Bury Hospice

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Bury Hospice is a charity which provides a range of hospice services for adults with a life-limiting illness. The hospice is purpose built and provides accommodation on the In Patient Unit for up to 12 people. The hospice also has a Day Hospice and Hospice at Home service. In addition the hospice offers a 24 hour telephone advice line for professionals, people who use the service and their families. The hospice is close to public transport routes and is situated in a residential area of Bury, not too far from the town centre. The hospice is set in well-maintained gardens with adequate parking and clearly defined parking areas for disabled visitors.

Services are free to people, with Bury Hospice receiving some NHS funding and the remaining funds are achieved through fundraising and charitable donations.

There were six people being cared for in the In Patient Unit during our inspection, 18 people being cared for in the community and 10 people attending the Day Hospice.

We inspected Bury Hospice on the 13, 15 and 19 April 2016. The first day of the inspection was unannounced. We last inspected Bury Hospice on 11 July 2013 where we found all the regulations that we looked at had been complied with.

The home had a manager registered with the Care Quality Commission (CQC) who was present during the inspection. A registered manager is a person who has registered with 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 and associated regulations about how the service is run.

We found there were four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

There was no auditing of the quality and safety of the service to ensure people were kept safe.

We found that staff had not received regular formal supervision; necessary to enable them to feel supported and be able to discuss their progress and training needs.

An inspection of the training records showed they were incomplete. Failing to keep records to demonstrate that staff have been appropriately trained and have the necessary skills to safely care for people places people who use the service at risk of harm. There were no records to show that checks had been undertaken to show that the registered nurses who worked at the hospice had a current registration with the Nursing and Midwifery Council (NMC).

There was no business continuity plan in place to deal with emergencies that could arise and possibly affect the provision of care.

People spoke highly of the kindness and caring attitude of the staff. The expressions of care and gratitude relayed to us, demonstrated that people were cared for with the utmost compassion, kindness, dignity and respect.

We saw that people's privacy was respected and people were assisted in a way that respected their dignity. We observed respectful, kindly and caring interactions between the staff, the people who used the service and visitors. People looked well cared for and there was enough equipment available to ensure people's safety, comfort and independence were protected.

The care records showed people were involved in the assessment of their needs. A person's preferred place of care at all stages of their illness and the arrangements in the event of their death were documented. The care records we looked at showed that risks to people's health and well-being had been identified, such as poor nutrition, the risk of developing pressure ulcers and the risk of falls. We saw care plans had been put into place to help reduce or eliminate the identified risks.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. The clinical staff showed they were highly skilled in pain and symptom control.

Visitors were made welcome and the staff recognised and considered the importance of caring for the needs of family members and friends.

We found the medication system was safe and we saw how the staff worked in cooperation with other healthcare professionals to ensure that people received appropriate care and treatment. The healthcare professionals we contacted told us they had no concerns about the service.

Staff were able to demonstrate their understanding of the principles of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions.

Staff sought people's consent before they supported them. The staff we spoke with had an in depth knowledge of the care and support the people who used the service required.

We found that suitable arrangements were in place to help safeguard people from abuse. Staff knew what to do if an allegation of abuse was made to them or if they suspected that abuse had occurred.

We found people were cared for by sufficient numbers of suitably skilled, competent and experienced staff who were safely recruited. Staff received the essential training and support necessary to enable them to do their job effectively and care for people safely.

All areas of the hospice were secure, well maintained and accessible for people with limited mobility. In addition good infection control procedures were in place; making it a safe environment for people to live and work in.

We saw that food stocks were good and people were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. People who were at risk of malnutrition and poor hydration had their food and fluid intake monitored to help ensure their well- being.

Suitable arrangements were in place for reporting and responding to any complaints or concerns.

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

Sufficient suitably qualified and competent staff who had been safely recruited were available at all times to meet people's needs and suitable arrangements were in place to help safeguard people from abuse.

The system for the management of medicines was safe. People received their medicines when they needed them. The care records showed that risks to people's health and well-being had been identified and plans were in place to help reduce or eliminate the risk.

All areas of the hospice were secure, well maintained and accessible for people with limited mobility. In addition good infection control procedures were in place; making it a safe environment for people to live and work in.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received regular formal supervision; necessary to enable them to feel supported and be able to discuss their progress and training needs.

Staff had undertaken the essential training necessary to enable them to do their work effectively and safely. Staff were able to demonstrate their understanding of the principles of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

People were provided with a choice of suitable nutritious food and drink to ensure their health care needs were met. People who were at risk of malnutrition and poor hydration had their food and fluid intake monitored to help ensure their well- being.

Is the service caring?

Good

The service was caring.

