

# The North Northumberland Hospice Castleside House

## 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?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

# Summary of findings

## Overall summary

This announced inspection took place on 28 November and 7 December 2016. We last inspected the service in January 2015 and at that inspection we found the service was not meeting all the regulations that we inspected. We found one breach of regulation 17, good governance in relation to records and assessing and monitoring the quality of service provision.

Following our inspection in January 2015, the provider sent us an action plan to show us how they would address our concerns. We undertook this inspection to check the provider had followed their plan and to confirm they now met legal requirements.

Castleside House provides a range of services, which consist of hospice support within people's own homes, a lymphoedema clinic to people with life limiting conditions, bereavement services, holistic therapy drop in sessions and drop in support services for people who need a quiet space to reflect or receive additional comfort or assistance. Lymphoedema is a long-term (chronic) condition that causes swelling in the body's tissues. As the majority of this service is free, a charity shop (although not part of the registered element of the service) had recently been opened in Berwick which sold donated items to raise funding to further support the service. We also noted that the service was supported by a large number of local volunteers who were recognised by the trustees and the staff team as invaluable to the service as a whole. At the time of the inspection there were five people registered for the hospice at home service.

The service 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.

The registered manager had implemented a number of changes within the service since we last inspected and had taken into account the improvements that were required. There were further improvements to be made within good governance, however not sufficient to warrant a continued breach of this regulation.

People and their relatives that we spoke with were very positive about the service and felt safe when in the care of the staffing team. One person said, "They [staff] use the hoist and they are really gentle when putting the sling round me and they make sure I am completely safe. I have total confidence in them."

Records showed that staff had received training on safeguarding vulnerable adults and the Mental Capacity Act 2005. Staff were able to tell us what they would do if they had any concerns and talked about when people were not able to make decisions for themselves.

Care Quality Commission (CQC) is required by law to monitor the operations of the Mental Capacity Act 2005 (MCA) and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'. We found the

provider was complying with their legal requirements.

People and their relatives generally managed their own medicines, however, when staff had cause to support people they followed safe working practices.

Risk had been assessed and we saw evidence in people's records that areas where risk could be reduced this had been taken to protect the people whom staff supported. No accidents or incidents were recorded but staff knew what to do and how to deal with them if something should occur of this nature.

There were enough staff and volunteers working at the service to support the people who used it. People reported that staff had never let them down and were always present when they should have been to provide them with care. Volunteers were used extensively throughout the hospice service, for example in the bereavement services. The various elements of the service provided substantial practical care and emotional support during people's illness and during bereavement.

The provider followed safe recruitment practices and supported the staff fully, with supervision and appraisal and training opportunities.

People were supported by staff that were kind and caring. Hospice staff were relaxed and the feeling when we visited the providers officers of helpfulness, tranquillity and calmness was what we were told from people it was like when staff supported them within their own homes.

People and their families had access to services which provided support and counselling with regards to their varying needs. Where the provider could not meet additional needs, other healthcare professionals were contacted for advice or support. The hospice service had quiet rooms at the provider's offices which could be used for reflection or one to one support.

People were communicated with effectively and provided with the information they needed. Staff involved people in all aspects of their care provision and ensured that families were also kept well informed.

People received care and support that was tailored to their individual needs and had choice in how this was delivered; they were also involved in making decisions about their current and future care and planning their end of life care.

The service was proactive in ensuring that feedback was regularly sought and used to develop the service. People and their relatives told us they would know how to complain but had never felt this was needed. No complaints had been received during the inspection period, however there were numerous compliments seen.

The registered manager attended a number of partnership meetings and the provider had worked with stakeholders to secure further funding and additional staff to work with people living with dementia at end of life and to promote this within the community.

Regular trustee meetings took place with the board and the registered manager had developed a strategy for the long term development of the service. Checks and monitoring procedures were in place and they continued to be developed to ensure that the service maintained quality care to the people it supported. We have made a recommendation regarding this.

The provider had complied with their responsibilities of registration to send notifications of any deaths to

the Commission.

