hospice in-patient unit and telephone support overnight was provided by staff of the in-patient unit for staff working in the hospice at home service.

Staff we spoke with told us that they undertook training relevant to their role to ensure people received the care they needed. Health care assistants told us that the training they received covered a wide range of topics, which enabled them to provide good and effective care. Topics included information on specific health conditions, dementia care and medicines. Staff were able to tell us how they used their training in caring for people, one example was staff understanding why people with dementia often paused when there was a change in the floor pattern. Staff told us they were able to provide reassurance to people when supporting them to walk around the hospice. The provider had a proactive approach towards staff development and learning. This meant that people using the service received care based on up to date practices and knowledge.

The quarterly clinical governance reports evidenced how training and development of staff was considered and prioritised. The reports identified staff training and development and the topics being covered and why.

For example updated training on safeguarding as a result of changes to local safeguarding procedures.

The voluntary services officer spoke to us of the recruitment and training of volunteers. Volunteers worked in a range of roles within the hospice, which included driving, working in reception and supporting people in the day therapy service with activities. Volunteers provided companionship to people in their own homes and within the in-patient unit. Volunteers undertook training in topics related to health and safety and their recruitment was subject to the same pre-employment checks that were carried out for permanent staff.

Nursing staff and health care assistants told us they had regular supervision meetings with their manager where they discussed their training needs and performance. This enabled the service to be confident that the care being given, was being provided by staff who were supported and valued and had the opportunity to reflect on their work and practices to drive improvement.

Staff had effective communication systems in place to ensure people received care which met their needs. People had information held about them and their care on an on-line system, which was accessible to all staff that provided care. This enabled staff to have access to up to date information as we saw information being added to people's records.

Staff working in the in-patient unit attended handovers, so that information was effectively shared between staff as shifts changed to ensure people received effective and personalised care. The handovers were recorded so that anyone arriving for work at a different time had access to the information. We sat in on an afternoon handover meeting. A representative from a range of services attended, which included a nurse, health care assistants, social worker and occupational therapist. Each member of staff was seen to take notes as to each person's condition, which they recorded on pre-printed information forms detailing the needs of each person. This demonstrated that staff were committed to understanding people's needs so that they could provide the appropriate care and support.

Staff who worked within the hospice at home service carried electronic devices which held information about people's needs which staff were able to update and could be accessed by the hospice at home co-ordinator, immediately. This enabled the service to make effective use of staff resources when prioritising people's support

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people 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 hospices are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found no one had a DoLS authorisation in place.

Nursing staff understood the role of the MCA and the need to act in a person's best interests if a health condition meant the person had difficulty making a decision for example about their treatment or their wishes as they approached the end of their life. Staff described how medical staff would assess the person's

mental capacity and they would discuss whether the service needed to make decisions in the person's best interest or whether they should apply for a deprivation of liberty authorisation (DoLS) from the local authority.

People we spoke with commended the food and told us there was a good element of choice. A relative told us. "[Person] is able to have lunch at any time they want." One person said, "They [staff] are very flexible." A second person said they were able to have "cornflakes for breakfast, followed by ice-cream and melon." Whilst another person commented. "I just fancied an American type of milkshake one afternoon and a member of staff went and got it for me."

A person in the in-patient unit told us that the chef visited them daily to ask them what they wanted to eat from the menu. They told us they were always asked if there was something specific they wanted that wasn't on the menu to ensure that any individual requirements were met. They went on to say, "The food is first class."

We spent time with people in the day therapy service during the lunchtime meal. People appeared to enjoy their meals; they were able to ask for and were served promptly with a variety of drinks, including beer and a glass of wine if they wanted. There was fresh orange juice, and the tables were laid nicely with flower table decorations. The meals were not rushed and there was a choice of three course meals. The meals were well presented and most plates returned to the kitchen empty. People had a pleasant meal time experience being served by volunteers who were polite, friendly and attentive to their needs.

People accessing the hospice had different dietary needs dependent on their health. Each person was therefore assessed individually and where specialist diets were required such as pureed, high calorie or low salt diets then these were provided.

People and relatives we spoke with said they were always able to speak with doctors and other health professionals and access advice and information when they needed it. One person said, "There is always a doctor on hand if I want one." A second person, who used the day therapy service, said that when they had an infection developing the doctor on site would fax over the prescription to their local GP, which meant they were not without essential medicines over a weekend period, if they were at home.