People spoke highly of the kindness and caring attitude of the staff. People were cared for with the utmost compassion, kindness, dignity and respect.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. The nursing staff showed they were highly skilled in pain and symptom control.

Visitors were made welcome and the staff recognised and considered the importance of caring for the needs of all family members and friends. The spiritual and pastoral support of people who used the service and their families was considered and respected.

Is the service responsive?

Good

The service was responsive.

The care records showed people were involved in the assessment of their needs. A person's preferred place of care at all stages of their illness and the arrangements in the event of their death were documented.

Arrangements were in place to seek feedback from people who used the service by the use of small post cards that were left in people's rooms

Suitable arrangements were in place for reporting and responding to any complaints or concerns.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was no auditing of the quality and safety of the service and no business continuity plan in place to ensure people were kept safe.

An inspection of the training records showed they were incomplete. Failing to keep records to demonstrate that staff have been appropriately trained and have the necessary skills to safely care for people places people who use the service at risk of harm.

Accidents or incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.

Bury Hospice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This was an unannounced inspection that took place on the 13, 15 and 19 of April 2016. The inspection team comprised of two adult social care inspectors.

Before our inspection we looked at the previous inspection report and records that were sent to us by the registered manager to inform us of significant changes and events. Prior to our inspection of the service we were provided with a copy of a completed provider information return (PIR); this is a document that asked the provider to give us some key information about the service, what the service does well and any improvements they are planning to make.

During this inspection we spoke with one person who was staying in the In Patient Unit and four relatives. We visited one person who was receiving care in their own home and their relative. In addition we spoke on the telephone with a relative of a person who was receiving care at home. We spent time speaking with the interim chief executive, the registered manager, four registered nurses, one health care assistant, three volunteers, the cook and the laundry assistant. We spoke with a healthcare professional who had involvement with the hospice. We looked around all areas of the hospice, looked at how staff cared for and supported people, looked at food stocks, two people's care records, the medicine management system and one medicine record, three staff recruitment and training records and records about the management of the hospice. We did this to gain information about the service provided.

Good

Is the service safe?

Our findings

Comments made by people who used the service demonstrated to us that they felt safe. Their comments included; "I can't thank them enough. I am safe in the knowledge that my [relative] is being cared for and I trust them" and "I have nothing to worry about with these girls, nothing at all".

Following the appointment of an interim chief executive from another hospice, Bury Hospice is receiving support from a health and safety officer from the other hospice to help them meet their obligation to reduce and control risks within the building. We were shown a recent health and safety audit that had been undertaken and the subsequent action plans in place to address the issues of concern identified. The audit showed where the areas of high, medium and low priority were and what action was to be taken and by what timescale. We saw that high priority issues had been dealt with quickly; such as ensuring that suitable fencing to prevent access to the deep pond in the grounds was erected.

Inspection of the staff rosters and discussions with staff and relatives of people who used the service showed there were sufficient, suitably qualified and competent staff available to meet people's needs. The medical team of two palliative care doctors was led by a Consultant Physician who visited the hospice at least twice a week. We were told the medical team cared for people on the In Patient Unit and the Day Hospice as well as people visiting for outpatient appointments. During our inspection we saw one of the doctors visiting people on the In Patient Unit and the Day Hospice. We were told there was a daily 'ward round' seven days a week. Although there was no doctor on site at all times we were made aware that 24 hour medical cover was provided. We were told that, in addition to one of the hospice palliative care medical staff being 'on call' for advice, the hospice used the 'out of hours' doctor service if necessary. Staff told us they were aware and knew how to contact the on call doctor and the out of hours service.

We were told by staff that because of the staffing levels in place they valued the opportunity to provide sufficient time to give effective and caring support and meet the personal needs of each person.

A relative told us, "They are always there when you need them" and "The volunteers are lovely, they will do so much for you".

We looked at three staff personnel files and saw a safe system of recruitment was in place. The recruitment system was robust enough to help protect people from being cared for by unsuitable staff. The staff files contained proof of identity, application forms that documented a full employment history, a medical questionnaire, a job description and at least two professional references. Checks had been carried out with the Disclosure and Barring Service (DBS).The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

We saw that suitable arrangements were in place to help safeguard people from abuse. Policies and procedures for safeguarding people from harm were in place. These provided guidance on identifying and responding to the signs and allegations of abuse. Each staff member we spoke with told us they had

received training in the protection of vulnerable adults. They were able to tell us what action they would take if abuse was suspected or witnessed.

The PIR informed us that one of the senior nurses was a member of the Safeguarding Quality Forum NHS Bury. We were told that the forum has a standing item on the agenda of 'learning from incidents'.

