Halton Haven Hospice

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Inspection report

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22 March 2016
29 March 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?	Outstanding ☆
Is the service well-led?	Good

Summary of findings

Overall summary

Halton Haven Hospice is a local charity that provides specialist palliative care, advice and clinical support for adults with life limiting illness and their families in the Widnes, Runcorn and surrounding areas. They deliver physical, emotional and holistic care through teams of doctors, nurses, counsellors, chaplains and other professionals including therapists and social workers. The service cares for people in two types of settings one at the hospice in a 12 bed 'In-Patient Unit' and the hospice also has a day hospice. The day service provides therapeutic support for patients and their carers who are living at home, and aim to maximise their independence and quality of life. Services are free to people and the Hospice is largely dependent on donations and fund-raising by volunteers in the community.

It was an unannounced inspection. There were six inpatients at the hospice on the day of our visit. The day hospice was not open . A further two days were spent speaking to patients and relatives via telephone to gain their views on 24 and 29 March 2016.

There was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also the director of care and operational services and oversaw the running of the service.

We found the ethos and culture of Halton Haven Hospice was positive and caring and staff spoken with were passionate about working at the hospice. They spoke of the importance of treating each patient as an individual which showed us that some aspects of the hospice were outstanding. They supported family and friends of patients with support networks and an innovative and unique support for men in the form of a "mens shed " which is the first of it's type in England.

A further outstanding initiative that the hospice was involved with in the local community was working with "Night Stop" a charity for homeless people in Halton to provide information and support.

Staff we spoke with were committed to providing individual care to the patients and relatives who were attending the hospice and put them at the heart of everything. Best practice guidelines were followed to ensure patients received the best care staff could give and patients were well supported by experienced well trained staff. All staff spoken with said they had received good training to help them to understand and care for patients at the hospice.

The registered manager was open and transparent and held a vision for the service.

Staff had received up to date training in how to protect patients from abuse and harm and they knew how to recognise signs of abuse and how to raise an alert if they had any concerns.

Patients we spoke with and their relatives felt that they and their loved ones were looked after by staff who were caring and had training so that they knew what they were doing.

Patients and relatives said the food was very good and there was always something to tempt patients if they were not feeling hungry. The menus were varied and alternatives were always available.

Care records showed that plans of care were person centred and reflected the needs of the individual. This ensured that patients were supported in the way they wanted to be.

The provider had effective procedures for ensuring that any concerns about patients safety were appropriately reported and were constantly striving for improvement.

Patients, relatives and staff felt that the home was very well managed. We found that all the staff team were well led and highly motivated to provide quality individual person centred care and all spoken with said they felt proud to work at Halton Haven Hospice.

Minor complaints had been received by the service since our last inspection. The complaints had been addressed promptly according to the service's policy and to a satisfactory outcome.

We found that risk assessments were centred on the needs of the individual patient and risks were discussed with all of the staff team and the patient.

Accidents and incidents were recorded and monitored to identify how the risks of recurrence could be reduced and patients were supported to be as independent as possible.

Staffing levels were calculated and adjusted according to patients changing needs.

There were thorough recruitment procedures in place which included the checking of references.

The environment was well designed, welcoming, well maintained and suited patients needs.

Training for staff was specific to the needs of the patients they supported such as palliative and end of life care as well as training with regard to moving and handling, safeguarding, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

All members of staff received regular one to one supervision sessions and there was a good support mechanism in place to reflect on care given. Trained nurses received clinical supervision.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to hospices. Appropriate applications to restrict people's freedom had been submitted and the least restrictive options were considered as per the Mental Capacity Act 2005 requirements.

Patients told us they were very satisfied about the staff approach and about how their care and treatment was excellent and outstanding. We saw positive comments and feedback about the quality of service patients received via surveys forms.

We found that all aspects of medication was managed safely and trained staff had a unique method of reminding them to give controlled drugs.

