

Tameside & Glossop Hospice Limited

Willow Wood Hospice

Inspection report

Willow Wood Close
Mellor Road
Ashton-under-Lyne
Lancashire
OL6 6SL

Tel: 01613301100

Date of inspection visit:
04 October 2016

Date of publication:
29 November 2016

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

Willow Wood Hospice provides in-patient hospice care and a day hospice from one site. The hospice holds condition specific clinics, has a bereavement support service, therapy services, a fundraising department and a team of volunteers all based on-site. The hospice delivers physical, emotional, spiritual and social holistic care through teams of nurses, doctors, counsellors, a chaplaincy/ spiritual care team and complementary therapists.

The inpatient facility accommodated up to twelve people and provided 8 single rooms and 2 double rooms. At the time of the inspection there were eight people using this service. The service also had its START day clinic where people could attend for a variety of therapies and activities.

The service is a registered charity with a board of trustees. Day to day the service was run by a management team drawn from all departments within the hospice.

There was a registered manager employed for this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was experienced in providing palliative care and worked for the organisation for a number of years.

People and professionals spoke highly of the complementary therapies that were available to both people who used the service and their relatives. The hospice provided family support, counselling and bereavement support. We also saw the service helped people carry out specific wishes such as helping someone get married and providing a wedding dress from one of their hospice charity shops to ensure people and their relatives could achieve their wishes.

People told us that staff were caring, compassionate and listened to them. People we spoke with who received personal care felt the staff were knowledgeable, skilled and their care and support met their needs. We found during the inspection that the people using the hospice services were placed at its centre and were treated very much as individuals and with respect and compassion. People and their relatives told us staff understood their specific needs.

Care plans in regard to all aspects of people's medical, emotional and spiritual needs were personalised and written in partnership with people so their preferences were made clear. Staff delivered support to people respecting these wishes and preferences about their care and life choices.

People's health care needs were met by the in-house medical team. This included consultants, GP's with a special interest in palliative care, an occupational therapy team and a physiotherapy team. We saw the service's medical team had established links with international services in relation to sharing knowledge and experiences about palliative care and regularly published research in the field.

Care plans were personalised to include people's wishes and views. People and relatives told us they were consulted about their care and treatment and that they regularly had the opportunity to speak to medical and nursing staff. Care plans were regularly reviewed in a multi-disciplinary framework. We observed staff caring for patients in a way that respected their individual choices and beliefs. We did feedback to the service that information about the hospice for people of different faiths and ethnicity could be displayed more prominently.

Staff recruitment processes were followed with the appropriate checks being carried out. There were sufficient staff on duty to meet people's needs. We were told by some patients that they sometimes had to wait longer for pain relief or support at night time. Staff we spoke with told they felt there were enough staff and that the registered manager would step in if needed. The hospice had a bank of staff who they could contact if they needed additional staff. Staff and volunteers received a thorough induction and regular training to ensure they had the knowledge and skills to deliver high quality care and support.

Staff followed risk assessments and guidance in management plans when providing care and support for people in order to maintain people's safety.

People were protected by the service's approach to safeguarding and whistle blowing. People who used the service told us that they were safe, could raise concerns if they needed to and were listened to by staff. Staff were aware of safeguarding procedures, could describe what they would do if they thought somebody was being mistreated and everyone knew who the safeguarding lead was within the service.

Staff told us they were very supported by their direct line management and could get help and support if they needed it at any time. Staff received regular group supervision and appraisals, but feedback told us the group supervision called 'well-being meetings' could be more structured. Staff members told us they felt part of a caring team and were proud to work for the hospice.

Staff worked within the principles of the Mental Capacity Act where appropriate and explained to us the process for making any best interests decisions with people. People had choices about their care and their consent was sought by staff.

People were supported to receive a nutritious diet at the service. Their appetite was assessed through talking to them which led to staff being able to give the person the type and amount of food they would be able to eat. There was a choice of menu on the day we inspected and drinks and snacks were available at any time. The service also provided a café for people, families and staff to enjoy a drink or snack.

The staff undertook the management of medicines safely and in line with people's care plans. The service had health and safety related procedures, including systems for reporting and recording accidents and incidents. The care records we looked at included risk assessments, which had been completed to identify any risks associated with delivering the person's care and their environment.

The registered provider had a system in place for responding to people's concerns and complaints. People and families were asked for their views and were involved in a group that considered ideas and developments at the service.

There were effective systems in place to monitor and improve the quality of the service provided. Staff told us that the in-patient unit had a very positive culture and the registered manager who was called the matron was very approachable and supportive. Feedback we received from in-patient staff indicated relationships could be improved in relation to communication with senior hospice management.

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.

Checks of the building and equipment were completed to make sure it was safe.