All members of staff had access to the whistleblowing procedure (the reporting of unsafe and/or poor practice). This was contained in the policy files that were kept in the staff office as well as on the computerised system in place. Staff we spoke with were familiar with the policy and knew how to escalate concerns within the service. They also knew they could contact people outside the service if they felt their concerns would not be listened to.

Prior to the inspection, over a period of several months, we had received anonymous information of concern in relation to issues of poor management and poor practices within the hospice. We relayed the issues of concern to the registered manager who worked cooperatively with us and the safeguarding lead person of the Clinical Commissioning Group (CCG) to investigate and address, where substantiated, the issues raised.

We were told that following a recent safeguarding incident relating to a whistleblowing allegation, the hospice had made some amendments to their whistleblowing policy. This shows that the service is willing to be subjected to scrutiny and change practice if necessary; helping to ensure people are protected from harm. Having a culture of openness where staff feel comfortable about raising concerns helps to keep people who use the service safe from harm.

The care records we looked at showed that risks to people's health and well-being had been identified, such as poor nutrition, the risk of developing pressure ulcers and the risk of falls. We saw care plans had been put into place to help reduce or eliminate the identified risks.

We looked at the on-site laundry facilities. The laundry looked clean, well-organised and secure; access to the laundry was by the use of a 'key fob' held by staff. Hand-washing facilities and protective clothing of gloves and aprons were in place. The laundry was adequately equipped with an industrial washing machine that regulated the temperature according to what was being washed. We saw that clean and soiled linen was kept segregated by means of separate laundry rooms.

We saw infection prevention and control policies and procedures were in place. We were told there was a designated lead person who was responsible for the infection prevention and control management. Colour coded mops, cloths and buckets were in use for cleaning; ensuring the risk from cross-contamination was kept to a minimum. Hand-wash sinks with liquid soap and paper towels were available in all clinical areas, bedrooms, bathrooms, sluices, toilets, the kitchen and the laundry. Alcohol hand-gels were in place at reception and throughout the corridors. Good hand hygiene helps prevent the spread of infection.

Arrangements were in place for the safe handling, storage and disposal of clinical waste. We saw that staff wore protective clothing of disposable gloves and aprons when carrying out personal care duties. This helps prevent the spread of infection. Disposable bedpans and urinals were in place to further help control the spread of infection.

We were shown a copy of the Infection Control Audit that had been undertaken in July 2015 by the local authority infection control officer. It showed that the service scored a commendable 96% compliance.

We saw that, following a recent food hygiene inspection, the hospice had been rated a '5'; the highest award.

We looked around all areas of the building. The car parking areas were well laid out with very clear signage and clearly defined parking areas for disabled visitors. During the daytime hours up to 6pm, people were able to enter the hospice via the automatic doors and be greeted at the reception desk by two of the hospice volunteers. Out of hours the external doors were locked and people had to ring the doorbell for access. CCTV monitors were in place at the reception desk and on the In Patient Unit. The provision of CCTV enabled the staff on the In Patient Unit to see who required admission to the building. This helped to keep people safe by ensuring the risk of entry into the building by unauthorised persons was reduced.

We looked to see how the medicines were managed. We saw a detailed medicine management policy and procedure was in place. The PIR informed us that the policy and procedure was updated and amended in March 2015 with the involvement of the clinical staff and the local hospital pharmacist. The PIR also informed that the hospital pharmacist and Greater Manchester Police were involved in the safe destruction of controlled drugs.

We found the systems for the receipt, storage (including controlled drugs), administration and disposal of medicines were safe. We found the medicine stocks were stored securely in a locked medicine room. Medicines in use were stored in individual locked medicine cupboards in people's rooms. The system in place for the storing and recording of controlled drugs (very strong medicines that may be misused) was safe and managed in accordance with legal requirements.

We checked the medicine administration record (MAR) of one of the people who used the service. The record showed that the person was given their medicine as prescribed and when they needed it; helping to ensure that their health and well-being were protected. We spoke with one person who told us, "They look after me and make sure I get my pain relief. I am never without what I need".

We had a discussion with one of the senior nurses about whether people were encouraged to take responsibility for taking and looking after their own medicines, including controlled drugs (self-administration). We were told that risk assessments would be undertaken and that if people wished to and were risk assessed as being able to, then it would be encouraged. We were told however that if people were taking controlled drugs then self- administration was not possible as the drugs had to be stored in a controlled drug cupboard. It was explained to the senior nurse and the registered manager that people who self-administer controlled drugs are able to do so if the drugs are kept secure. A controlled drug cupboard that complies with the requirements of the Misuse of Drugs (Safe Custody) Regulations 73 is not required if people are self-administering. The senior nurse told us that self-administration of controlled drugs would be given some consideration.