People within the in-patient unit and day therapy service had access to on-going healthcare support. People had access to a range of health and social care professionals, which included a range of therapists, social workers and clinical staff.

We contacted external health care professionals who worked with the hospice for their views about the service. They provided written comments. 'The Macmillan team attend the MDT meeting at the hospice on a weekly basis, the two-way provision of information is extremely effective. We have the opportunity to look at care plans discuss patients on the case load, report on their experiences and ensure that all of their wishes and wants are being met.' This meant people's care was delivered by services which were aware of all aspects of their care enabling services to provide consistent and effective care.

MDT meetings showed that the needs of people who use the service were discussed and any changes made to the level of support people required was reviewed. Those attending the MDT had positive links with external health and social care professionals and in some instances staff also worked within local hospitals, as they were employed by both the hospital and hospice. Staff were able to tell us how this enabled them to provide effective care as in some instances staff had already met and worked with people before being transferred to the services of the hospice. Minutes at the MDT were recorded directly onto the electronic

system, which meant immediate up to date information was accessible to all staff.

The hospice at home service had a dedicated team of staff who provide support to people and their relatives within their own home. The co-ordinator of the service had the responsibility of assessing and reviewing people's needs on an on-going basis throughout the day. This enabled them to deploy staff where they were needed. This meant that people received a service which effectively met their needs. This aspect of the hospice service identified people who needed respite care, those who required support by telephone and those who may needed a rapid response to their deteriorating health. The hospice at home service was actively co-ordinated between 8am and 10pm by the care co-ordinator in prioritising calls, with an on-call system being provided for staff by the in-patient unit to answer queries related to people's care between 10pm and 8am.

The in-patient unit staff during the night had a folder which detailed the services provided overnight by the hospice at home service. This contained information about the needs of people using the hospice at home service and helped to monitor the safety of staff who were working alone.

The hospice at home team worked with other services within the community, which included those specialising in palliative care along with district nurses, social workers and general practitioners. This ensured that information was effectively used to provide support to people and their relatives within their own home.

## Is the service caring?

### Our findings

People who use the service and their relatives spoke with enthusiasm about the quality of the care they received within the in-patient unit, the hospice at home service and day therapy service. All spoke positively about the attitude of the staff and their kind and caring approach. People's comments included. "It's just unbelievable what they do for us, and for the visitors. Nothing is too much trouble for them [staff]." "The carers are excellent. What they can't answer they find out for you.", "Both treatment and care are excellent.", "Wonderful. I don't know what I would do without this place.", "Their [staff] attitude is fabulous.", "They [staff] are always thinking of you first." one person said, "They [staff] are gifted."

Discussions with staff identified how staff went the 'extra mile' to provide additional support and care to people to improve the quality of their lives. A member of staff had found that a reclining chair at a person's home, which they chose to sleep in, was broken. Whilst the person was using the in-patient facilities staff identified a new chair at a re-cycling centre, the person with the support of staff purchased the chair so that it was in place for their use when they returned home. This meant that the person was able to sit up in a comfortable position and be safe in the same time.

People who used the hospice at home service were overwhelmingly positive about the staff who delivered the service. One person said, "Absolutely amazing, very caring and professional. I can't fault them [staff]." Another person told us, "They [staff] are brilliant, couldn't cope without them." A relative who received a respite service during the night told us how staff always arrived on time and how before they left in the morning they always asked if there was anything else they could do. This showed that the staff were valued by those using the service.

We spoke with people's relatives about the chaplaincy service. A relative told us they had been made aware of the chaplaincy service and that they had an appointment later in the day with the Chaplain, which showed information provided to people enabled people to access the services of the hospice. A second relative told us how the Chaplain had given them both Holy Communion, and provided a holding cross for their relative to hold in their hand and a Bible. Later in the day we listened into the staff handover, the information about the person being given the Bible was part of the information shared amongst the staff, which included the positive impact this had on the person's well-being and showed how staff recognised the holistic approach to care and the benefits this had on people.

A relative told us that their view of the hospice before their relative was admitted had changed a lot. They said, "I thought that the hospice was the last place – the end. It's not like that. If they can help you and sort you out they do. They try and get you better so you can go home again." Whilst a person using the service told us, "The nurses want to work here."

Staff told us they were proud to work at the hospice and support people in their journey. One staff member told us when we asked for their views about working at the service, "It's a privilege to be here."