Staff we spoke with could explain indicators of abuse and the action they would take to ensure people's safety was maintained.

On the day of our visit we saw staffing numbers and skills mix were sufficient to provide a good level of care to keep people safe.

Robust recruitment procedures were in place to make sure staff were suitable to work with vulnerable adults.

Staff had a good understanding of the safe management of medication including controlled drugs.

Is the service effective?

Good 

People's healthcare needs were carefully monitored and discussed with them.

Staff told us they felt supported by their team and registered manager and an appraisal system was in place.

Staff of all levels had access to on-going training to meet the individual and diverse needs of the people they supported. Staff were trained to provide the specialist care people required.

People were assessed to identify risks associated with poor nutrition and hydration. We saw people were supported to have choice in relation to meals.

Is the service caring?

Good 

The service was caring.

People told us that staff were kind and compassionate at all times and treated everyone with dignity and respect.

The service provided emotional support to people, their family and friends via a team of counsellors, chaplaincy, nurses and healthcare staff on an on-going basis.

People were supported spiritually. People were encouraged and supported to make decisions about their care and given time to make their own choices; this included their end of life care.

Is the service responsive?

Good ●

The service was responsive.

People told us they felt confident to express any concerns or complaints about the service they received.

People and their families were fully involved in assessing their needs. People fed back they were supported to make choices about their care and treatment.

Staff delivered people's care in a person-centred way, treating them as individuals and encouraging them to make choices about their daily lives.

Is the service well-led?

Good ●

The service was well led.

There were clear management structures and lines of accountability. Staff told us the in-patient unit was well managed.

Systems were in place to monitor the quality of the service provided to ensure it was run in a safe manner.

Staff told us they felt part of a caring team and were dedicated to providing person centred care.

Willow Wood 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.

The provider was given 48 hours' notice because we did not wish to impact on the day to day running of the service and wanted to enable nursing staff to be available to speak with us.

On the day of the inspection there were two adult social care inspectors, a specialist advisor in end of life and palliative care and an expert by experience who had experience of caring for someone at the end of their life.

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. Before the inspection we reviewed the information in the PIR as well as all the information we held about the service, this included notifications of significant changes or events.

Prior to the inspection we contacted external health care professionals and commissioners of the service from the Clinical Commissioning Group (CCG) by email. We did not receive any responses to our requests.

At the time of our inspection visit there were eight people who used the in-patient service and there were people using the day hospice on a sessional basis. We attended the daily multi-disciplinary team meeting with medical staff, nurses and other heads of department.

During the visits we spoke with 11 staff, this included the chief executive, the registered manager, the medical director, human resources manager, the head of house-keeping, the chef, the lead for day services, nurses, and health care assistants. We also spoke with two in patients, three relatives, three patients who used the day service and four volunteers.

During the inspection we reviewed a range of records. This included people's electronic care records,

including care planning documentation and medication records. We also looked at staff files, including staff recruitment and training records, records relating to the management of the hospice and a variety of policies and procedures developed and implemented by the registered provider.

Is the service safe?

Our findings

People and their relatives told us they felt safe in the hospice. One person told us, "The staff explain everything and assist when I am using the hydropool."

Staff we spoke with also felt the hospice was a safe place. Two staff members told us, "We completed safeguarding adults training with Tameside Training Consortium." Staff members displayed a good knowledge of safeguarding adults and children including how to report any concerns they had. They knew about various types of abuse and potential warning signs to look out for. Staff members said if they had any concerns they would report them straightaway to the person in charge and the safeguarding lead at the hospice whom everyone knew by name.

Staff were aware of the provider's whistle blowing procedure. None of the staff we spoke with had previously had cause to use the procedure.

We asked staff if they felt comfortable and confident in managing potential conflict situations. One of the senior nurses confirmed that no form of restraint was ever used but did say more people were being admitted with on-going dementia and could have behaviour that challenged. "We can usually manage this behaviour but it can affect staffing levels. If needed, we bring in extra staff."

The staff files we looked at showed us that the provider operated a safe and effective recruitment system. The staff recruitment process included completion of an application form, a formal interview, previous employer reference and a Disclosure and Barring Service check (DBS) which was carried out before staff started work at the home. The Disclosure and Barring Service carry out a criminal record and barring checks on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults. Appropriate checks with the Nursing and Midwifery Council were completed for nursing staff to ensure they were eligible to practice. We saw evidence to demonstrate that the registered manager monitored all PIN's for nursing staff via a computerised system which flagged when they were due for renewal.