## 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.

Safeguarding procedures were understood by staff and ensured people were kept safe.

Risk assessments reflected how care should be provided to each person to minimise any risks to them.

Where medicines were administered by staff they followed safe working practices.

### Is the service effective?

Good ●

The service was effective.

The hospice contributed to the development of best practice with the securing of a pilot which would focus on end of life in people who lived with dementia.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) 2005.

Staff had received suitable training and induction to ensure they could safely meet the needs of the people they cared for. Staff also received appropriate support from the management team.

People were supported by other healthcare professionals when the need arose.

### Is the service caring?

Good ●

The service was caring.

People were treated with care and compassion and were enabled to live as full a life as possible.

People and their families told us their views about the care and treatment provided were sought, respected and acted on. They also told us they were given privacy and dignity during their end of life care.

People and their families were provided with the emotional and bereavement support they needed, both during and after end of life care.

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

The service was responsive.

People were involved in developing their care plans which were person centred and clearly described the care and support people needed and these were reviewed regularly with the person and their family.

Staffing arrangements ensured people received care and support when they needed it. A 24-hour telephone line ensured that people and their families felt supported at all times.

People told us that they would be confident expressing any concerns or complaints to staff, although we found no complaints had been made and people confirmed this.

**Good** ●

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

The service was well led.

There was a board of trustees and a registered manager who met regularly and had a strategy for the long term development of the service.

Audits and checks were in place, but a new audit tool which had been devised earlier in the year had only just started to be implemented. We have made a recommendation here.

People and their relatives told us that high quality care and support was provided by staff and volunteers at the service. The registered manager was particularly well thought of from the people and relatives we spoke with.

**Good** ●

# Castleside House

## 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 28 November and 7 December 2016 and was announced. 48 hours' notice of the inspection was given because the registered manager was often out of the office supporting staff or providing care. We needed to be sure they would be in attendance at the office to enable us to access records. Due to the nature of the service and the need to contact people who used it, we also needed to give notice to ensure that if possible we could contact or visit them in their own homes.

The inspection was carried out by one inspector 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. This person contacted people and their relatives via telephone to gain their views.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to support the planning and the judgements we made about the service.

We reviewed other information we held about the service, including the notifications we had received from the provider about deaths. We also contacted the local authority commissioning team, the local authority safeguarding team, Healthwatch and the clinical commissioning group (CCG). Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services. Where we received a response, we used their comments to support our planning of the inspection.

We spoke with three people who used the service and six family members/carers. We also spoke with the registered manager, two nurses, the chair of the board of trustees, two administration staff, three volunteers and four members of the public who were local to the area. We looked at a range of records which included

the care and medicine records for four people who either used or had used the service, five staff personnel files, three volunteer records, health and safety information and other documents related to the management of the service.

# Is the service safe?

## Our findings

At the last inspection, the provider was in breach of regulation 17 of the Health and Social Care Act 2008, in connection with the failure to fully identify, assess and manage risks to people using the service. We found they had made improvements and were now meeting this regulation.

People that we spoke with thought they were safe in the care of staff at the service. Comments included, "They [staff] are marvellous. They have provided a life line for me. I like to go shopping but because I have a vent pac (ambulatory ventilation equipment) I only have four hours to be away from home. They are really careful about planning shopping trips so that I don't feel restricted but I'm not in any danger"; "They [staff] use the hoist and they are really gentle when putting the sling round me and they make sure I am completely safe. I have total confidence in them" and "I feel very safe with them [staff]."

One relative told us, "We don't have a regular time slot because it's really the overnight we need and we're happy to fit in but we do get as much as we need which is just brilliant." Another relative told us, "I hear them [staff] laughing with (person) and she is always so much brighter when they've been. They are always on time."

Staff at the service were aware of safeguarding vulnerable adults and had received training. When we questioned staff, including the registered manager, they were fully aware of their responsibilities to report any concerns and would do so without delay.

