

Sue Ryder

Sue Ryder - Manorlands Hospice

Inspection report

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Ratings

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

Summary of findings

Overall summary

The inspection was carried out on 30 August 2016 and was unannounced. On the day of inspection there were seven people receiving care and treatment on the in-patient unit and the hospice was supporting approximately 200 people in the community.

Sue Ryder Manorlands provides palliative care and complementary therapy services to support people with life-limiting conditions which can involve complex physical or psychological problems. The hospice offers support to people living in Craven, Airedale, and Wharfedale as well as central, northern and western areas of Bradford. The hospice has a 16 bed in-patient unit, a day therapy unit and a team of specialist nurses who support people in the community. This inspection did not include the day therapy unit.

The last inspection was carried out in September 2013 and at that time the service was meeting all the regulations inspected.

The hospice had a registered manager in place. 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.

There were systems and processes in place to protect people from the risk of harm and people told us the service was safe. Staff had been trained and understood the different types of abuse. They knew how to recognise signs of abuse and how to report any concerns about people's safety and welfare.

The building was clean and well maintained. Checks were carried out on the premises, equipment and installations to make sure they were safe. Risks to people's safety and welfare were identified, assessed and managed.

Staffing levels were kept under review and there were enough staff to provide people with the care and support they needed in a timely way. The hospice employed a multi-disciplinary team of health and social care professionals. The recruitment procedures were robust and all the required checks were completed before new staff started work. This helped to protect people from the risks of receiving care, support and treatment from staff unsuitable to work with vulnerable adults.

People's medicines were managed safely and people told us they were able to have their medicines when they wanted them.

There was a comprehensive programme of staff training which showed staff were supported to develop their skills and knowledge. Staff had annual appraisals and had the opportunity to attend reflective sessions which were led by the Chaplain.. The arrangements for clinical supervision had changed recently and we found some staff were unclear about the arrangements and the provider's expectations.

The hospice was working in accordance with the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. We found staff understood their responsibilities. There was a multi-disciplinary approach to assessing people's capacity to understand and make decisions about their care and treatment. We found appropriate referrals had been made when people lacked capacity to consent to their care and treatment. This helped to make sure people's rights were protected.

We found people were asked for their consent to care and treatment and their wishes were respected. This included their right to refuse interventions.

People's nutritional status was assessed and their dietary needs and preferences were catered for. People were offered a variety of food and drinks and snacks were available outside of set meal times.

People had access to the full range of health and social professionals and complementary therapists. Everyone we spoke with told us they were extremely satisfied with the support they received. People who used the community services told us they had full access to the out of hour's services and praised the effectiveness of the communication between the different teams. They said the fact that the out of hours team knew about their individual circumstances was very reassuring.

Everyone we spoke with told us they were treated with respect, compassion and kindness. People were involved in discussions about their care and treatment and given time to make decisions. The family support team provided practical and emotional support for people who used the service, their carers and children.

People's needs were assessed. We found the hospice was responsive to people's individual needs and the care which people received was person centred. However, this was not always reflected in people's care records. The management team had identified this and were addressing it.

People told us they knew about the complaints procedure but told us they had never any reason to complain. The provider obtained feedback from people who used the service in a variety of ways which included leaflets and notices in the hospice and real time surveys carried out by volunteers.

The provider had systems in place to assess, monitor and improve the quality of the services provided. However, we found these systems were not always as effective as they should be. When we looked at the action plan from the providers audit in June 2016 we found some actions which had been marked for completion within one month were still outstanding.

We found there was one breach of regulation. You can see the action we asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good 

The service was safe.

Staff were trained and understood how to recognise and report abuse. This helped to protect people from harm.

There were enough staff deployed and the required checks were carried out before new staff started work.

The building was clean, well maintained and suitably equipped to meet people's needs. Risks to people's safety and welfare were identified, assessed and managed.

People's medicines were managed safely.

Is the service effective?

Good 

The service was effective.

The hospice was working in accordance with the Mental Capacity Act 2005 and this helped to make sure people's rights were protected. People were asked for their consent to care and treatment and their wishes were respected.

People were offered a variety of food and drink which took account of their individual needs and preferences.

People were supported by a team of health and social care professionals and complimentary therapists.

People received care and treatment from trained and competent staff.

Is the service caring?

Good 

The service was caring.

Everyone we spoke with told us they were treated with respect, compassion and kindness.

People were given information and supported to make decisions about their care and treatment options. People's relatives, carers

and friends were involved and supported.

People were offered spiritual and emotional support.

Is the service responsive?

Good ●

The service was responsive.

People's needs were assessed and care was delivered in a person centred way which took account of people's needs and preferences. However, this was not always reflected in their care plans.

People were supported to maintain their independence and to exercise choice in all areas of their care, support and treatment.

There was a complaints procedure. People told us they knew about it but had never needed to make a complaint.