Through our observations and discussions with people and staff members, we found there were enough staff with the right experience and skills to meet the needs of the people who used the service. We reviewed duty rotas and spoke with the staff team about staffing levels and shift patterns. Most of the staff we spoke with during the inspection told us they thought there was sufficient staff on duty that day to meet people's needs. Only one member of staff raised any concern saying, "I don't think we are always sufficiently staffed, especially at weekends". All staff we spoke with told us everyone worked well together as a team to pull together to ensure the service was staffed appropriately. One nurse told us, "If we request extra staffing the managers understand, there is a pool of bank nurses we can use and our own staff can do a shift and be paid or get the time back instead." One person told us they had to wait some time at night for pain relief. They told us, "There were not sufficient numbers of staff at night time, there were definitely less staff." Most people told us that there were enough staff always around. Two patients told us staff responded to the

nurse call alarm promptly. The management team we spoke with at the feedback at the end of the inspection told us that staffing levels were reviewed regularly and additional staff would be brought in if feedback or concerns were raised by the in-patient nursing team.

The service had a good level of medical cover and we spoke with the medical director for the organisation. They told us how medical cover was provided which included an on call service at weekends although the service did not take admissions over the weekend.

Risks to people's safety were appropriately assessed, managed and reviewed. Care records we looked at during the inspection contained a number of risk assessments specific to the needs of each person. We saw risk assessments were in place for falls, moving and handling, bed rails and skin integrity.

The treatment room where medicines were kept was locked and was clean and tidy. Medicines liable to misuse (controlled drugs) were kept in a wall mounted double locked cupboard. The cupboards that all the medication (including controlled drugs), were kept in, were also well organised and medicines were easy to find. The equipment within the room was clean. We examined the syringe drivers and asked questions relating to the type of syringe driver used. The hospice used the McKinley T34 syringe driver; which is a lockable unit and recommended for use in end of life care. The unit manager discussed the procedure for cleaning and servicing of the syringe driver.

We observed a controlled drug being prepared for administration to a patient. We saw the staff check the patients' prescription sheet for the controlled drug that was due. We observed them review the drug required and prepare it for injection. They counted the amount of medication and checked it against the stock documented in the controlled drug book. Then they checked the patients' prescription sheet again to check they were preparing the correct drug, including when it had last been given and if the prescription had been prescribed correctly and was signed and dated by the medical officer (Doctor). They checked the drug expiry date, dose and that it was the correct medication. We followed them to the patients' room and stood at the doorway where we heard them explain to the patient and their family member what they were about to do. We did not observe the medication being administered as it was not appropriate to do so.

The controlled drugs were checked each night by the nursing staff and then countersigned by the pharmacist on their next visit to the hospice. We randomly checked three controlled drugs in the controlled drug cupboard correlated with the controlled drug book and found records correct and clearly maintained.

We discussed the ordering, storing safe containment, and removal or destruction of medicines and controlled drugs with the unit manager. We observed the receiving of ordered medication from the pharmacy and the process undertaken to ensure it was entered into stock safely.

The medication used in the hospice was ordered from the local NHS Trust, and a pharmacist visited the hospice on a weekly basis to check prescriptions, medication sheets, ordering and removal or destruction of drugs had all been done correctly. All the staff we spoke with had a good understanding of the safe management of medicines including controlled drugs.

There were clear, comprehensive and up to date policies and procedures covering all aspects of medicines management.

Nurses and healthcare assistants told us they received training in medicines management and also specialist equipment used by nurses such as syringe drivers. One healthcare assistant told us, "The pharmacist trained me how to calculate the drugs – to convert from micrograms etc." One nurse told us,

"We do get training. We have received intense training in the use of syringe drivers and we receive good support from our pharmacist. We (nurses) are all up to date with medicines management and have a policy we can all refer to when needed."

Arrangements were in place to ensure medicines incidents were reported and fully investigated. We found there was an open culture around reporting medicine errors. All the staff members we spoke with were aware of how to report any medicines incidents.

We asked about the arrangements for auditing of medicines handling and storage in the hospice. We saw medicines were checked frequently. These checks helped to identify any issues in order to learn and prevent the errors happening. There was also a system to receive and act upon national drug safety alerts.

We met with the maintenance staff who oversaw the health and safety checks undertaken at the service. We looked at records which confirmed that checks of the building and equipment were carried out to ensure health and safety. We saw documentation and certificates to show that relevant checks had been carried out on the fire alarm, fire extinguishers, nurse call system, emergency lighting and gas and electrical safety. We saw records that showed water temperatures were taken regularly. We saw that all water temperatures were within safe limits. The maintenance lead showed us they were trained and certified to carry out Portable Appliance Testing and they would undertake this on request if people bought in electrical appliances from home.