We looked to see what systems were in place in the event of an emergency. We saw personal emergency evacuation plans (PEEPs) had been developed for the people who used the service. These were kept in a central file in the staff office. This information assists the emergency services in the event of an emergency arising, helping to keep people safe. The registered manager told us they were considering keeping a copy of the PEEPs at the reception desk.

We saw the emergency resuscitation equipment that included a heart defibrillator, airways, oxygen and face masks was located in a designated prominent position on a corridor.

We looked at the documents which showed equipment and services within the hospice had been serviced and maintained in accordance with the manufacturers' instructions. This included checks in areas such as gas safety, legionella, portable appliance testing, lift, hoisting equipment, and the fire and call bell system. These checks help to ensure the safety and wellbeing of everybody living, working and visiting the hospice.

Inspection of records showed that a fire risk assessment was in place and regular in-house fire safety checks had been carried out to check that the fire alarm, emergency lighting and fire extinguishers were in good working order and that the fire exits were kept clear.

We saw that accidents and incidents were recorded and monitored to identify how the risks of re-occurrence could be reduced.

Requires Improvement

Is the service effective?

Our findings

People we spoke with told us their relatives received the care they needed when they needed it. Relatives' comments included, "They sorted my [relative's] pain control so well" and "They relieved her anxiety and this helped us too". One of the responses from the 'feedback surveys' that had been given to families in 2015 stated, "Carry on doing exactly what you are doing. An excellent marvellous service".

We looked at how staff were supported to develop their knowledge and skills. We looked at the induction programme that newly appointed staff had to undertake on commencement of their employment. Induction programmes help staff to understand what is expected of them and what needs to be done to ensure the safety of the staff and the people using the service. The induction training programme included topics such as; health and safety, understanding the philosophy of the hospice, their goals and values and areas of practice in the clinical setting. We were told that staff were fully supervised until their competency had been assessed. Staff we spoke with confirmed that this information was correct. One staff member told us about their induction programme and how they were supervised and mentored throughout their six month probationary period.

The staff we spoke with told us they had undertaken the essential training necessary to enable them to do their work effectively and safely. A discussion with the qualified nursing staff showed they had received clinical update training in topics such as; pain and symptom control, counselling, verification of death, advanced communication skills, medication management and syringe drivers.

The PIR informed us that the hospice had links with organisations such as Hospice UK and Members of North West Chair and Chief Executive group. The senior nursing staff also attended meetings with their peers within other hospices. Having these links enabled them to share good practice, develop ideas and offer support to each other.

The staff we spoke with told us that although regular monthly de-briefing sessions were now in place to discuss 'patient issues' they had not received regular formal supervision. Supervision meetings help staff discuss their progress and any learning and development needs they may have. The registered manager acknowledged that formal supervision for staff had not been in place. We were told this was due to the previous lack of senior management support. We found this was a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We were told that supervision of newly employed staff was in place as this was part of the process when they were undergoing induction.

Staff told us they did not feel unsupported. They told us they received support and advice in relation to clinical issues when they requested it. Comments made were, "We are a good team and we support each other", "My mentor was good to me and showed me the ropes" and "We are looked after in other ways too. We can have individual time with [the counsellor] to talk about anything we want to".

The volunteers we spoke with told us they felt supported and valued. They told us about the induction and the training they had received when they began working at the hospice.

We were told that verbal and written 'handover' meetings between the staff were undertaken on every shift. This was to help ensure that any change in a person's condition and subsequent alterations to their care and treatment were properly communicated and understood. We were shown the written handover sheets that were in use. We were also told that the palliative care doctor undertook daily 'ward rounds' and that any subsequent change in a person's treatment and care was relayed to the nursing staff straightaway.

We asked the registered manager to tell us what they understood about the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The 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, hospices and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We asked three of the registered nurses and the registered manager if they knew about the MCA and DoLS. What they told us demonstrated they had a good understanding of the MCA and DoLS and knew the procedures to follow if an authorisation was required. We were told that no person in the hospice was subject to a DoLS.

From our discussions with people, our observations and a review of people's care records we saw that people were consulted with and, if able, consented to their care and support. We saw how staff requested people's consent before attending to their needs. The registered manager told us that if people were not able to consent then a 'best interest' meeting would be held on their behalf. A 'best interest' meeting is where other professionals, and family where relevant, decide on the course of action to take to ensure the best outcome for the person using the service.

We checked to see if people were provided with a choice of suitable and nutritious food to ensure their health care needs were met. We looked at the kitchen and food storage areas and saw good stocks of fresh, frozen and dry foods were available.