People accessing Katharine House Hospice and their relatives had access to services which provided

support and counselling with regards to their emotional, spiritual and religious needs, which includes bereavement support before, during and after death. The Chaplaincy was made up of a Priest in the Church of England who was supported by Pastoral Care Volunteers who are an Anglican, a Methodist and a Quaker.

We spoke with the Chaplain, who told us that they facilitated religious services within 'The Sanctuary', such as Holy Communion, which was also used as a place of peace, reflection and prayer. Part of the Chaplains role in supporting people with their spiritual welfare included celebrating life events such as the performing of weddings and christenings. They told us how they supported people to write letters to relatives, so that they could leave memories behind for the younger generation. In addition to 'The Sanctuary' there was 'The Chapel' which was a quiet space open to all of any faiths and none.

The Chaplain told us they held a monthly memorial service, to which all relatives who had experienced bereavement were invited to attend. An individualised bereavement support letter was sent inviting them to the monthly evening meeting and the memorial service, whereby they could light a candle for their relative. Bereaved relatives were provided with a bereavement support leaflet, which contained information about bereavement support evenings within a group and one to one support. Within the information provided was an invitation to explore counselling.

An annual service, 'Light up Life' took place in December and held in the gardens of the hospice, alongside a Christmas tree where people could sing Carols and remember their relatives and those they had cared for.

The Chaplain spoke of how they visited people both within the in-patient unit and day therapy service providing people with an opportunity to talk with them. The Chaplain if requested supported people in organising their funeral and would officiate at the service if asked. The Chaplain was part of the 'Together Group' and was active in promoting interfaith work locally. This partnership working enabled the Chaplain to access representatives of other faiths if people using the service required. This meant that the service promoted equality and diversity and respected peoples values and beliefs.

The chaplains' role extended to include their being the Family Support Services Manager. This provided managerial responsibility for social work, complementary therapies along with bereavement and counselling. The hospice in addition provided counselling for people and their relatives following diagnosis, supporting people to come to terms with progressive illnesses and its impact. These services worked alongside and in conjunction with the carer`s support and patient group. This meant that the services offered by the hospice were centred on people and their family's needs and equally recognised that spiritual support was as important to offer as physical care.

Relatives said that were given sufficient information about their relative`s conditions. One relative said. "The nurses give me regular updates." They went onto say, "If you ask them they will come and explain to you anything you want to know." staff shared information with relatives with people`s consent.

Relatives visiting people within the in-patient unit told us how they were kept informed by staff of their relatives changing needs. They told us how they had been given information about the services provided, which included practical information such as the code so as they could access the Wi-Fi service. They told us how staff approached them and their relative, who was in bed, by not speaking over the person, but including them in all conversations. They said they had found staff to be committed to ensure people's comfort and wellbeing.

People's records contained information in preparation for end of life care and staff from the day therapy unit told us part of their role was to introduce to people discussions and the support available in making

advanced decisions about their future care and treatment. Social workers told us part of their role was to undertake assessments of people's needs and support them with organising funding for their care. They told us they were able to guide people to services that could assist them in writing wills. The MDT meetings discussed 'preferred place of care and death' and people's views about their care, which included where people had made an advanced decisions with regards to withdrawal of treatment.

People's care plans were regularly reviewed and when treatment was withdrawn this was managed openly, with open discussions between the person, their family and the staff of the hospice. All aspects of people's treatment were reviewed by clinical staff and a care plan put in place that supported and promoted a comfortable and dignified death for people. People's records detailed that following a person's death what bereavement support was offered to families. A plan of care commenced which included an information book that was given to relatives. A bereavement card was posted out to the family to reach out to them and provide a continued link between them and the staff of the hospice.

People had access to information about the services provided by Katharine House Hospice, which were readily available throughout the service. The information provided covered a range of topics, which included practical support with finances, along with information about advocacy services, the services provided by the hospice and information of other organisations that provided support.

We spoke with two relatives who use the hospice at home service. They told us that the information given to them had been useful. They told us of their intention to access the carers group.

The inpatient service has a ward made up of two bays that accommodate up to four people; in addition there were individual rooms, which provide en-suite facilities. To promote people's privacy and dignity within the ward, each bed and individual room had a curtain screen which was pulled around and the door closed when people were receiving care and treatment to promote their privacy.