The people we spoke with told us that either they or their relative dealt with their medicines, but also confirmed that if staff needed to, they had the information required to do this safely. Records confirmed that where staff were responsible for administering any form of medicines to people, that this information was detailed. It included which medicines this involved, how the medicine was to be administered (i.e. dose/frequency) with any additional instructions, for example, the person's ability to swallow and had been signed by the person or their family member. There was a medicines administration record in place which was used by staff if the person was in need of support with their medicines.

Any risk for people using the service had been identified and risk assessments had been carried out including, for example, a very detailed moving and handling risk assessment of people who required support from staff with their mobility. The registered manager told us that any risk that was identified was risk assessed to ensure the safety of the person and the staff member was maintained.

A full and detailed risk analysis was completed by the provider. This included areas in connection with governance and management, environmental issues, operational and clinical risk and financial risk. The analysis had identified what the potential impact would be if, for example, moving and handling of people was not done correctly or what impact it would have on the service if medicines were mishandled. The provider had taken steps to mitigate potential risk and this was monitored by the board of trustees.

Although there had been no accidents or incidents recorded in the service and people confirmed this, staff

understood what to do if anything untoward occurred. Policies and procedures were also in place to support staff in addressing and recording any issues arising and the staff we spoke with were competent to deal with any reported accidents or incidents.

People and their relatives told us they thought there were enough staff and that they had never been let down by staff not attending. There was a core team of staff providing care to people in their homes, this included nursing staff and bank support staff employed to ensure that all hours were covered. The registered manager completed hands on work in the community as part of her normal role. One of the nursing staff took the lead on the lymphoedema support offered to people with life limiting conditions and there was a coordinator for the bereavement side of the service. Lymphoedema is a long-term (chronic) condition that causes swelling in the body's tissues. Volunteers were used extensively throughout the hospice service, for example in the bereavement services. We spoke with one volunteer who told us, "I love working here, it's a service which makes such a difference."

The recruitment records we checked showed that the provider had followed safe practices, including receiving suitable references, DBS checks, obtaining a full previous employment history and recent identification checks. We also looked at the questions asked during the interview process, including those asked of volunteers. These included questions about why the potential staff or volunteer wished to work in this type of service. This meant that the provider had tightened its recruitment process to ensure that it only employed suitable staff to work with the people they supported.

We checked volunteer records and found that one volunteers driving information had expired, for example, their MOT. Staff were aware of this and were in the process of ensuring they obtained up to date details before the person was allowed to use their car for work. The staff member responsible for monitoring this information told us that they were in the process of reviewing all drivers' information records, including insurances, MOT and driving licences.

## Is the service effective?

### Our findings

At the last inspection, the provider was in breach of regulation 17 of the Health and Social Care Act 2008, in connection with the record keeping as we found that supervision and appraisal sessions were not always formally recorded. We found actions had been taken and these were now taking place and being formally recorded.

Staff had the knowledge and skills to carry out their roles. People told us that they thought staff were well trained and knew what they were doing. One relative told us, "I think they [staff] are really well trained in the care they deliver. We have some overnight cover and (person) must not lie on her back because she can't swallow. They watch her like a hawk to make sure that doesn't happen." Another relative told us, "There are four different people in the team but they all know what they are doing."

We spoke with one nurse who told us that they were undertaking a palliative care degree, which included time spent at a local university. We saw minutes and other evidence to confirm this. They told us, "It will be worthwhile when it is completed." We saw training records for staff to confirm they had undertaken a variety of training, including moving and handling people, cardio pulmonary resuscitation, health and safety, medicines management, bereavement and first aid. The training was completed in a number of ways, including through the local authority learning and development unit, through the providers own established computerised eLearning programme and through other face to face training. Some staff who had other employment provided the registered manager with copies of their certificated training. This meant improvements had been made to ensure that all training we checked was recorded on staff personnel records.

The provider had a huge range of support and training material in their offices at Alnwick. We saw power point presentations on moving and handling people which was presented by one of the nursing team to other staff members. We also saw a range of DVDs, booklets and other types of training material which could be used insitu or taken away by staff to further enhance their learning on particular issues, for example, Parkinson's Disease, various types of cancer and heart failure. This meant the provider ensured that staff had a range of best practice materials in order to help them carry out their roles fully.