A discussion with the cook showed they worked closely with the nursing staff to ensure the texture, variety and content of the meals provided was appropriate for the people who used the service. The cook was very knowledgeable about any special diets that people needed and was also aware of how to fortify foods to improve a person's nutrition. We were told none of the people who used the service had any religious or cultural dietary requirements. The cook told us there would be no problem accessing halal or kosher foods if required. We were told that if people didn't like the choice of meal on the menu they could always have something else from the food stocks. We were told that food was always available out of hours. In addition to some food stock areas of the main kitchen always being available, the cook told us that each evening the In Patient Unit kitchen was stocked up with drinks and snacks.

The PIR informed us that the hospice had access to a 'palliative dietician' who would advise them on any specific concerns they may have.

We observed the lunchtime meal being served in the Day Hospice. The food served looked appetising and there was plenty of it. We heard a person at the dining table say, "Lovely meals".

Drinks and snacks were regularly offered to people who used the service and to their visitors. Visitors told us how they were encouraged by staff to make drinks for themselves in the kitchen/dining room on the In Patient Unit. They told us how they were able to have meals and snacks for a nominal fee and how the staff encouraged them to have refreshments and dine with their relative where possible.

The care records we looked at showed that people had an eating and drinking care plan and they were continually assessed in relation to the risk of inadequate nutrition and hydration. People who were at risk of malnutrition and poor hydration had their food and fluid intake monitored to help ensure their well- being.

We were told by the registered manager about the services and facilities in place to support people's health care needs. The Day Hospice offers a service one day a week, on a Wednesday. The Day Hospice is managed by one registered nurse who is supported by a healthcare assistant. Whilst attending the Day Hospice people are able to access the services available to the inpatients, such as medical, nursing, spiritual and psychological support. We were told that due to financial constraints the hospice can no longer provide complementary therapies such as aromatherapy.

The Hospice at Home consists of an experienced small team of registered nurses who care for people in their own home who are seriously ill and nearing the end of their life. We were told the service operates from 8am to 4pm, Wednesday to Saturday.

There is also a 24 hour advice telephone line managed by the registered nurses on the In Patient Unit. The nurses are able to offer advice to patients, families and healthcare professionals on symptom control and/ or signpost them to other relevant services. We were told that the phone calls were followed up the next day to monitor progress.

We found that sufficient and suitable equipment and adaptations were available to meet people's needs. Each bedroom had a special type of bed that helped staff position people more easily. The beds and chairs had a pressure relieving mattress in place to promote comfort and help prevent pressure ulcers developing. Each bedroom also had a 'rise and fall' chair to assist people with their mobility and provide comfort. The bathrooms and toilets had assisted bathing or showering facilities and fixed aids and adaptations were in place. This helps to promote people's independence and comfort and assist in their safe moving and handling.

Good

Is the service caring?

Our findings

People spoke highly of the kindness and caring attitude of the staff. We spoke with one person who was being cared for on the In-Patient Unit. They told us, "You don't get a 'help up' you get a 'hug up'. What a wonderful place. I have never experienced such love and warmth and that applies to everybody who works here".

We visited one person in their own home who was being cared for by the Hospice at Home team. They told us, "They have the best staff ever; wonderful girls, so caring and so kind. They know everything about me and even though they are busy they find time to sit and talk with me and hold my hand. I am so lucky". This person's relative told us, "I would give them a thousand pounds a week if I could. They will do anything at any time and are always kind, respectful, understanding and cheerful. They are like daughters to me; all so lovely. Brilliant". This relative also told us of a time when another of their relatives was an in-patient at the hospice. We were told, "One of the nurses sat and held my hand until the very end. They knew I was upset and frightened and did not want to be on my own. How can you measure that kind of care"?

Whilst we were visiting the person at home they received a telephone call from one of the Hospice at Home team. We were told the nurse was ringing to see if, 'everything was ok'. The relative told us that the staff often rang them between visits to check if, 'all was well'. Another person whose relative was receiving care and support from the Hospice at Home team told us, "The care my [relative] receives is wonderful. The staff are very helpful, kind and considerate".

Families we spoke with on the In-Patient Unit made the following comments; "It is better than a five star hotel. The staff are so kind and caring to my [relative] and also to us. They listen and they are also so respectful of our need, at times, to be alone" and "Excellent, so good and so caring. They care about us too. I can't praise them enough".

We looked at some of the responses from the 'feedback surveys' that had been given to families in 2015. Comments included; "Exceptional medical and nursing care with compassionate and caring staff. The support for us as relatives has been of the same excellent standards that were provided for our [relative]" and "What wonderful staff".

We looked at some of the Thank You cards that had been sent to the staff. The messages in the cards included words such as; "Your kindness was an inspiration and helped ease our pain", "You are all truly amazing and extremely empathetic in very difficult circumstances. We always felt [relative] was safe in your capable hands" and "Thank you so much for making [relative's] last hours comfortable and peaceful".