People's families were supported to visit the hospice at times to suit them and the person receiving care. There were spacious facilities provided for people's visitors and several seating areas where they could relax in private. There were facilities for visitors to make their own drinks. Where people were near the end of life, their families were supported to stay overnight in rooms that were specifically designed for this purpose.

There was a light and airy atmosphere within the hospice. All bedrooms were on the ground floor with direct access to landscaped gardens. If people were unable to leave their beds, the doors on to the patio and gardens areas were designed so that people could look out into the garden.

We spoke with staff to find out what arrangements were in place which made sure that the body of a person who had died was cared for in a dignified way. Staff told us how they continued to respect and care for people following their death. They told us how they continued to speak with the person about things they had spoken with them about when they were alive. We were told that when someone was dying or had died then relatives and friends were encouraged to spend time at the person's bedside. The hospice had a dedicated room, known as the Chapel of Rest, which was decorated to create a calming environment, where the body of a deceased person was placed. Relatives could spend time with their loved one if they wished.

## Is the service responsive?

### Our findings

People were referred to the hospice services through a health or social care professional, the reason for referrals were for emergency care, respite care, pain relief and symptom management or a long term life limited health condition and end of life care. Where a person was referred to the hospice at home service, then a member of staff organised a meeting with the person or their family at their home to carry out an assessment to identify what they wanted from the service. The visit to the person was carried out quickly so that the person's needs could be quickly met, with support being provided.

People told us they always received assistance from staff when they needed it. One person said. "At night I've only got to push the button and someone is there." They went onto say "Once I pressed the emergency button by accident and someone came down the corridor straight away."

We observed this in practice and saw members of staff being quick to respond to any request from people and were pro-active in asking people if they needed anything. A person said "The nursing staff can see something coming before you do. They mention it to you and go and tell the doctor."

People spoke about how the service was responsive to their needs. They said. "They give me pain relief for my legs. I only have to ask. They write down everything. Even when I have a drink they put it on the notes." Whilst another person told us how staff had suggested a way they could dress themselves without touching their legs, which were painful.

A relative told us how staffs response had changed the outcome for their loved one. They said they thought their spouse had come into the hospice to die, but that the care provided made them feel better. Their medicines were sorted out and this had made the person more comfortable, reduced their pain and increased their appetite, they went onto say they were hoping that their relative would be able to return home soon.

A relative of another person in the in-patient unit, told us how since the person's admission, they had noticed improvements in their relatives well-being. They told us this was because staff from the hospice had responded to their needs by carrying out a range of tests to identify what was happening and had made changes to their medicine. They said this had resulted in an improvement of their appetite and had significantly reduced their pain. The relative went onto say, "They (staff) spoil you, it's natural to them. All the nurses have a lovely personality and appear to be recruited on that basis." The person using the service told us in their view the changes to their health were due to the care they received. They said, "It's the care and attention and they have time to talk to you."

The provider in response to people's feedback and with collaboration with a local hospital had within the service created a 'rehabilitation room' based within the day therapy service. This facility provided equipment which enabled occupational therapists and physiotherapists to assess people's ability to carry out everyday tasks, such as climbing the stairs, cooking and eating. We spoke with (O.T.) who told us they assessed people's ability to carry out these tasks and identify whether specialist equipment was needed.

This aim of the service was to promote people's independence service within the in-patient unit, day therapy service and in their own home.

Relatives of people accessing the hospice said they had attended a carers meeting. One person said, "It's an opportunity to meet with people in a similar situation, to share your feelings." They went on to say that they had benefited from accessing the aromatherapy sessions, which had helped them with their stress. Whilst another person told us that the meetings included talks on different subjects. They told us that sessions on financial matters, benefits and aids were of particular use for them. The carers group provided emotional support and included the opportunity for people to socialise by the organising walks and pub lunches. Practical information was provided on a range of topics, which included diet, complementary therapies and relaxation sessions. To enable family carers to attend the meetings at the hospice the service provided a sitting service where a volunteer sat with the person in their own home.

Staff from the service facilitated a 'well-being day', for people and their relatives who were recently diagnosed with an illness and was seen as a first step into the hospice. This was provided over a six week period, one day a week to offer support and information about the treatments available for people along with support for people struggling psychologically and emotionally. The 'well-being day' provided an opportunity for people to meet with representatives of all the services the hospice provided in order that they were informed and could access services, receiving support to enable them to manage their health and its implications on them and their family.