We saw checks in relation to moving and handling equipment under LOLER regulations had been carried out. People and staff were also protected by a plan to monitor infection control risks. We met with the head of housekeeping who explained the measures the service took on a daily basis to reduce the risk of infection. These included cleaning schedules, colour coded equipment and separate colour coded rooms for equipment storage. They also told us that two nurses were linked with the housekeeping team in relation to infection control and the service could liaise with a specialist team at Tameside Hospital if needed. This showed the service had procedures to keep people safe and free from the risk of infection.

Tests of the fire alarm were completed on a regular basis to make sure it was in safe working order. We saw all staff had training in relation to evacuation procedures. The maintenance lead told us, "If we need anything I tell [name] the chief executive and they take it very seriously. I liaise with companies and the nurses and staff as we need any equipment or systems to work for them. I enjoy it here, it is a lovely place to work."

We looked at the arrangements in place for managing accidents and incidents and preventing the risk of reoccurrence. We saw the hospice used Hospice UK's benchmarking process to monitor the occurrence of slips, trips and falls. The registered manager told us that any person who had a fall was reviewed by a doctor on site. All accidents or incidents were reviewed and shared with the clinical governance group to ensure any learning or actions were taken forward.

Is the service effective?

Our findings

Our observations demonstrated, and training records confirmed, that nursing, medical and care staff had the knowledge, expertise and communication skills to provide people with a high standard of holistic care and treatment. People using the service were entirely positive about the staff and care provided. The hospice employed a range of staff. This included doctors, nurses, healthcare assistants, a team of people who provided family support and counselling, physiotherapy and occupational therapy professionals and complimentary therapists to help to ensure people's needs were met.

We asked people if they had confidence in the staff team. One person told us, "Staff know what they are doing. Seem to have it all on hand". Another person said "I am sure they do (know what they are doing) they are very knowledgeable."

We saw records of group discussions called 'Well-being meetings'. One staff member told us, "I think the group supervision does work, but only because we have a good team." Another staff member said, "We have wellbeing sessions but this depends on staffing levels. They are planned but do get cancelled. We can request a one to one with our line manager." Other comments we received stated some staff felt the group supervision meetings lacked structure. One staff member said, "They mainly become 'chit chat' meetings rather than anything structured." Another staff member said, "We don't have individual supervision but do attend wellbeing meetings. These are like a staff forum and they started off as being useful but now don't always serve the purpose." We fed this back to managers at the end of our visit who stated they would review the process. We saw records to confirm staff received an annual appraisal which included a review of performance and progress within a 12 month period.

Staff we spoke with told us about the very good support received to carry out their role. One post graduate trainee doctor told us, "I like working here, because I can follow patients' up that I have referred, I work in Elderly Care, and by observing how care is given here I can see I have done the right thing in other situations. It has been very helpful to me".

Staff told us they received the training they required to care for people effectively. One staff member told us, "Most training is done on line but I don't think you take as much in as you would with face to face training. I will be going on a care of the dying course on 17 November; I'm looking forward to that as its external training." Another staff member said, "I make sure that I complete my entire mandatory training first. I take responsibility for my own training and have no problem in getting support from the manager with my training." All staff we spoke with spoke negatively of the online training used to support mandatory training requirements for staff. The management team at the feedback session acknowledged this could be improved to engage staff better. However people spoke positively of sessions run by senior nurses, pharmacists and the medical director. One person said, "We have received intense training in the use of syringe drivers and we receive good support from our pharmacist," and "The registered manager will support us to undertake any training specific to this service."

We spoke with several staff including one nurse, the head of housekeeping and the catering manager who

had undertaken a leadership course with the organisation in the last year. All three staff were extremely positive about this course. One told us, "The organisation paid for me to complete a leadership course, "Leading from the Middle" which started in January 2016 and finished in July 2016. This was really good training and really encouraged me in my role. Since doing this course I have become more involved with the volunteers and at looking at the whole service being provided." The head of housekeeping told us, "I had never been to another hospice and I went all over the North West, I learnt loads and it really helped me."

All staff had induction and training tailored to the roles they would fulfil and the specific needs of people using the hospice. Mandatory training was concerned with minimising risk and adhering to safe procedures and policies. This included moving and handling, symptom management, end of life care, nutrition and hydration, wound management, skin care, assessment and prevention of falls, incident reporting, the Mental Capacity Act (MCA) and safeguarding. This showed staff received training to understand the role they were to perform in a safe and effective way.

There was mixed feedback about the experience of volunteers at the service in relation to training and communication at the hospice. One volunteer told us, "I have had no formal training or information about the hospice ethos, I had to find out by myself," Another volunteer working in the reception area said, "We are the first point of contact and information is not shared with us. When we answer phone calls it can be difficult to find the right staff if we don't get their information". We did see there were monthly meetings for volunteers and that minutes were available but we gave this feedback to managers at the end of our visit who said they would explore the issues raised by volunteers after our visit.