The expressions of care and gratitude relayed to us, demonstrated that people were cared for with the utmost compassion, kindness, dignity and respect.

We saw that visitors, and this included children, were made very welcome by the staff. Routine visiting times were between 11am and 9pm. People were able to visit the person in their own room, the dining room or the

lounge, where there was a play area for children. In the event of a person nearing the end of their life, visitors who wished to stay close to them could stay either in the person's room or in one of the two 'family rooms available'. We spoke with two relatives who had been using one of the family rooms. They told us the staff had been, "Wonderful" and they were so grateful for the opportunity to stay.This showed to us that the service recognised and considered the importance of caring for the needs of all family members and friends during such a difficult time.

From our observations we saw that staff approached people in a kind and sensitive manner and made 'eye contact' before they spoke. We saw staff offering a gentle touch of their hand when needed. Staff knocked on doors, waited and asked permission before they entered people's bedrooms. All the staff we spoke with, including volunteers, spoke passionately about ensuring that people and their families were cared for with dignity and compassion. Staff told us they felt proud to be working at the hospice and proud of the care they delivered. We found that staff had a very good understanding of the needs and wishes of the people within their care.

We spent some time in the Day Hospice and saw there was a friendly relaxed atmosphere. People were sat in the lounge area and were talking with each other and with the staff. We saw that the staff were polite and attentive. The staff told us that attending the Day Hospice gave people the opportunity to have a meal, talk about things that mattered to them and to join in, if they wished, with the activities that were taking place.

We were told that people were supported at the end of their life to have a comfortable, dignified and pain-free death. A discussion with the nursing staff showed they were highly skilled in pain and symptom control. One person told us how the staff had managed to deal with their relative's anxiety and breathing problems and how their ability to do this had helped their relative and the family to stay calm and peaceful. Another relative told us, "We know it won't be long now. The staff have discussed things with us and we know what to expect. All we want is for [relative] to be free from pain and be peaceful and she is".

We were told that some staff had undertaken training in 'enhanced communication skills'. This training is designed to enhance skills for communicating effectively with people in a way that embodies compassion, dignity and respect.

We saw that the hospice had links with a Dementia Project Worker for a local dementia service. We were told they were available for advice and support. We spoke with one of the registered nurses and asked them about their experiences of caring for someone living with dementia. They told us, "It is more time consuming, but that's what we are here for".

The nursing staff told us, and visiting relatives confirmed this, that people's wishes were recorded and respected. The care records showed where discussions had taken place with people about their wishes, especially in relation to whether they wished to be resuscitated or sent to hospital.

The nursing staff we spoke with told us that the spiritual and pastoral support of people who used the service and their families was always considered and respected. We were told visits to the hospice were regularly undertaken by a Roman Catholic priest and a Church of England minister. We were briefly introduced to the Church of England minister who was chatting to people in the Day Hospice. Staff told us that people could choose to have their own clergy visit them and also take Holy Communion if they wished. We saw that information about the beliefs and practices of various religions was kept in the staff office on the In-Patient Unit. This helps staff to meet the needs of the cultural and religious community they care for.

The hospice has a Sanctuary room where people who use the service and their families and visitors can sit

peacefully or talk with staff in private. We were told the Sanctuary was open 24 hours a day and was for the use of everybody, including staff. During the inspection we sat in the Sanctuary whilst we were talking with relatives. We found the room to be quiet and calming. There was a 'memory tree' in the Sanctuary where bereaved people could hang a message on a branch in memory of their loved one.

We saw there were lots of information leaflets available for the people who used the service, their relatives and visitors. There was a 'general information for visitors' leaflet that gave information in relation to visiting times, telephone enquiries, meals and refreshments and the facilities provided by the hospice. In addition there were leaflets about the hospice care team, bereavement and family support, coping with dying, planning for your future care, advocacy services, the Macmillan services available and useful contacts such as Cruse Bereavement Services and The Child Bereavement Charity.

We asked the registered manager to tell us what happened when a person was extremely ill but wished to spend their final days at home. We were told that everything possible would be done to ensure the person's wishes were respected. We were told about the partnership working in place within the community services, such as the district nurses, occupational therapists and physiotherapists to ensure that suitable staffing and equipment would be made available within the person's home to ensure their needs and wishes would be met. We were shown a copy of a recent case conference that had been held to assist in the safe discharge of a person who wished to go home. An occupational therapist had been involved in the case conference due to the fact that specialised equipment was required to enable the person to access and move around their home.

We also asked about the care provided to a person after they have died. We were told that people remained in their own temperature controlled room after death. This enabled family and friends to spend quiet, private time with the person before they were taken to the funeral home.