Staff supervision and support sessions took place with yearly appraisals, including reflective practice and we saw evidence of this in staff member's personnel records. We also saw a piece of reflective work which considered the thoughts and actions of an older person who was not ready to die. Staff had listed the facts and what had happened, they had then considered what could have been done better and had learnt from this.

Competency checks were also completed for staff, for example for the use of syringe drivers. A syringe driver helps reduce symptoms by delivering a steady flow of injected medication continuously under the skin. We saw evidence that a self-assessment had been completed and a further formal assessment of the staff member's competence. This included checking if staff knew how to clean the device and if they knew how to start infusion.

Staff communicated well with the people and their relatives they supported. We were made aware of one person who had communication difficulties. Staff told us they used email to communicate with them because they were unable to verbally communicate with staff. We saw evidence in their care records that iPad and alphabet boards were used to promote communication. iPad's are hand held devices which are similar technology to computers. One relative told us, "(Person) is now very shaky and her speech is getting harder to understand but they [staff] do seem to understand her which is wonderful." This showed that staff tried a range of techniques to enable them to continue to communicate with people in a way which suited and enabled them.

Where the provider could not meet additional needs, other healthcare professionals were contacted for advice or support. We saw evidence that district nurse teams, cancer specialists/nursing teams and GP's, for example, were contacted and we confirmed through records that joint working had taken place to benefit the person and their family, for example, when end of life drug changes were required.

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. We checked whether the service was working within the principles of the MCA and found they were. We saw that staff had encouraged people to make decisions about their care, treatment and preferred place of death whilst they still had the mental capacity to make these decisions independently.

People and relatives confirmed that staff had gained their consent to any care provided at the onset of receiving their services and on a daily basis asked for consent before undertaking any particular task. One relative said, "They [staff] would never do anything unless we had agreed, they are very good like that."

The hospice was working alongside the SEED (Supporting Excellence in End of life care in Dementia) project at Newcastle University. This was to develop a two year programme supporting staff in care homes to deliver good end of life care to people with dementia. It was noted that one of the trustees who is a psychiatrist will provide guidance and advice to the pilot throughout. It was noted that one of the trustees who is a consultant psychiatrist specialising in older people with dementia, will provide guidance and advice to the pilot throughout.

One of the areas we check during an inspection is in connection with food and fluid. However, the registered manager explained that support staff and nurses don't have this as a need in the care provided to people they support as this is generally provided by their families. This was confirmed by some of the people that we spoke with. Records also confirmed that this was not an area of need met by the provider.

## Is the service caring?

### Our findings

All the people and relatives spoken with were full of praise for the caring nature of the staff. We were told that staff were kind and compassionate. People said that staff were respectful and polite and observed their right to dignity. People were supported by staff that were caring. Hospice staff were relaxed and the feeling when we visited the providers offices of helpfulness, tranquillity and calmness was what we were told from people it was like when staff supported them within their own homes.

One person said, "They [staff] are very special people. It takes special people to do this job." Another person said, "It's not just about being kind. They [staff] are empathetic as well. I don't know how they do it but they aren't just sorry for me, they understand me." Another person told us, "I really look forward to seeing them. One of them sings to me which always makes me laugh. We always have a bit of fun and they don't mind me teasing them."

Staff that we spoke with told us they provided a very caring service. One nurse told us, "We are exceptional when it comes to the people we work with. We think outside of the box and make sure we listen to what the carers want too." One nurse told us, "I spent time writing a list of flowers with [person's name] which they wanted at their funeral. It's such a sad time but its important people are able to do the things that are important to them." We were given an example of one person who was on ventilation and who found it difficult to gain access to the community because of this. We were told, "The staff member was trained in ventilation, they take their [person's] DNAR form and any documents they might need and the person goes out in a wheelchair taxi if needed. It's great." DNAR otherwise known as DNARCPR is in place and means that people should not attempt cardio pulmonary resuscitation – which is a decision made when it is not in a person's best interest to resuscitate them if their heart should stop beating suddenly. It is signed off by a suitably qualified healthcare professional.