The staff spoken with demonstrated a sound knowledge base in specialist palliative care in-keeping with roles and responsibilities and the service specification. In addition staff with link roles had training and development focussed on service needs, for example leadership and management and dementia care. The Chief Executive had undertaken a Masters degree in hospice management and other key clinical staff were qualified to academic degree level in palliative care. All staff spoken with were well supported with personal and professional development via face to face in-house or externally sourced education. The medical director for the service was passionate about teaching and training and they shared with us research papers they had produced as well as showing us how the service developed links with overseas students to share learning and experiences in palliative care.

Nurses were organised regarding revalidation and there was a system in place to support individual staff with a designated confirmer to sign off evidence within the process of revalidation.

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 care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. When people were first admitted to the hospice they were asked if they were happy to be cared for at the hospice.. At the time of our visit, there had been no applications to place a restriction on a person's liberty. We spoke with staff to check their

understanding of MCA and DoLS. One staff told us, "Whether people have got capacity to accept or refuse treatment – if not, we would hold a best interest meeting. DoLS mean we do not deprive a person of their liberty unless there was danger to them or others. We would then have to apply for an assessment to be done." Staff demonstrated a good awareness of the code of practice and confirmed they had received training in these areas. Procedures were in place to enable staff to assess people's mental capacity, should there be concerns about their ability to make decisions for themselves, or to support those who lacked capacity to manage risk.

The DNACPR forms were not kept at the front of the people's case notes where they could be seen immediately. We discussed this one of the doctors who told us that this was because the medical assessment was kept at the front of the case notes in the hospice.

The DNACPR forms were completed appropriately and countersigned by the Consultant as required. In two out of the three forms audited by us, the patient had been involved in the discussion the third form stated that the patient was unable to make this decision because of their diagnosis and condition on admission.

Discussions about DNACPR with patients and relatives were recorded in sufficient detail within the patient's record. Individual care records indicated that attention was paid to making sure that people were supported to give consent and make decisions about their care and treatment if their conditions changed or deteriorated. We saw that people's treatment wishes were documented in their records. It was clearly recorded what people's end of life preferences and preferred place of care were and these decisions had been reviewed.

Staff we spoke with understood the importance of seeking consent before providing any care or support. Staff confirmed they would respect people's right to refuse. We observed this happening during our inspection. When they went to give an injection for pain control, we heard them ask for consent and wait for it to be given.

People informed us that staff would ask their consent before providing care and treatment. One person said "I was assessed for one and half hours by the doctor who explained everything and offered different therapies". Another person stated, "Yes they do ask for consent". This showed the service respected people's rights and obtained their consent where possible.

Staff told us how important it was that they offered people choices, favourite foods and high calorie snacks if their appetite had reduced. They said they could offer people high calorie drinks or snacks if people felt they were unable to eat a full meal. People told us they were happy with their meals. People we spoke with told us that there were set times for the meals. There was always plenty to eat and drink. We saw that regular hot and cold drinks were served during the day.

One person told us "I have lost my appetite to eat, and too large portions served." Another person told us, "Staff know your name and preferences. I am on a special diet. The chef came to discuss soft diet options".

We met with the catering manager for the service. They told us how the catering service had become more flexible in their four years in the role. For example, they ran a 'Look good, feel good' session which gave people using the day service a pamper day with a three course meal. They told us they had taken additional training in nutritional needs and conditions such as dysphagia and they were also qualified to teach food hygiene. They told us, "Food should be pureed on the day so it is freshly presented." We saw that nursing staff had access to the kitchen out of hours and so they could access food stuffs for patients.

Nutrition risk assessments were carried out with people to identify specific risks associated with poor nutrition and these were subject to continuous review. This identified people's dietary needs, if they needed assistance to eat or drink and what type of food they had to have, such as soft, pureed or a normal diet. If people found it difficult to eat or swallow, advice had been sought from the dietician or the speech and language therapist (SALT). There were clear management plans and checks for staff if nutrition had to be provided via a percutaneous endoscopic gastrostomy (PEG). This is a system by which people that are unable to take food or fluid by mouth receive supplements via a tube directly into their stomach.

There were daily multi-disciplinary team meetings held, one of which we observed as part of our inspection. This meeting was attended by all heads of departments and the medical director. Each person was discussed individually and great concern was shown to ensure each person had a good, pain free day as possible. This information also confirmed those people currently on end of life care and the support being received from friends and relatives. The registered manager and medical director then proceeded to work through referrals that had been made for people requesting admission to the hospice. Before people received care and treatment at the hospice their individual care and treatment needs were assessed to help make sure these could be met. Once the meeting concluded, the nurse in charge then held a staff meeting to inform the team on duty of the status of each person currently on the unit, and the plans for admissions for the day. This meant people's needs were reviewed daily.