Clear information about the hospice, the service it provided, the facilities, and how to complain was provided to patients and visitors.

Staff sought and respected patients consent or refusal before they supported them.

We looked at the audit system in place which was comprehensive and identified how the service could improve. When needs for improvement were identified, action was taken which improved the quality of the service and care. The service worked in partnership with other organisations to drive improvements.

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

Patients said they felt safe.

Staff had received training and knew how to protect people from harm and abuse.

There were enough staff to ensure people were able to receive personalised care and support.

Medication was stored and administered effectively and was in line with current controlled drug legislation.

Robust and safe recruitment procedures were followed in practice.

The environment was secure and well maintained.

Is the service effective?

Good

The service was effective

Staff were supported with regular formal supervision and clinical supervision..

Staff understood the Mental Capacity Act 2005 (MCA) which enabled them to support people to make decisions.

People were involved in menu planning and given food they chose, and supported to eat and drink if required.

People had access to health care professionals on a regular basis as part of their treatment.

Is the service caring?

Good

The service was caring.

Patients and relatives were very complimentary about the care and support provided.

Patients were involved in the planning and review of their care plan.

Patients were treated with dignity and respect, and had the privacy they required.

The service was very flexible and responded quickly to patients changing
needs or wishes.

Visitors were welcomed at any time and were supported by staff.

Is the service responsive?

Outstanding ☆

The service was very responsive.

People's feedback described the service as, "Outstanding" and "Exceptional."

Patient care and support was planned and reviewed in partnership with them to reflect their individual wishes and what was important to them.

The service had innovative ways to involve patients and their families, for example the "mens shed" which provides unique support for men. The hospice was also heavily involved in the local community.

Patients families were encouraged to remain involved with the hospice
for as long as they wished after their loved ones had reached the end of their life.

The service worked with the local homeless shelter in conjunction with "Night Stop" so local homeless people could be aware of what the hospice has to offer and improve homeless people's access to healthcare.

Is the service well-led?

Good ●

The service was well led.

The service had a registered manager who was supported by a staff team and a board of trustees.

Strong emphasis was placed on continuous improvement of the service and
best practice. There were comprehensive quality audit systems

in place.

Staff felt supported, valued and inspired under the registered manager's
leadership.

Halton Haven 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.

A visit to the hospice was made on 1 March 2016 and was unannounced . A further two days were spent speaking to patients and relatives via telephone on 24 and 29 March 2016.

The inspection team consisted of one social care inspector and a specialist advisor in palliative and end of life care.

Before the inspection we checked the information we held about the service and the service provider, and spoke with the local authority. No concerns had been raised and the service met the regulations we inspected against at their last inspection which took place on 23 July 2013.

We spoke with two patients who were staying in the inpatients unit. It was not possible to speak to other patients on the day of our visit as their condition and preference for privacy and consent did not allow this. Following the visit we spoke with three men who attended the "men's shed", four relatives and one person who had been a patient at the inpatient unit via telephone.

We also spoke with the registered manager, three registered nurses, two permanent staff, one who was on induction, one bank nurse and one complimentary therapist. The learning and development co-ordinator and operational support lead.

We looked at all areas of the hospice, for example we viewed lounges, bedrooms and communal bathroom/shower rooms.

A range of documentation was looked at which included three care records, three staff files, medication records and audits of accidents and incidents in the hospice,. and records concerning the monitoring and safety and quality of the service. We attended a multidisplinary team meeting and observed the

administration of medicines.

We sampled the hospices' policies and procedures most of which had been completed in an easy read format to assist patients who were unable to understand the usual format such as patients living with dementia or a learning difficulty.

Good

Is the service safe?

Our findings

Patients told us they felt very safe whilst they were staying at the hospice. One person said "I would not hesitate to go back in to the hospice." One relative told us," The people who work here are just wonderful."