The hospice at home service worked collaboratively with other organisations to help people to remain at home. They shared information effectively between all the agencies involved in people's care which helped them to respond in a timely way to people's changing needs.. One health care professional we contacted for feedback about the service told us, 'The Macmillan team as a whole feel valued by the hospice and we value their input into the lives of many of the Stafford patients we see. In particular, the responsiveness of the hospice at home service is extremely efficient and can sometimes make the difference to a patient remaining in their preferred place of care/death.

The hospice at home service had a system which enables it to respond well and a dedicated team of staff supporting people and their relatives within their own home. The care co-ordinator role within the service has the responsibility of assessing people's needs and continued changing needs on an on-going basis throughout the day to enable them to deploy staff where the need is greatest. The service has recently introduced a system whereby staff have a hand held electronic device, which enables them to record the care they provide as it takes place, which includes any changes to people's needs. This enables the care co-ordinator to continually assess people's needs and make changes to how and where staff are deployed. The system also enables the care co-ordinator to send alerts to staff to advise them that someone's needs have changed and that there has been a change to their planned calls, this enables staff to instantly be made aware of their services being needed elsewhere and to respond appropriately.

The hospice at home service provided respite care for people's relatives during night and day. We spoke with two the relatives of two people and asked them how the service helped them. One relative told us. "It gives me a chance to sleep in my own bed, instead of sleeping on the settee. I am so grateful, I couldn't cope otherwise."

In addition to respite service, the hospice at home service provided telephone support to people who were in the early stages of their diagnosis by keeping in contact with them. This enabled staff to identify any changes in people's health and to take any necessary steps to provide additional support or refer people to other agencies if their health declined.

People within the in-patient unit received support both with care and socially through activities by care volunteers. This was a recently developed role and used to work alongside staff to improve the experience of people.

The day therapy service provided people with a 12 week programme, which was reviewed after eight weeks, with people's individual needs being taken into account when planning the service. The day therapy service provided an opportunity for people to receive support and to access other services at Kathleen House Hospice, such as complementary therapy and counselling. The service enabled people to meet with others and to develop relationships within a safe and supportive environment. We spoke with people in the day therapy service who told us, "I can come here and know that I will be looked after and will meet people in a similar situation to myself." Another person said, "I never thought this was the sort of place I would get any benefit from. I was wrong, I thought I would come once and never return, however I have, I come here regularly and would not know what I would do without it."

A health care professional told us, 'We regularly refer patients to the service for inpatient admission plus hospice at home and day services. The hospice is always efficient and responsive. Day services such as the health and well-being clinic are very valuable where patients are able to discuss their on-going health needs. The day centre is also a lifeline to some of our patients. Patient reports are always favourable about the care that they receive from the hospice and we are in constant communication with the staff at the hospice.'

An aspect of support was 'lean on us' this service provided support to people once they were discharged from day therapy. Volunteers from the 'lead on us' service following people's discharge visited them within their own home to provide an on-going link with Katharine House Hospice. In part this to ensure any concerns about a person's health and welfare were reported if necessary. An aspect of the service was to ensure people were not isolated, especially those living alone. These service 'lead on us' was also used to enable people's relatives to attend the carers group for those of working age, by providing a sitting service, so that relatives could attend the meeting, knowing that someone was providing care to their loved one.

The medical director told us how they were part of the executive team and worked with eight doctors employed by the hospice, who were supported by two part time consultants. They said that the hospice was a nurse led unit, which provided holistic care and support through medical services and day therapy. Staff from the in-patient unit had access to out of hours general practitioner support if required. This service was rarely accessed as people's needs were regularly reviewed and therefore potential needs of people were identified and systems such as anticipatory medicines were prescribed and made available to nursing staff should they be required so that people received a responsive service.

We attended the weekly MDT meeting, which was attended by a range of health and social care professionals both internal and external to the hospice. Representatives from all aspects of the services attended. Meetings were used to review people currently using the service, new referrals and those discharged. This collaborative approach enabled all the representatives of the services to discuss and review people's needs. This enabled staff to respond in a co-ordinated manner and promote continuity of care for people.

The holistic approach of meetings meant all aspects of people's welfare were discussed, which included physical symptoms, the psychological effects of their illness, social and spiritual needs were also considered. Topics discussed related to symptom control and nutritional needs and where a person's health was deteriorating the impact of this with regards to pain management and psychological support. The wider family needs were also discussed with regards to support.