Is the service well-led?

Requires Improvement ●

The service was not consistently well led.

The provider had systems and processes in place to assess, monitor and improve the quality of the services provided. However, we found these systems were not always as effective as they should be.

There was a clearly defined management structure and staff told us they were well supported. However, some staff were not clear about the arrangements for clinical supervision.

There were effective systems in place to obtain and act on feedback from people who used the service.

The hospice worked in partnership with other palliative care providers and had received awards in recognition of good practice.

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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 inspection visit was carried out on 30 August 2016 and was unannounced. On 12 September 2016 we carried out telephone interviews with people who used the service.

The inspection was carried out by two adult social care inspectors, a pharmacy inspector, a specialist advisor in palliative care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case palliative care services.

Before the visit we reviewed the information we held about the service, this included notifications of significant changes or events. We contacted Heathwatch and the Airedale, Craven & Wharfedale CCG (Clinical Commissioning Group). Heathwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The registered provider completed a provider information return (PIR) prior to the inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit to the hospice we spoke with two people who used the service and two relatives. We spoke with 11 staff including the registered manager, the support services manager, the ward manager, a doctor, nurses, health care assistants, social workers and the chef. Following the site visit we spoke by telephone with seven people who were being supported in the community.

We looked around the hospice and looked at various records which included people's care records, medication records, staff recruitment files, training records, meeting notes and other records relating to the management of the service such as maintenance records and policies and procedures.

Is the service safe?

Our findings

People who used the service told us they felt safe at Manorlands. They also told us the staff were "excellent" and "nothing was too much trouble". One person told us they had been an in-patient at Manorlands on four separate occasions. They said it would always be their "first choice of place to go" when they could not get the care and treatment they needed at home.

Staff felt the hospice was a safe place for people to receive care. One staff member commented, "Everybody knows what they are doing." Another staff member said, "I have no concerns with patient safety." A third staff member said, "You can see people relax as they come through the door because they know they will be looked after."

Staff showed a good understanding of safeguarding adults, including how to report any concerns they had. They knew about various types of abuse and potential warning signs to look out for. We spoke with two hospice social workers about the process for recording safeguarding concerns. They told us there had been no previous safeguarding concerns raised in connection with the care provided at the hospice. Where any other concerns had been identified, these had been shared with the local authority safeguarding team and logged in the relevant person's care records.

Staff knew about the provider's whistle blowing procedure. None of the staff we spoke with had used the procedure whilst working at the hospice. One staff member told us, "I have not used the whistle blowing procedure. I wouldn't think twice, I would just do it [report concerns]." Another staff member commented, "They [provider] would definitely encourage us to raise concerns."

A consistent and reliable staff team provided people's care. One person who used the service told us they appreciated seeing the same [staff] faces all the time, they felt it was good the hospice did not have a lot of staff changes. Another person told us that although there had been occasions when staff seemed very busy they had not suffered because of this. They said, "When I rang the bell they were there in an instant." A third person, when asked if they had ever noticed any staff shortages, said, "Absolutely not".

We discussed staffing arrangements with the registered manager. They told us staffing levels were reviewed constantly on the in-patient unit to ensure there were enough staff on duty to meet people's needs. For example, night time staffing levels had been increased. The registered manager told us this had led to a reduction in people experiencing falls. The registered manager and staff we spoke with all felt staffing levels were appropriate. One staff member told us, "Staffing levels are good or excellent when they are all here." Another staff member said, "Staffing levels are quite good, except for sickness. They try and cover them, they do try to cover." Both staff members went on to say issues with sickness were not frequent.

Effective systems were in place for the employment of new staff members. Prospective new staff members were asked to complete an application form covering areas such as their previous experience and qualifications, a full employment history and details of two referees. Pre-employment checks were carried out, such as requesting and receiving references and checks with the Disclosure and Barring Service (DBS).

DBS checks are carried out to confirm whether new care workers have a criminal record or have been barred from working with vulnerable people. Checks were also completed regarding professional registration and qualifications for nursing and medical staff.

Within people's care records we saw risks to their safety and welfare were assessed. This included areas such as pressure sores, falls and the use of bed rails. We saw that action was taken in response to identified risks. In addition, we saw the hospice had information leaflets for people providing practical advice on how to prevent falls and pressure sores.

We viewed the provider's risk registers. These were updated and reviewed continually and reported to the Quality Improvement Group (QIG) every six weeks. These consolidated all general risks to people and staff into a central register to enable close monitoring. Risks were scored based on the likelihood and impact of the risk. The highest scoring risks were added to a separate risk register and discussed in more detail during the QIG meetings. These related to medicines prescribing, staff sickness and medical cover. The measures needed to minimise potential risks were clearly recorded on the risk register.