Staff we spoke to and records confirmed that staff had received safeguarding training via an eLearning system available via the organisations education department. Those spoken with said they would feel comfortable raising the issue with the nurse in charge, the ward manager or the hospice manager. Staff training records confirmed that training in the safeguarding of adults was also part of the induction for all members of staff. We saw that the hospice had a copy of the local authority's policy and procedures for identifying, reporting and managing safeguarding incidents.

On speaking to the registered manager they were aware of the relevant process to follow. They said they would report any concerns to the local authority and to the Care Quality Commission. We checked our records and saw that they had done this appropriately when required. They had also notified the local authority safeguarding team. There were safeguarding notices in the building giving information on how to report abuse. A whistle blowing policy was in place and all staff spoken with were aware of this.

One staff member told us "Everybody here is absolutely lovely, open helpful and approachable; I would feel comfortable contacting them". Staff members spoken with were able to describe what could be classed as abuse, for example; incorrect medication, physical or mental abuse.

Care records looked at contained up to date risk assessments, which included; pressure areas, moving and handling and nutrition. Documentation we looked at within patients care records had been developed with input from the person themselves, the staff team and other health care professionals where appropriate. We looked at the other individual risk assessments for patients staying in the hospice. We found they were personalised and highlighted individual risks to patients and saw these were effectively managed. Other risks identified were for patients who were at risk of pressure ulcers,(waterlow scores), risk of choking and risk of weight loss.

We also saw risk assessments with regard to personal evacuation plans so staff would be aware of how to assist patients if they needed to be evacuated from the service in case of an emergency.

The home had been awarded a five star hygiene rating by the local authority (which is the highest award) and we saw that the kitchen area was well organised clean and tidy.

There was an infection control lead and infection controls audits were carried out regularly by the staff at the hospice. Detailed infection control policies were in place and had been reviewed to reflect current national guidance. These included hand washing policy and standard precautions, such as instructions concerning how to deal with spills of bodily fluids. We saw prevention of infection hand dispensers which contained soap, alcohol hand rub, and hand conditioner, and staff were observed using them and aprons and gloves throughout the day whilst on the ward. These measures protected patients and staff from the

risks of acquiring an infection as much as possible to keep them safe. A recent visit by the Infection Prevention & Control Practitioner from the Five Boroughs Partnership Clinical Commissioning Group (CCG) showed an audit score of 98 % overall had been achieved by the hospice. This meant that the hospice was compliant with the checking system used by the infection control team.

Records looked at showed that accidents and incidents were reported and documented and accidents/incidents and near misses were audited by the registered manager.

On the day of the inspection in the inpatient unit there were sufficient numbers of staff on duty, which included two ward sisters, three registered nurses and three health care assistants. There was also one consultant and a specialist registrar, to manage the care of six patients.

Patients spoken with told us they felt there were enough staff on duty to provide the care they required. Staff also told us there were enough of them and they were supported by a large number of volunteers. Staffing rotas we looked at showed a good skill mix of staffing levels on all shifts. The registered manager told us that if agency trained nurses were used they had to undertake a full induction and this included shadowing of the trained nurses who were employed by the hospice. We observed that staff did not appear rushed and were able to spend quality time with people.

We saw that there was a robust recruitment policy in place. To check this we looked at the staff files for four staff members. We saw files were well organised and contained all relevant information required. This included appropriate checks, for example; two references, proof of identity and Disclosure and Barring Service (DBS) check. These checks also applied to volunteers and therapists. Staff members had provided proof of their identity and references had been taken up before staff were appointed and were obtained from their most recent employers. There was evidence that Nursing and Midwifery Council personal identification numbers had been checked to ensure valid nursing registration.

As a part of the inspection of the inpatient unit we observed medication being administered to some patients. This was done safely, the nurse wore a tabard which identified they were undertaking the medicine round; this is done to alert other staff that they should not be interrupted at this time in order to prevent errors taking place. This was carried out correctly following policy and procedure. As part of the procedure the patient was asked to tell the nurse their date of birth. The patient was wearing a wristband which was also checked. For those patients unable to answer this question (because of their condition) the wristband is checked against the patient medicine prescription sheet.