Sensitive scenarios were discussed by staff in meetings. For example a person with complex family dynamics and another person who was neglecting themselves through choice. Staff considered involving other agencies, such as charities in order to maximise the support these people received at home after discharge.

The meetings identified how positive and proactive links with services within the wider health and social care community helped people to access services in a timely manner as the service was able to respond to individual needs. The occupational therapist talked about a patient they were seeing within the hospital setting that may require hospice care. Whilst a second person was identified as requiring on-going outpatient support, the need for this was discussed and nursing staff agreed there were sufficient staff to support the person at home, which included community nurses and equipment.

People's preferred place of death was discussed with in-patients as appropriate and their requests as to whether they wished to be within the hospice or at home were recorded. Staff discussed the inappropriateness of discussing an advanced decision with a patient regarding Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) due to other issues affecting the person at the time. The minutes of the meeting were recorded to enable staff within the hospice to have access to up to date information following the MDT meetings.

There were care plans for each person, which focused on all aspects of their care and support. All were detailed and reviewed regularly. There were options for staff to make comments when acknowledging each care need. There was a range of care plans that could be adapted for each person to ensure each person received personalised care. People's records included care plans for the symptom management and end of life care and the role of staff in providing the appropriate care.

Patients told us about the activities they had been able to participate in including flower arranging, quizzes and bingo. They told us how they benefited from the complementary therapies such as massage and reflexology. We observed within the day therapy service a volunteer leading a card making sessions in the craft area.

Patients and their relatives said they were comfortable raising any issues and would do so with any members of staff. The complaints procedure was displayed and clearly visible for anyone to use.

Complaints and adverse comments were managed effectively and used to improve the service for people, which included additional training to staff in advanced communication skills. A summary of concerns, any action taken along with the outcome were recorded and were included within the quarterly clinical governance report, which was shared with The Board of Trustees.

People and their relatives are encouraged to share their experiences and provide feedback on the services offered by Katharine House Hospice. People's comments along with any action taken as a result of people's feedback were detailed within the clinical governance report. The patient user groups were asked for their feedback regarding the proposal to introduce more occupational therapist support for patients admitted to the in-patient unit. It has been agreed that each bed space could have a box containing useful items which include equipment for promoting people's independence such as hand exercises and stretch bands.

The occupational therapist had suggested a memory box which included cards to stimulate people's memories for the individual to be used by either the staff or volunteers to occupy a patients time whilst in the hospice. The box could also contain items such as puzzle books, colouring books along with pens and paper. The O.T. as part of their role assisted people where they found verbal communication difficult. Communication cards were used and put onto a ring binder so that people could make their views and

wishes know, for example using cards to indicate they were in pain.

## Is the service well-led?

### Our findings

External health care professionals told us the hospice team promoted an open and inclusive culture. One professional advised us, 'The hospice does projects to promote an open and positive culture. Since the Macmillan team moved there we have very much felt like part of the team, it is very much apparent that everyone who walks through the hospice doors is welcomed with a smile and nothing is too much trouble. Management are also very much part of the team and are as approachable and accessible as all other staff.'

The provider's collaborative approach with external health care providers and those using the service enabled them to gather views as to how the service could be developed and improved to meet people's needs. This collaborative approach had resulted in an improved service being provided by staff through the development and provision of the 'rehabilitation room' and its equipment which enabled people's daily living skills to be assessed. A relative told us how the O.T. had visited their home to undertake an assessment and that as a result of their visit a bed was delivered so that when the person returned home their care needs could be met.

The provider actively sought to promote a positive culture that was open and inclusive to people who used the service, their relatives, staff who worked at the service and the wider community. The service provided a 24 hour advice telephone line, which was accessible to everyone, including health care professionals.

Accessible information about Katharine House Hospice is provided through the provider's website, which includes both practical information along with details as to the services available. It includes information about the day to day running of the hospice, information on its financial accounts, newsletters along with how the public can become involved through voluntary work and fund raising.

Staff told us how the registered manager upon their initial appointment had requested staff to write down their comments, seeking their views on training and their views of the service and how it could improve. Staff told us that following their comments training had improved to cover a wider range of topics and that there were systems in place for them to develop their competence and progress in their career if they wished to.