We saw that support was also extended to relatives and friends of people who used the service by means of the Family Support Service. The service offers a one to one listening service to people, either at the hospice, their home address or by telephone. The service gives people the opportunity to talk to someone outside of their family and friends about their feelings and emotions at a time when they are involved with someone who has a life limiting illness. One relative we spoke with was aware of this service and told us they intended to use it as they had, "Every faith that they [family support co-ordinator] would help them".

The hospice also offers a Bereavement Support Service. The service offers caring support to any family members or friends of someone who has died in the care of any of the hospice services. We were told that approximately six weeks after a person has died a letter is sent to their main carer and/or close relatives or friends to offer bereavement support. We were told that people can also contact the hospice directly. Bereavement support is offered on a one to one basis either at the hospice or in some circumstances, in people's own homes. The length of time people receive support depends on how they feel.

The hospice holds regular remembrance services three times a year at Bury Town Hall. They are non-religious services and are dedicated to people who have recently died. The visiting clergy from the hospice, the nursing staff and volunteers from the hospice give up their time to attend the service and help support people who have been bereaved. During the service the names of those who have died are read out and a candle may be lit in their memory.

Staff we spoke with were aware of their responsibility to ensure information about people who used the service was treated confidentially. We saw that care records were kept in the staff office in both the In-Patient Unit and the Day Hospice; this helps to ensure that information about people is kept secure. We saw

that information leaflets were displayed throughout the hospice explaining to people how the hospice kept their information safe and confidential. The leaflet explained what information they kept on people, why it was needed, how the information is used, how it is kept safe and when, how and by whom, it can be accessed.

Good

Is the service responsive?

Our findings

A relative we spoke with on the In Patient Unit told us that the response by staff to people's needs was, "Second to none". We were told that staff took the time to listen to them. When we spoke with a relative in the community they praised the staff of the Hospice at Home team. They told us they could pick up the phone when they needed advice and that being able to do that was a great comfort to them.

The registered manager told us that if a language translator was required they could contact the local hospital or social services for assistance. We were told there was a Polish speaking volunteer who was willing to assist with translation.

The Hospice at Home team told us how they worked in partnership with the community district nurses and specialist palliative care nurses to ensure the best possible outcomes for people. This was in respect of being able to access specialist palliative medical and nursing services and also the appropriate equipment.

The staff in the Day Hospice, although understanding of the financial constraints placed on the hospice, spoke of their disappointment that the service was operating for only one day a week. They told us they knew there were people in the community who would benefit greatly from being able to attend the Day Hospice. They felt the service was not responsive to the needs of people out in the community. A comment made was, "We could do more if we were open more days".

The PIR informed us that all referrals to the hospice were held on a waiting list which was reviewed daily by the multidisciplinary team of medical and nursing staff. If an assessment of the person showed their need was urgent they would be admitted to the In-Patient Unit that same day. We were told the Hospice at Home team liaised with other healthcare professionals at the start of their shift to determine priority of need for the care required in their own home.

We saw that the admission documentation contained information that 'followed' the person throughout the service. The care records showed people were involved in the assessment of their needs. The two care records we looked at contained sufficient information to show how the person was to be supported and cared for. A person's preferred place of care at all stages of their illness and the arrangements in the event of their death were documented.

We were told that people were discharged from the hospice services if and when it was appropriate and a written summary of their needs accompanied them. The discharge of people involved an individual assessment of their needs, including needs of their family, and liaison with other specialist palliative care professionals. We were told that lines of communication were established with people, both past and present, by ensuring that the hospice contact telephone number and 24hr advice line numbers were offered to people.

The hospice had a complaints procedure that was made available to people and their families. The registered manager told us they had not received any complaints from people who used the service. We

were told that any complaints made would be taken seriously, and appropriate action taken to address any issues raised. Prior to the inspection CQC had received a complaint that included issues around the provision of food. We relayed the allegation to the registered manager who investigated it appropriately by following their complaints procedure. The findings were then forwarded to us. We concluded that the complaint was not substantiated We were told that any complaints made would be reported through to the Hospice Board. The PIR informed us that the hospice has a Duty of Candour policy which promotes and reaffirms a culture of openness.

We were told that feedback questionnaires had last been sent out in 2015. The registered manager told us they now sought feedback from people by the use of small post cards that were left in people's rooms. It was felt by staff that this was a less formal way of seeking people's views about the care and facilities available. We saw that some of the collated responses were displayed in 'speech bubbles' on the walls of the In Patient Unit .We saw many expressions of praise and thanks to the staff. Thank you cards and letters were displayed throughout the hospice.