All the families we spoke with who used the service told us their loved ones privacy and dignity was respected and it was their choices that staff worked with. We were told that staff respected family and carer knowledge and "Took notice of my suggestions". All the staff we spoke with told us about the importance of having a good relationship and "mutual respect" between them and the people they cared for and that this was at the basis of their supportive relationship. One staff member was clear on maintaining people's dignity and said, "I make sure I talk to people, and make sure I preserve their dignity." Relatives told us they had confidence in the staff that came to help them and one said, "We (the family) were at breaking point and really couldn't cope. They [staff] have given fantastic care and support to us as well as our relative."

People were supported to remain as independent as possible and supported to maintain activities which were important to them. One person said, "We have a wet room and they help me to shower. It's important for me to feel clean."

Staff showed a great commitment to supporting people and making a difference to their care and quality of life. Staff we spoke with knew the people they were supporting well and their different individual and family situations, needs and preferences. One nurse told us they were working through one person's 'bucket list'.

The term 'bucket list' is used sometimes for a list of activities or 'things' someone wants to do or complete before they pass away. The nurse said, "It's really important for people to do the things that matter to them, no matter what you think."

We saw evidence that staff at the service followed best practice guidelines in end of life care for people, including in regard to symptom and pain control. People and their relatives told us, "We have nothing but praise for the care given in [person's] final days, the staff did everything in their power to make it as best as they could."

We saw that advance statements had been put in place for some people, which recorded what the person would like to happen when their condition deteriorated and they were unable to make those decisions then. We saw recorded in one person's records that they had updated the statement to include details of where they wanted to be when their condition became worse.

A comprehensive bereavement support service was available for all relatives consisting of either one to one, group or telephone support depending on the needs and preferences of individual relatives. We received positive feedback from relatives about the support they had received after their family members had passed away.

Information on advocacy services was available to people. An advocate is a person who is independent of the service and who can support a person to share their views and wishes if they want that help. Although most people were seen to have family member involvement, we did see evidence of an advocate who had been involved for one person and we were told that this had been arranged via the service. This meant that where people needed additional support with decision making, the provider had made arrangements to support this.

## Is the service responsive?

### Our findings

Relatives told us that the service was responsive to the changing needs of their family member. One relative said, "They [staff] are really flexible which is important. My relative was having two daily visits, morning and evening but as she is deteriorating, we're finding that she just gets too tired so we're starting to have visits from about 11am until around 4/5 o'clock and they are going to 'play it by ear.'"

Referral forms were completed at the service when a new 'patient' was about to start using the service. The forms gathered details about the person's needs and wishes, including details about their medical condition and any medicines they currently were taking. It also included details of other support being received, how the service could further support the person and also how to access the person's property. It also included an 'other information' section which could be used to note any additional risks posed. This information ensured that the service had enough detail to gauge the support required and protect both the person and the staff member against any issues arising. We saw the referral criteria for the service and the registered manager confirmed that this was in the process of being updated due to the changes within some elements of the provision offered.

People told us that they are able to make decisions and that their preferences were taken into consideration. One relative told us, "My (relative) requested one particular carer because she really 'gelled' with him and there was no problem. That was organised for her. It made her really happy."

The provider completed in depth care plans for each person who received support at home from the service. This included details on how each person's identified need would be addressed and what goals and outcomes the person wanted. The type of intervention that would be carried out was recorded and whether this was a short term intervention or goal. One person required support due to the risk of having a seizure. The outcome the person wished for was that the seizure time would be reduced if possible and the intervention information included how staff would respond if a seizure occurred, including making the person as comfortable as possible. There were care plans in place to support people with swallowing difficulties, pain, sleeping and with their personal care. Records were detailed and included evidence that staff had been responsive to the changing needs of people.