The hospice team developed strong links with the local community, many of whom were involved in events to raise fund for the service. The hospice team were passionate about raising awareness of what services the hospice could provide to people with life limiting conditions apart from end of life care. Information on fund raising events and activities were displayed within the hospice and on their website. Staff's commitment to fund raising events was evident. For example we saw pictures of a member of the nursing team who had taken part in a parachute jump and raised funds for the hospice.

We found that the provider and staff worked with local organisations, which included other hospices, hospitals and prisons within the wider community to provide on-going support and advice to people through partnership working. This enabled the provider to reach a wider audience to provide information for people with a life limiting condition about the care and support available for them.

As part of collaborative working, the provider in partnership with another hospice and charitable trust had established the Holly Road Supportive Care Centre to provide additional resources within the wider community for people with live limiting conditions. The provider supports the service by utilising staff from the Katharine House Hospice to provide a range of support and therapies at the centre.

Volunteers were an important part of the service and provided support in a variety of ways. Volunteers who were trained provided group support for bereaved people and visited people within their own home as part of the home visiting service. Volunteers were also used to support people within the in-patient service, fundraising events and activities as well as supporting in welcoming visitors by working on the reception desk and within retail shops located in the wider community.

The registered manager understood the importance of using feedback from people, staff and visitors about the service to evaluate the quality of the care provided. The service provided extensive opportunities for families and staff to shape the services, which included the Patient User Group (PUG) whose role was to share views and experiences to help improve Katharine House Hospice services. People's involvement in PUG had brought about practical changes to improve people's experiences, which included altering the time of fire alarm testing so that it didn't interrupt people's morning tea breaks. In addition raised flower beds were made in the garden to create gardening opportunities for people who were using mobility aids. PUG were involved in the development of new literature for life limiting conditions and revised existing information leaflets, to ensure the information was targeted and relevant to people who used the service and their relatives.

People's views about the service were gathered in form of satisfaction questionnaires and covered the in-patient unit, day therapy services, hospice at home, complimentary therapies, counselling and bereavement services. Results from these questionnaires were analysed and used to develop the service with an action plan. This was monitored by The Board of Trustees and senior management. We found that the results of the questionnaires showed that people were given information about Katharine House Hospice and there was a high level of satisfaction in the services received. The theme from compliments as identified by the provider reflected the kindness, compassion, support and outstanding quality of care and dignity provided to people who used the hospice services.

There was a clear management structure in the hospice with senior staff allocated in lead roles, which included a registered manager for the service. Throughout the organisation staff understood their lines of responsibility and accountability for decision making about the management, operation and direction of the hospice and its services. The management team demonstrated a strong commitment to providing people and those closest to them with a safe, high quality and caring service and promoted high standards.

We spoke with staff and asked them for their views of the management and leadership of the service. One staff member told us, "[The registered manager] is really approachable and really open. I can speak to the Chief Executive as he is also approachable." A second staff member described the management team as "Very approachable managers" and spoke about how the Chief Executive visits the hospice. They went onto say that the registered manager was highly visible within the hospice and had an open door policy. They said this had ensured that the culture was one of being approachable and a no blame culture, which identified that people could make mistakes so that that lessons were learnt from these to improve the service.

The Chief Executive and the Director of Care Services [registered manager] spoke with us about the governance of the hospice and the role of The Board of Trustees, whose members had specific areas of responsibility for which they were responsible for. The Executive Team regularly met to discuss the different

aspects of the hospice, which included its governance, clinical operations, staffing and a report to the Board of Trustees. The Executive Team had specific areas of responsibility and undertook a range of audits to assess the quality of the service, in relation to financial matters, the clinical aspects of the service and staffing related topics.

The Chief Executive shared with us their views about the service. They told us, "It's extremely personalised. I am impressed by how much staff will do for each patient." They went on to say that they visited the hospice, met people, their relatives and staff. They told us, "I get a sense of staff feeling empowered to 'just do it', enabling staff to provide the care patients need." They described their role as 'enabling and empowering' the registered manager to carry out their role. They confirmed the arrangements for the governance of the service and the flow of information to enable the service to continually review the quality of the service it provided.

The Board of Trustees had an active role in the leadership of the service and regularly met providing clear directives to enable the service to work well. The Katharine House Hospice website provides information about members of The Board of Trustees, and their role within the service. Senior management had the responsibility for running the service, under the direction of The Board of Trustees. The Chief Executive and Director of Care Services attended board meetings; this promoted good governance and an open and transparent system which reviewed all aspects of the services provided.