During the course of the medicine round one patient had been prescribed a controlled drug. The nurses have an innovative idea to use as a secondary aid memoir. A small toy fireman is inserted into the room identifying plaque on the wall outside the patients room. When the nursing staff saw it on the wall plaque they knew the drug had not been given and would check the prescription sheet. Nurses spoken to said they thought it was an excellent idea as sometimes they may be stopped by a relative during the drug round. The "fireman" could clearly be seen from either end of the corridor and nursing staff would be reminded that that particular patient was due medication. Once the drug had been given to the patient then it is removed from the wall plaque and put back at the bottom of the drug trolley. They told us"The doll is affectionately known as " fireman Sam " by the staff and patients."

The senior nurse on duty took us to the medication room which was securely locked. They were able to explain the various systems including ordering, administering and disposal of medicines and we saw records to confirm this. The temperature of the room and fridges were taken daily to
ensure medication was kept at the correct temperature. We checked the medication records for three

people. These had been completed correctly. We carried out a stock check of some medication which balanced correctly.

Medical equipment was looked at, for example syringe drivers. We found they are maintained regularly and all the syringe drivers we checked had maintenance stickers on which were all in date for example one stated that the next review date was April 2016. There were suction machines in the treatment room and they too were serviced and maintained on a regular basis and had review dates attached to them stating the date they were next due for service.

Good

Is the service effective?

Our findings

Patients we spoke with and their relatives felt that they and their loved ones were looked after by staff that were caring and had training so that they were competent in carrying out their roles. One relative told us,"The staff are wonderful and we can't fault the care they have given to our relative and support they have given to the family." One patient said "I had all but given up when I was admitted and they gave me back my life, I have never looked back. I attend the special respiratory day at the day hospice and it has helped me to carry on living." Other comments made were " The staff are exceptional they are so professional and give you a sense of calm and peace," " The place is excellent and staff fall over themselves to help, nothing is too much trouble" and " the people who work there are amazing and I can't speak highly enough of everyone."

During our inspection we saw that the relationships between staff and patients at the hospice were warm and caring, respectful, dignified and with plenty of smiles and laughter and hugs. The atmosphere was calm and restful.

Staff spoken with and training records seen confirmed that staff were up to date with their mandatory training. There was an education lead and operational lead who reviews when mandatory training is due for completion and who undertakes clinical supervision with the staff on .a regular basis. Supervision is a regular meeting between an employee and their line manager to discuss any issues that may affect the staff member. This may include a discussion of the training undertaken, whether it had been effective and if the staff member had any on-going training needs.

One staff member spoken with was new to the hospice and was on an induction programme. On looking at the induction and speaking with the staff member we saw that some mandatory training had been completed in the first week of the induction programme via e-learning. The staff member had a named mentor who would be working with them for the next three months or longer if they felt they needed further support. The registered manager told us that staff who were mentors had completed a course at Liverpool John Moore's University to assist and support them with their mentoring role. Staff told us this had helped them immensely. The induction training programme was designed to ensure any new staff members had the skills and knowledge they needed to do their jobs effectively and competently. Following this initial induction and when the person actually started to work they would shadow existing staff members and would not be allowed to work unsupervised for a period of time. Shadowing is where a new staff member works alongside either a senior or experienced staff member until they are confident enough to work on their own.

In addition,two trained staff members will be attending a nurse prescribing course which means that they will be able to assess patients and make clinical decisions about the care and treatment of patients in the absence of a doctor. This means that patients will receive a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice. This has been shown to improve patient care by ensuring timely access to medicines and treatment, and increasing flexibility for patients who would otherwise need to wait to see a doctor.