People and their relatives confirmed that reviews of care had taken place either face to face or via telephone calls. We saw through records we looked at that this was the case. We noted that when a change in a person's needs were assessed, the plan of care was tailored to those changes to ensure that the person remained at the centre of attention. The registered manager and a nurse told us that they provide a flexible service, so that when changes occur they are flexible in their approach to ensure that any changing needs continue to be met. The service had a 24 hour telephone which was carried on a rota basis by nursing staff. This was accessed by hospice staff and other professionals to respond to people and their families needs and to ensure the safety of staff. This meant staff could instantly respond to queries from people or their families who used the service and were able to quickly provide additional support if required.

The service responded in a holistic way to the needs of the whole family, particularly when the person has

passed away. The registered manager told us, "We respond to the family when a patient dies and always make a referral for them to our bereavement service. They also would receive a leaflet explaining the service. If the family or relative does not get in touch, we will follow it up to ensure they are getting any help they may need."

People and their relatives confirmed that they had received questionnaires from time to time from the service in order that their views and experiences of the service could be gathered. From the questionnaires that we saw, all of the comments people and their relatives had made were positive. Comments included, "You provide a fantastic service"; "handled very well"; "very helpful" and "I would just like to say that all the staff involved with [person's name] care often went above and beyond what is expected of them. We think of care staff as friends not just carers."

We saw a large selection of compliments, including cards and letters from people and their relatives to thank the staff team for the care and support given to either them or their relative. One relative had recorded, "Cannot thank you enough for the care you showed [person] before they passed away. Your response to detail was second to none." These examples showed how responsive the staff team had been and how appreciative people were.

People and their relatives knew how to complain if they felt they needed to, but all we spoke with felt they had no cause to complain. One relative commented, "I've never questioned any complaints process. I'm sure there must be one but the service is so good it's never crossed my mind." We checked records and information issued to people and their relatives who used the service. We found complaints procedures were available and were given out in packs to people at the onset of using the service. We checked the providers information pack which is distributed to new 'patients' and is also available at their main office base. The pack contained details of the provider's complaints procedure. The registered manager told us, "The form was not routinely handed out before, but it is now."

## Is the service well-led?

### Our findings

At the last inspection, the provider was in breach of regulation 17 of the Health and Social Care Act 2008, as we considered that there was not sufficient time allowed for the registered manager to fully monitor the quality of the service that was being delivered to people. This also included issues with record keeping. At this inspection the provider had made some positive changes and met the regulations.

The provider had sent us notifications of people's deaths which they are legally obliged to, as part of their registration.

At the time of our inspection there was a registered manager in place, who had worked for the provider for 10 years and was a registered nursing sister with a first class honours degree in palliative care. They were present during the majority of the visit and assisted with the inspection process. Prior to working for the provider they had worked within the care sector in the local area, including end of life care, and prior to that as a district nurse in Hampshire. A board of trustees had responsibility for overseeing the service and this was made up of 12 board members with backgrounds in a range of expertise, including one general practitioner, a consultant psychiatrist for older people, a retired social worker, and those with finance, law and business expertise.

People and their relatives felt that the service was well led and they spoke very highly of the registered manager. One relative told us, "The carers are wonderful and the manager is one on her own. She is always in touch either by phone or visits and nothing is too much trouble for her." Another relative told us, "The manager did an assessment of my relative's needs at the beginning and they wrote down what needed to be done but it's not in tablets of stone. She keeps in constant touch and things can be changed just as we agree it's needed." A third relative told us, "I'm very happy with this service. It is so valuable and makes such a difference. My relative really didn't want to go into hospital and this service has meant she can stay at home with her family."

The registered manager told us that administration hours had increased which meant that they had more support to deal with quality assurance and record keeping. We saw evidence of this from records. There was also a forthcoming board meeting to further discuss additional support which would ensure that the registered manager maintained the levels of help they required to ensure that standards were maintained and regulations met. The registered manager also confirmed that they were continuing in the process of developing one of the nurses to enable further support to be offered to them via this role and the likelihood that the nurse would become a deputy to her, particularly in her absence.