Representatives of the Board of Trustees undertook unannounced visits to the different services provided by the hospice, demonstrating their commitment to the monitoring of the services and bring about continued improvement. We looked at a report of a visit carried out by them in October 2015 for the in-patient unit. The audit used the CQC method in answering the five key questions. Each area was explored thoroughly and areas for development identified with proposed actions to improve the service. We found that the areas identified for development had been actioned. For example the ward sister had been given days above the required numbers of staff on the rota to focus on managerial aspects of the in-patient unit. They also provided additional training on safeguarding adult procedures to ensure staff were confident and able to take action where concerns were noted.

A clinical governance report was produced quarterly and shared with the Board of Trustees. The report provided information about different aspects of the service, the in-patient unit, day therapies, community services which included the hospice at home service and the family support team, which included the carers group and complementary therapies. Statistical information was included in the report which enabled the Board of Trustees to see how many people had accessed the service. The report provided an analysis from a range of departments following internal audits and identified any themes or lessons learnt, supported by recommendations to drive improvement.

The provider produced an annual quality account, which provided information as to the priorities for the hospice for the next twelve months. The report included information provided by people who had used the service through questionnaires, the involvement of people who use the service and their relatives in the services development along with information gathered from complaints and compliments. Clinical audits were monitored by the services clinical governance group and the Board of Trustees. This was accessible to external agencies, which included the CCG and the public through its website.

The provider had a programme of audits, covering clinical and non-clinical aspects. The topics audited included food and nutrition, communication and record keeping. Clinical audits covered topics such as falls, tissue viability, medicines and infection control. Action plans were produced following audits, which detailed any recommendations for actions to be done to improve the service.

We spoke with a nurse who told us they were the infection control link nurse. They said they had a management day each month and submitted a report monthly to the clinical subcommittee. Their report included how they liaised with other services such as hospitals, the local authority and other hospices for ideas as to how systems for the management of infections could be improved.

Audits undertaken on infection control included hand washing which ensured staff were thorough in maintaining hygiene standards. They told us they were supported by other staff who were 'hand washing champions' who they shared updates with and who cascaded information to other staff.

We spoke with staff to find out their views as to the quality of care they provided and how the level of care was delivered by them. They told us "Patient care is our priority, it is a good team, and we have got the time and never feel rushed when looking after someone." One member of staff described how they had spent several hours with a patient that morning without fear of other staff asking what they were doing. Another member of staff told us, "We work well as a team." A measure of staff views as to the quality of the care provided was reflected in comments about whether they would recommend the service. "Without a doubt, I could leave my relatives knowing they would be well cared for and safe." They went on to say. "The food is excellent and there is enough staff."

The provider was committed to continually reviewing how the service they provided could improve and how its success could be monitored and measured. The hospice was in the process of implementing OACCS which is a suit of five patient outcome measures including patient reported outcomes, carer's assessment, phase of illness clinical prognosis and nursing holistic assessment. This will be used by the provider and staff to inform care planning, MDT discussions and discharge planning. It will be added to the referral process to assist in decision making. Once implemented its aim is to be able to demonstrate that the outcome of the care provided is appropriate to the person using the service.

This project included a number of health care services and research facilities. We spoke with an occupational therapist who told us they had recently attended training on how the assessment process would work. They told us how this programme would be rolled out and implemented and how they would liaise with other hospices, to influence and improve care practices for people using hospice services.

The provider worked in collaboration with Hospice UK, an organisation which supports professionals working within hospice care. The organisation helps promote clinical excellence by enabling hospices to use information and to measure their performance, against other hospices within the United Kingdom.

The provider and staff of the service worked in partnership with other agencies to further develop joined up care, where packages of care and support were provided by a range of services and agencies. To facilitate this the registered manager had set up co-production workshops with the NHS providers locally to change the referral pathway to ensure services were responsive to people's needs and access to services improved, promoting continuity of care.

The provider has funded and supports two District Nurse posts in the NHS community service in response to the need for people with end of life care to receive consistent and effective end of life care. The posts have been set up to support district nurses with general palliative care and support of people.

To further develop continuity of care across care settings the registered manager and medical director were involved in the development of jobs plans for two consultants in palliative medicine, providing support across the hospice, community and acute settings. The hospice has supported the community Macmillan team by providing office space on site to base the team. This ensures that all care is seamless across settings

and has improved communication between hospice care teams and the community to the benefit of patient experience.