The registered manager informed us during the visit that recruitment to posts had been difficult. She had been working with Warrington General Hospital to undertake an exchange programme for registered nurses to enable the nursing staff from the hospital to work in the hospice and vice versa. The hospital staff working at the hospice would gain skills and knowledge with regard to end of life and palliative care. The hospice staff would in turn work with the trained staff in the hospital setting to receive skills and knowledge about life limiting illness's other than cancers such as respiratory disease, heart failure and kidney failure.

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 refuse care and treatment when this is in their best interests and legally authorised under MCA. The authorisation procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS).

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated DoLS with the registered manager. Discussion with the registered manager showed he had a clear understanding of the principles of the MCA and DoLS, and we saw that if it was considered that people were being deprived of their liberty, the correct authorisations had been applied for.

We spoke with staff and and other health care professionals and asked asked them to describe their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and how this related to the people living in the home. All said they were able to learn about it on the e-learning system on the intra-net, and were knowledgeable about the MCA and Deprivation of Liberty Safeguards.

We saw that all of the patients at the hospice at the time of our visit had sufficient capacity to make specific decisions without the need for capacity tests and best interest decisions.

Within care plans we saw information was recorded for the nutritional status of the patient. Within the case notes the information was used when patients had been identified as requiring support to improve their nutritional status. For example, if they needed food to be given via a peg tube, or simply needed to have nourishing food to help improve their diet. Many people at the end of life do not feel hungry and may need to have smaller portions of food served to them rather than on normal sized dinner plates. They may also prefer small meals more often. This was recorded in patients care files so that all staff were fully aware of their preferences and choices.

We asked patients about the food that was on offer at Halton Haven Hospice and were told "The food is very good, I am not eating much at present but they give me whatever I ask for" and " Food is lovely and all you need to do to is ask if you don't want items on the menu." Staff spoken with knew about and provided for people's dietary preferences, restrictions and reduced appetite.

Care plans also contained information with regard to referrals to other healthcare professionals which had been made. For example it was recorded that the physiotherapist had visited the patient in the unit. On discussion with the patient they confirmed they had seen the physiotherapist and that the staff on the ward had arranged this. Patient's notes also had up to date information about referrals to other clinics such as the oncology unit.

During the inspection we attended a multidisciplinary team meeting, these meetings took place weekly. Those in attendance included the medical director of the hospice a community Consultant, Specialist Registrar, GP, Clinical Nurse specialists, social workers, physiotherapist and hospice nurses from inpatient and day hospice. During the meeting staff discussed new referrals to the hospice, from the hospital, community and day unit. They also discussed in patients and out patients, these may be patients who are attending the complimentary therapies department of the day unit who now need further input from the Specialist Palliative care team at the hospice.

During the inspection staff were observed to request consent from patients for the inspectors to talk to them about their stay in the hospice. When staff approached patients they were observed to explain to the patient what they were doing and clarified that they (the patient) was happy for staff to continue.

Good

Is the service caring?

Our findings

People spoken with said "The place is brilliant, can't fault it. " "This is not a place to die it is a place to live." "Staff are exceptional people and are earth angels, nothing was too much trouble and they went the extra mile." "Staff go out of their way to look after not just my relative but the whole family; I felt we were all wrapped in cotton wool." "This is a place of calm and peace yet the staff are always smiling."

We saw that there was an individual plan of care in place for people who reach the end of life whilst in the hospice. This covers nutrition, pain and symptom control and it also refers to psychosocial, social and spiritual support and prompts staff to endeavour to ensure these areas are discussed with the patient and their carers or family members. For example, if the person is identified as following a specific religion a minister is contacted if this is the persons wish or a family member identifies if they would want to be seen by a minister of their faith at this time.

The individual care plan includes what to do after death and includes prompts for the staff to hold conversations with families and carers about the persons particular wishes if the person has not already identified them to the staff, for instance whether the person wishes to be buried or cremated. The death certificate will be completed by the Doctors within the unit this is then given to the next of kin or the family member or carer identified by the patient.