The layout of the environment helped to ensure that people's independence was promoted and their privacy and dignity were respected. Bedroom, bathroom and toilet doors had overriding locks to ensure privacy and the bathrooms and toilets had aids and adaptations to promote people's safety, independence and comfort. In addition to people having their own en-suite bedroom there were several quiet areas within the hospice that afforded privacy for people.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager who was present during the inspection. A discussion with the registered manager showed they were clear about the aims and objectives of the hospice. This was to ensure that the hospice was run in a way that supported the need for people to have the best quality specialist palliative and end of life care. We saw that a poster was displayed throughout the hospice showing what the 'core values' of the hospice were.

Prior to the inspection we had been made aware of the changes that had taken place in relation to the hospice governance structure. The previous chief executive and several members of the board of trustees were no longer employed by or associated with Bury Hospice. We were made aware that a new interim chief executive and a new board of trustees had been appointed. The new interim chief executive, in addition to working at another hospice, was appointed to support Bury Hospice for a minimum of two days a week.

We asked the registered manager to tell us what systems were in place to monitor the quality of the service to ensure people received safe and effective care. The registered manager was only able to show us three audits of practice. These were in relation to a general medication and a controlled drug audit undertaken on 31 December 2014 plus a Hospice at Home audit undertaken 1 April 2014. We were told that no further audits of practice had been undertaken.

No checks had been undertaken to show that registered nurses who worked at the hospice had a current registration with the Nursing and Midwifery Council (NMC). The registered manager assured us that checks had been undertaken by the human resources (HR) manager who no longer worked at the hospice. We were told that access to the previous HR manager's computerised information was proving difficult. On the second day of the inspection we were shown an updated list of the NMC checks that had been undertaken that day by the registered manager. The registered manager told us it was their intention to have a system in place whereby the PINs of the registered nurses would be checked regularly.

Failing to audit the quality and safety of the service placed the health, safety and well- being of people at risk of harm. We found this was a breach of Regulation 17(2) (a) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

The registered manager told us that, due to financial constraints, the previous training manager had been made redundant. It was explained to us that because of this and the difficulty trying to access information both from the previous training manager and the previous HR manager's computerised information, the training and induction records were not up to date. We were told that training such as safeguarding, infection control, food hygiene and manual handling had been undertaken but had not always been recorded. An inspection of the training records showed they were incomplete. Failing to keep records to demonstrate that staff have been appropriately trained and have the necessary skills to safely care for people puts people who use the service at risk of harm. We found this was a breach of Regulation 17(2) (d) of the Health and Social Care Act 2008 (Regulated Activity)

We spent some time speaking with the newly appointed interim chief executive. They told us of the action plans they were putting in place to address the issues of concern they had identified on commencement of their appointment. The interim chief executive told us there was no business continuity plan in place to deal with emergencies that could arise and possibly affect the provision of care. We were told this was being addressed as a matter of urgency and that a planning meeting was being convened the following week and the business plan was being' drawn up'. We were told that priority was being given to the provision of a 'back up' electricity generator. We found that failing to have a business continuity plan in place was a breach of Regulation 17(2) (b) of the Health and Social Care Act 2008 (Regulated Activity).

We were told of the support they were providing in relation to managing health and safety, training and human resources within the hospice. We saw some of the systems they had implemented such as a detailed health and safety audit and records of training that were being sourced from various agencies.

The PIR informed us of the proposed development of a new 'governance framework' for the hospice. It was said that this this will provide greater transparency and clearer lines of accountability. A review will also be undertaken of mandatory training and management skills along with the annual training calendar. A new approach to internal communications is being produced that is intended to provide increased knowledge, awareness and information flow between all tiers of the organisation.

Several months before the inspection concerns had been expressed by some staff about the previous management of the hospice. During this inspection we asked the staff if they felt there had been any improvement. Our conversations with the staff showed they felt more included and consulted with. Comments made were, "Morale is on the up", "Morale is getting better", "We are more at ease, things are calmer and I feel we are getting somewhere" and "I feel supported, it's better", "If I have any concerns I know I can go to [senior nurse]or the manager. Not a problem".

The staff also told us how they were pleased that the new interim chief executive had been appointed. One comment made was, "He is a presence and he walks the floor".

Records we looked at showed the hospice managers, clinical and non- clinical, held weekly meetings. The meetings were held to discuss many aspects around the management of the hospice such as; care issues, recruitment, training, health and safety and income generation.

We checked our records before the inspection and saw that accidents or incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There was no auditing of the quality and safety of the service to ensure people were kept safe. Regulation 17(2) (a) Accurate records of staff training were not in place to demonstrate that the staff had the necessary training and skills to safely care for people who used the service. Regulation 17(2) (d) There was no business continuity plan in place to deal with emergencies that could arise and possibly affect the provision of care. Regulation 17(2) (b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received regular formal supervision Regulation 18 (2)(a)