There were 12 beds on the in-patient unit, two of which were shared rooms and all named after trees for ease of identification. The service was modern, light and airy and the outside garden area was accessible and attractive. There was a room set aside for relatives to stay at the hospice if needed. As part of the service's development it had a lead dementia nurse, had developed a dementia café and was part of the local dementia network group. The service was planning to make a couple of bedroom's dementia friendly by providing a safe, clear environment with specific mattresses. One of the nursing staff told us, "We are currently looking at providing dementia friendly rooms. You need to get to know the person who has dementia, talk to them and their family, anyone who has been involved in supporting them." This showed the service ensured its environment supported the needs of the people who used it.

Is the service caring?

Our findings

People and family members told us they were cared for by kind, considerate and caring staff. One of the nurses told us about a day when the team had arranged for a patient's daughter to have a "wedding blessing" performed at the unit. They told us the bride desperately wanted their parent to attend the wedding but that it was unlikely they was going to be there because their condition was deteriorating, so the team had arranged a wedding blessing to take place in the garden of the unit. The staff had wheeled their bed out so they could attend. The nurse said, "It was a team effort, we arranged to get the wedding dress from the distribution centre, I took the bride in the car we also got the husband a shirt. We arranged the chaplain for the blessing and the flowers. It was discussed, arranged and done in a few hours." They told us the bride was so happy with the blessing they had decided to use the wedding dress they had used, for the official ceremony later. A relative told us, "To fulfil the last wishes staff arranged an early Christmas party on 26th September for the family. We had everything, decorations, Christmas food, it was wonderful". This showed the service supported people to have their wishes met and provide support for the whole person's family and network.

People gave us only positive feedback about the care they received from the hospice. People using the hospice expressed to us how much they valued what the service did for them. One person shared with us how it had really made a difference to how they felt both physically and emotionally. They said, "I have been coming here for two years and I go home feeling brighter. The staff are so joyful, cheerful I don't know how they do it always the same." Another person told us, "Buckets and buckets of support are offered here".

People were very positive about the staff at the hospice. One person said, "Staff were uplifting".

People were treated with dignity and respect by staff who listened to them. Staff told us how they worked in a way that protected people's privacy and dignity. For example, the importance of making sure people were happy with them coming into their room, knocking on their doors and asking permission to come in before opening the door. We saw that doors were closed and curtains drawn while any care, consultations or treatment was in progress. One person told us "Staff knock on the door they will wait to come in". Another person said "Staff close the curtain in the room to provide privacy".

One staff member said, "The service is patient centred, individualised, supporting families at a very vulnerable time." Staff all spoke about person centred care being a priority and individual care was centred around the patient's wishes and choices. A relative informed us that "There is always someone to talk to".

The hospice had a bereavement service which had recently gone through some staff changes due to vacancies. One of the nurses told us they had stepped into the role of leading this group, although we were told by the Chief Executive that a new bereavement counsellor had been appointed and was due to start shortly at the service. The bereavement service provides counselling support both at the hospice and through a drop in service in partnership with Age UK. We spoke with the day services lead who told us the hospice had a vision to develop children's bereavement services and also to expand upon the drop in sessions to provide a real focus on the issue of loneliness for people with long term conditions with

befriending schemes and more community presence so people could access the hospice services more readily.

People informed us that staff responded quickly to requests for help and support and some of them stated that staff understood their needs. Other people told us, "I feel very comfortable here, the staff are amazing and I can have one to one discussions."

We saw that the way care was organised focused on the individual and their views and life choices. All of the people we spoke with stated staff and volunteers had informed them on the range of services on offer. This information promoted a holistic and person centred approach as staff had the information to support people in a way that met their wishes, beliefs and preferences. Records showed that staff worked with people supporting and giving them information so they were empowered to make their own decisions about their care and treatment.

We saw people had been able to discuss with staff their spiritual and cultural beliefs and how they wanted these to be met and respected. The hospice had its own chaplaincy service and staff had information to source support from a variety of faiths and cultures as and when required. The chapel provided multi faith opportunities; although we fed back that there was a lack of displayed information for people of different cultures and language on display generally within the hospice environment.

The service recognised the significance of family throughout people's involvement with the hospice services. People's family members and friends were able to visit freely. We found the hospice environment to be calm and informal and the unit was open to relatives and visitors to visit and stay day and night if they needed to. A relative stated that "Staff were always around to provide emotional support whenever they needed it". Another relative told us, "Staff have arranged for our family to have complimentary therapy on offer". The lead nurse told us about the culture of the service, they said, "In my opinion – compassion – people are priority – compassion is the driving force – the alleviation of suffering." Places were available for people to use if they wished including for prayer or reflection, the café, the reception area, the gardens and a quiet family room for care and privacy after death. The hospice held events within the community to help families and friends remember their loved ones and to help alleviate a family's pain. These included remembrance ceremonies to offer families the opportunity to come together to reflect upon their loss.