Care plans looked at identified that there were individual" Do not attempt cardio pulmonary resuscitation" (DNACPR) consent sheets in them, they had been signed by the Consultant and the patient. One of the patients spoken with told us that they were happy that they had signed it and felt they had done the right thing. The staff were supporting them to explain their decision to their adult children.

The hospice unit had single rooms each room had a wall plaque outside displaying the room number; however the patients name was not displayed. This helped to maintain their privacy and confidentiality. The staff had put a notice on one person's door restricting visitors to immediate family only; this was done at the patient's request.

Care plans were discussed with the nursing staff with regard to the patients preferred place of care and preferred place of death. Staff spoken with told us that these documents were often completed in both the hospice and community setting. These documents empowered patients to make decisions about their care at the end of life about where they want to be cared for and where they wish to die. The document stayed with the patient so if they go home or are readmitted to hospital their wishes are written down. Patients can then choose who they show the document to.

Staff discussed with each patient the support they needed to make decisions about care, treatment and symptom control. Patients were supported at the end of their life to have a comfortable, dignified and pain-free death and their wishes were at the centre of the service. Advanced care planning was in place so that families, friends and professionals involved in patient care knew what was important to them for a time in

the future where they may be unable to do so.

Emotional support was provided to staff due to the nature of their work and they were also able to receive counselling if they needed it.

The hospice provides a range of complimentary therapies such as reflexology, aromatherapy massage,reiki, indian head massage and relaxation. These therapies are offered alongside standard medical care because they have many beneficial effects such as aiding relaxation, reducing stress and helping to induce feelings of wellbeing.

Leaflets were provided for patients and relatives to enable information with regard to practical situations, for example one acknowledged how people and their relatives may feel when coping with a terminal or life limiting illness and end of life care. Another included information about coping with bereavement and what support was available, Others available included supporting a child when someone in the family had a terminal illness and 'what to do' when someone died.

Outstanding ☆

Is the service responsive?

Our findings

The staff spoken with told us they enjoyed working in the hospice and felt connected to the organisation. One nurse told me "The management are very good, I enjoy working here, they are all professional and I very much feel part of a team."

As part of the improvement of the hospice a patient/carer representative visits in patients and day patients to observe interactions between patients and staff. This is then fed back to the registered manager to improve the service.

The staff also told me about the duty of candour and were proud of the care they gave to patients They understood that duty of candour encourages openness and transparency.

We spoke with the registered manager about the vision and values of Halton Haven hospice and she told us everybody with a life limiting illness should have quality of life and dignity at the end stages of their life.. They told us "We at the hospice help our patients to have a person centred approach in their preferred place of care and ensure everyone has a dignified death with the wishes of the patient as paramount and to support the families through this difficult time."

We saw survey forms that had been completed. Patient's testimonies included, "Anything big or small they will do it for you" and, "All staff are wonderful from the cleaning staff, office staff right through to the carers and nurses they are marvellous." A relative said, "There are no adequate words to describe how exceptional all the staff are in this place, they are all earth angels."

Patients, relatives and staff felt that the hospice was very well managed. We found that all the staff team were well led and highly motivated to provide quality individual person centered care and all spoken with said they felt proud to work at Halton Haven Hospice. The hospice had policies and procedures in place which supported staff to carry out their roles and staff had a good understanding of how people wanted their care delivered. Staff told us that they followed the concept of providing real person centred care to ensure that each person who was supported at the hospice was empowered to be cared for during treatment and at the end of their life in a way they choose.

We saw that the staff had handovers at each shift change to ensure all information was passed to the new shift.

On speaking to staff they told us that regular staff meetings were being held and that these enabled managers and staff to share information and / or raise concerns. We looked at the minutes of the most recent meeting and could see that a variety of topics, including quality, health and safety, care issues, human resource issues and training expectations had been discussed.