We spoke with the chair of the board of trustees who told us he was disappointed in the previous inspection report and said it had been part published in the local paper. They said the registered manager, staff and volunteers worked hard to provide a good service. They told us there had been a number of changes within the service since our last inspection. The provider had reviewed the lymphoedema management service and this was now focussed on people with life limiting conditions. The service had also obtained funding to develop an end of life in dementia care service which would run for two years and was due to start in the

near future. The provider had also opened a new charity shop in Berwick to support the funding of the service. They said, "I hope that you can see what excellent work is done here and the commitment of all the staff team."

Clinical reports and qualitative data were presented at board meetings for the trustees to monitor and discuss. Information prepared showed that the service had increased referrals between the years 2014 to 2016 to almost double. Changes in the last year to the running of the lymphoedema service, employing bank staff and further developments had meant that this had not impacted on the service provided and people continued to report on a positive service. We saw board minutes which indicated that consideration had been given to a range of topics, including for example, governance, clinical issues and finance. We noted that a conversation had taken place in connection with monitoring of risk and how the risk assessment process was to be revisited with actions delegated to particular individuals. We looked at the minutes for the next meeting to check if actions had been completed and saw that the actions were still outstanding as the people tasked had not yet met up. There were no further minutes available at the time of inspection, but this showed that the provider monitored actions to ensure they had been carried out. We saw evidence of a long term plan for the development of the service which indicated that thought had been given to the future sustainability and continuing presence of the service working within the local community of Northumberland. This included looking at the possible opportunities of developing the service into areas currently not fully covered, for example, Morpeth.

Audits, checking and monitoring processes were in place and there was a monthly schedule of audits and checks which should take place. These processes had been modified since our last inspection and included, for example, checks on records, checks on employee personnel information and organisational procedures. Although these were in place with actions noted, we observed that some of the checks had only been in operation for a short period of time. The registered manager confirmed this to be the case. They also confirmed that at the next board of trustees meeting, which was due in the next few weeks, they were going to further discuss quality assurance and review the new process in place.

We recommend that the provider ensures a review of quality assurance is made and is reviewed at each board meeting.

We were told by the chair of trustees and records confirmed that the registered manager had attended a number of meetings with other organisations to ensure that robust relationships within the area was maintained. This included meetings with care home managers, other hospice providers and working closely with general practitioners and community nursing staff. The registered manager confirmed that office space at the Berwick premises was used by Macmillan support services for a support group for cancer patients and their families. We were also made aware that other groups hire the rooms when not in use at the Alnwick offices.

Staff we spoke with told us they worked as a team. One nurse we spoke with described how staff go above and beyond what is required in their job role. We saw meetings with staff had taken place and had been recorded. This showed that discussions had occurred in connection with training, care planning, new projects taking place and any issues arising within the service. A range of staff had attended, including the registered manager, other nursing staff and support workers. This meant that the registered manager had the opportunity to promote an inclusive culture within the service and allow staff to raise any issues and contribute to the quality of the service provided to the people using it.

Service user feedback forms were analysed by the provider and discussed as part of board meetings. We saw the summary of the analysis which included the number of forms received and scores given in each

area/question. For example, in the question "how did you feel your first contact with the service was handled", we noted that 10 forms had been received in August. Out of the 10 forms seven people had scored a '10' for that question, which was the highest score possible and meant they thought the service was 'very helpful' as opposed to a score of 1 which was 'not helpful'. All of the comments made from the feedback that we saw were positive and comments included, "You provide a fantastic service"; "handled very well" and "very prompt when the time came."

A detailed newsletter (booklet form) was published regularly, called "Hospice Happenings". This booklet was delivered to the local population by the post office. This ensured that people, relatives, staff, volunteers and regular members of the public were aware of the activities within the service and as the booklet contained stories from people and their families, including staff and volunteers; it played a vital role in showing first-hand what support was available to people within the North of Northumberland area.