Is the service responsive?

Our findings

We saw a holistic assessment covering each person's needs and preferences had been completed. This was available to view in care records. One person said "I was assessed for one and half hours by the doctor who explained everything and offered different therapies". We observed in the day service area lounge there were first time users of the service and staff were engaging both the patient and the relatives by showing the facilities and arranging appointments. Staff assisted patients to a small private room for assessments. Staff and volunteers engaged patients in conversation whilst they waited for therapy sessions.

Each person's care and treatment was fully discussed during the daily multi-disciplinary team (MDT) meeting. This included changes in their health and care needs. The MDT meeting which comprised of a range of professionals including nursing staff, medical staff, an occupational therapist and a physiotherapist. The meeting discussion included a short case history on each individual and explored issues such as treatment options and a discussion about meeting people's holistic needs such as checking all therapy options had been explored as well other individual issues such as spiritual needs. This meeting ensured anyone either receiving inpatient or community support was reviewed by a multi-disciplinary team in a responsive manner. These meetings helped ensure that people's care was individual and person centred.

We reviewed care plans for fatigue and nutritional status. In people's case notes these were used when they had been identified as requiring support to improve their nutritional status. For example, if they needed food to be given via a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube inserted into the stomach which nutritional feeds are drip fed into. This is done when people are unable to swallow for physical reasons), or those patients who simply needed to have nourishing food or supplements to help improve their diet.

There were care plans for the care of pressure ulcers and any wounds requiring dressings. These were evaluated and updated appropriately. We saw individualised care planning for falls, pain control, end of life care, the use of syringe drivers and care after death. We discussed risk assessments and care plans for moving and handling and was told these were currently being updated by the team. There was also documentation relating to conversations held with patients, their families and carers. This included a patient who was being discharged home.

There was evidence of discharge planning; we discussed a fast track discharge often used to discharge a patient to their home or a nursing home with support. We asked the staff and the senior nurse asked about rapid discharge for patients who want to go home to die. This is when a patient can be discharged home within a few hours of making the decision to go home. Although rare the nurse told us that this has been arranged when required in the past.

We reviewed medicine administration records for one person in relation to anticipatory medicines for near the end of life. Their medication had been prescribed included analgesia (pain control) other medication which may be required at the end of life was prescribed, this included medication for sedatives if required by

the patient and medication to prevent/reduce excessive secretions which can be very distressing for the family/carers. This meant people received medicines to ensure they had a comfortable and pain-free death as possible.

We saw people's cultural and religious needs were recorded. Nurses we spoke with described the need to explore spirituality further with the person capturing what was most important to them. Nurses we spoke with were aware of how to gain further support or advice regarding people's spiritual or cultural needs from the chaplaincy service at the hospice.

The hospice had developed its services to provide a greater range of disease specific clinics at the day hospice. This included lymphoedema sessions. The START programme running at the day hospice gave people a person centred care plan to enable them to participate in a variety of therapeutic activities with qualified staff, such as a physiotherapist and other trained therapists. Sessions included complementary therapies, such as physically active sessions such as Tai Chi, Pilates and yoga which complemented existing therapies such as Reiki, reflexology and massage. Other sessions such as craft, 'Looking Good, Feeling Better', hydrotherapy and physiotherapy helped promote people's sense of well-being.

The service had a patient and family support team led by counsellors. The support team remit was to offer support to anyone affected by a life limiting illness. The day hospice lead told us this was a purposely broad remit to ensure as many people as possible could access its services. They told us about other services available which included bereavement support that provided support to families after death. They told us how counselling was available to people who used the service and their relatives. The day services lead told us they wished to increase the hospice's community participation by developing befriending schemes to support people with long term conditions who often experienced loneliness.

People told us they felt listened to. People and relatives told us they were aware of how to make a complaint and they would have no hesitation in making a complaint to staff or the registered manager. We were shown a copy of the complaints procedure. The procedure gave people timescales for action and who to contact. Discussion with the registered manager confirmed that any concerns or complaints were taken seriously although there had not been any formal complaints within the last 12 months.

There was a strong multi-professional approach to responding to people's different needs. The hospice had a daily palliative care multidisciplinary team meeting and a monthly doctor's team meeting. These meetings encouraged good communication across professional boundaries and the establishment of a practical network with partner agencies. This approach had led to collaboration in service provision and to establishing a more seamless and effective care and development of services people could use.

The hospice had embraced care and support for people with dementia and their families. The hospice was part of the Tameside and Glossop multidisciplinary dementia working group, which aims to promote collaborative service provision and the development of a dementia friendly community. This development was aimed at making palliative care services more responsive to the needs of people at the end of their lives or with life limiting conditions that were also living with dementia.