We saw that accidents and incidents were recorded and analysed which ensured relevant action was taken to minimise risks of recurrence. Monthly and quarterly reports of accidents and incidents, and of near

misses, were written and scrutinised at meetings that included the registered manager and senior nurses.

Meetings were held every two months with a health and safety team and a clinical governance group to discuss each occurrence and other issues that may affect people in the hospice. There was also a board of trustees which met on a regular basis

We found that the hospice had robust systems in place to identify, monitor and improve the quality of the service provided. There was an extensive programme of clinical audits to check that quality of care and best practice were maintained. These included audits on blood transfusion, medicines, dignity in care, health and safety, record keeping and infection control. The system in place was effective and timescales were given to ensure any errors found were improved and assessed in a timely manner with the person or people responsible having accountability for actions to be taken.
audit included a recommendation when a need for improvement had been identified.

Information held by CQC showed that we had received all required notifications. A notification is information about important events which the service is required to send us by law in a timely way.

.As part of the auditing system a record for checking that the registration (Personal Identification Numbers) for any nurses working in the hospice were still in date was maintained. This is an annual process and registered nurses in any care setting cannot practice unless their registration is up to date.

During and following our inspection visit, we were repeatedly requesting folders, files and documentation for examination. These were all produced quickly and contained the information that we expected from the various departments at the hospice. This meant that records were stored effectively.

Good

Is the service well-led?

Our findings

The staff spoken with told us they enjoyed working in the hospice and felt connected to the organisation. One nurse told me "The management are very good, I enjoy working here, they are all professional and I very much feel part of a team."

As part of the improvement of the hospice a patient/carer representative visits in patients and day patients to observe interactions between patients and staff. This is then fed back to the registered manager to improve the service.

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Patients, relatives and staff felt that the hospice was very well managed. We found that all the staff team were well led and highly motivated to provide quality individual person centered care and all spoken with said they felt proud to work at Halton Haven Hospice. The hospice had policies and procedures in place which supported staff to carry out their roles and staff had a good understanding of how people wanted their care delivered. Staff told us that they followed the concept of providing real person centred care to ensure that each person who was supported at the hospice was empowered to be cared for during treatment and at the end of their life in a way they choose.

We saw that the hospice strived to constantly improve through good practice and learning based on up to date guidance.

We saw that the staff had handovers at each shift change to ensure all information was passed to the new shift.

On speaking to staff they told us that regular staff meetings were being held and that these enabled managers and staff to share information and / or raise concerns. We looked at the minutes of the most recent meeting and could see that a variety of topics, including quality, health and

safety, care issues, human resource issues and training expectations had been discussed.

We saw that accidents and incidents were recorded and analysed which ensured relevant action was taken to minimise risks of recurrence. Monthly and quarterly reports of accidents and incidents, and of near misses, were written and scrutinised at meetings that included the registered manager and senior nurses.

Meetings were held every two months with a health and safety team and a clinical governance group to discuss each occurrence and other issues that may affect people in the hospice. There was also a board of trustees which met on a regular basis

We found that the hospice had robust systems in place to identify, monitor and improve the quality of the service provided. There was an extensive programme of clinical audits to check that quality of care and best practice were maintained. These included audits on blood transfusion, medicines, dignity in care, health and safety, record keeping and infection control. The system in place was effective and timescales were given to ensure any errors found were improved and assessed in a timely manner with the person or people responsible having accountability for actions to be taken.
audit included a recommendation when a need for improvement had been identified.

Information held by CQC showed that we had received all required notifications. A notification is information about important events which the service is required to send us by law in a timely way.

.As part of the auditing system a record for checking that the registration (Personal Identification Numbers) for any nurses working in the hospice were still in date was maintained. This is an annual process and registered nurses in any care setting cannot practice unless their registration is up to date.

During and following our inspection visit, we were repeatedly requesting folders, files and documentation for examination. These were all produced quickly and contained the information that we expected from the various departments at the hospice. This meant that records were stored effectively.