Is the service well-led?

Our findings

Feedback collected from relatives was very positive and this had been recorded by the service. The themes running through the letters, cards and general feedback given to the hospice included the dedication of staff, the competence of staff and the compassion and sensitivity shown to people and their families. Our observations supported that staff across all areas within the service were motivated and committed to the continuous development of a high quality service to people and their families within and outside the hospice. All staff we spoke with demonstrated a positive culture and they were all enthusiastic to work at the hospice.

People using the service, their relatives and staff said the immediate in-patient managers were approachable and supportive and they could speak to them whenever they wanted to. One nurse told us, "The matron (registered manager) and ward manager are very supportive," and another said "I can't fault the support by the matron (registered manager)." Some staff said they felt senior management support was lacking. Comments included "I think overall it is a well- managed service, but I'm not sure what the management team do on a day-to-day basis", and "I do feel at times unsupported by senior management."

Willow Wood had a number of different ways in which it assessed and monitored the quality of the service it delivered. We looked at performance reports, audits, risk management, governance systems, meeting minutes and questionnaires carried out by people, families and staff.

The hospice had a robust risk management approach. The system was found to be comprehensive allowing staff in each area to report clinical and non-clinical incidents. Accidents and incidents were reviewed and graded. A three-monthly report was then produced with recommendations and an action plan drawn up. This was then passed down to teams for implementing a "lessons learnt" approach.

Staff members told us they had opportunities to give their views about the care provided at the hospice. Regular team meetings were held where staff were kept up to date with developments and could have discussions about the running of the service. We saw minutes of the meetings where staff had discussed end of care plans, day services update and volunteers. We saw that staff were consulted about the new day services START provision and received updates on its implementation so staff were kept informed with service developments. Staff members told us there was a good atmosphere in the hospice. One staff member said, "I absolutely love working here."

We met with the registered manager and Chief Executive for the hospice. They explained the documents provided by the hospice showed how trends and themes of concern were monitored and acted upon by the clinical governance group. For example, they explained how an audit on controlled drugs had highlighted the service needed to make improvements. The service changed the audit process so that night staff who had more considered time could audit the medicines and during the last 12 months recording in relation to controlled drugs had improved considerably. Other regular audits took place in relation to health and safety, care records, infection control and catering. We saw minutes of these meetings where actions were clearly identified, delegated and given timescales for completion.

Other important feedback from people using the hospice were sought via questionnaires and the service explained it was planning on running a questionnaire on the new START day service to see if the views of people before and after the new service had begun were positive in comparison. People we spoke with on the in-patient unit informed us they had not been involved in any surveys or meetings to give their opinion of the service. We noted that there were no meetings advertised on the notice boards.

We saw the hospice shared its lessons learnt to identify any improvements which could be made to improve the outcomes for people using the service. We were given examples of improvements which included the re-structure of the day service unit to provide more bespoke person centred sessions that people could opt in to rather than a traditional, 'these are the sessions we provide' approach. This showed the service was willing to implement change.

We saw the service was positively planning toward change which included having a clear three year strategy to explore issues such as increasing the presence and awareness of the hospice in the local community and ensuring the service was at the forefront of education in end of life care.

The service had recently been awarded a Queens Award for Voluntary Services and was planning a big party to thank its volunteers. We saw the service was working with its volunteers to increase their presence across the hospice following feedback. We saw that some nursing staff had 'swapped' roles and had worked in the retail and distribution side of the hospice's fundraising department which had given them more insight into the wider role of volunteers. One of the in-patient nurses had a link role to support the further integration of volunteers into the inpatient unit to provide support. Volunteers we spoke with informed us that monthly meetings took place and minutes were distributed. Some volunteers we spoke with felt communication could be improved and that they did not always have information they felt they needed when in front line roles such as reception. We fed this back to the management team at the end of our visit.

We saw the service as part of their contractual arrangements supplied the Clinical Commissioning Groups they worked with (CCG) with an annual Quality Account in which they gave information regarding their achievement against Performance Indicators and Quality Improvement and Innovation goals set with the CCG.

Using a benchmarking toolkit from Hospice UK, the management had developed an action plan from identified areas for further improvement in relation to medication errors, falls and pressure sores. Benchmarking provided the hospice with a mechanism to compare performance across a range of activities and against similar establishments.

We saw the service worked closely with other partners such as the NHS, local care homes and dementia groups. The hospice ran a 24 hour advice line operated by experienced nurses from the in-patient unit. Any health care professional, relatives and carers who had palliative care concerns could use service to access advice, support and information for any queries they may have. The data from these calls was monitored through the clinical governance group.