The hospice was clean, well maintained and suitably equipped to meet people's needs. Regular health and safety checks were carried out to help keep the premises safe for people to use. These included checks of fire safety, gas and electrical safety, water safety and emergency lighting. Most of these checks were up to date at the time of our inspection. Records confirmed specialist equipment, such as hoists were serviced regularly.

The service had a business continuity plan which gave details of the actions to be taken to continue the operation of the service in the event of an emergency. This included scenarios such as the loss of the building and staff. The plan clearly documented the contingency plans to manage any of these situations. The head of support services told us desk based testing of these scenarios had been carried out previously. These were done to check how effective the plans were and to look for any lessons learned. However, we found no record of these tests was available to view during our inspection.

We found the provider had a robust system of incident and accident reporting. All incidents and accidents were logged onto a computer based system which provided an overview of incidents and any actions required to prevent the situation happening again. There were checks built into the system to ensure incidents received the required scrutiny from senior managers and to also ensure each incident was risk assessed. The QIG reviewed all incidents to check actions had been completed and areas for improvement and learning were identified.

We looked at the way that medicines were managed within the hospice. One person we spoke with told us they never had any problems with medication. They said staff were always "bang on time". Another person told us they could have their medicines "more or less anytime". Both people told us when they had taken medicines for the relief of pain staff always checked back with them to make sure it had worked.

We found that people who used the service were protected against the risks associated with medicines because appropriate arrangements were in place to manage medicines. Medicines were prescribed by the in-house medical team.

During our inspection we spoke with three nurses on the ward and with the provider's Accountable Officer about the hospice's arrangements for handling controlled drugs (drugs liable to misuse). The Accountable Officer is a person designated under The Controlled Drugs (Supervision of Management and Use) Regulations 2013 by the provider to ensure that appropriate arrangements are in place for the secure and

safe management of controlled drugs in the hospice.

Medicines were stored safely and securely. There was a system for the ordering, receipt and disposal of medicines and Controlled Drugs in place. We saw that the temperature of the medicines refrigerator was regularly monitored and in range. The service was visited twice weekly by a pharmacist, who provided advice on prescribing and medicines management. Appropriate arrangements were in place for the recording of medicines. The medication records we checked were fully completed and showed that people received their medicines as prescribed. People received their medicines from members of staff who had received appropriate training and had been assessed as competent to do so. All the staff members we spoke with were aware of how to report any medicines incidents and one of the nurses we spoke with explained how medicines errors were anonymised and shared in the office and at ward meetings so all staff could see details of these. If staff made an error they completed a reflection and discussed this with the ward manager to reduce the risk of this reoccurring.

We saw that controlled drugs were audited regularly by the Accountable Officer and pharmacy staff checked medicines stock on a regular basis. Actions were taken when issues had been identified during the audits.

Is the service effective?

Our findings

Staff felt well supported to carry out their caring role. One staff member said, "I am very well supported. If I have any problems I can go and talk to people." Another staff member told us, "The staff are really supportive, really approachable."

The provider told us appraisals were completed in April and all staff had a mid-year review. We found appraisals were up to date at the time of our inspection.

The provider told us they had a comprehensive programme of staff mandatory training and had achieved a compliance rate of 90%. This was confirmed by the training matrix which we looked at. The provider told us all the nursing assistants were qualified to NVQ (National Vocation Qualification) Level 2 and were encouraged and support to achieve Level 3. We saw training opportunities were displayed on the ward noticeboard.

We found the provider had processes in place to support nurses with the NMC (Nursing and Midwifery Council) revalidations process. This is a process nurses are required to complete to maintain their right to practice.

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 so that they can 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. At the time of the inspection no one using the service was subject to Deprivations of Liberty Safeguards. Staff we spoke with understood their responsibilities in relation to the MCA and DoLS.

The hospice staff assessed people's capacity to understand information and make decisions as part of their multidisciplinary team meetings. One of the doctors explained they would speak to people at different times of the day as people's ability to understand and retain information sometimes varied throughout the day. They also explained when people were approaching the end of life they tried to get anticipatory consent to their care and treatment plan so they could be sure people's wishes were being respected. When people were assessed as lacking capacity to agree to stay at the hospice the appropriate referral was made to the local authority DoLS team.

People who used the service confirmed they were always asked for their consent to care and treatment. They also told us the hospice staff respected their right to refuse care and treatment. For example, one person told us the doctors had recommended they go to the local hospital for some tests but they did not want to go. They said the doctor had explained the risks and possible consequences but had accepted their decision and agreed they would continue to provide the best possible care and treatment at Manorlands.

We received positive feedback about the provision of meals at the hospice. One person told us they were offered a good choice of food and also told us drinks and snacks were provided between meals. A visitor told us their relative was no longer able to eat much but said they were offered plenty of drinks to make sure they were well hydrated.

The provider told us people's nutritional status was assessed when they started to use the service. This was confirmed by the care records we looked at. The records also showed people's food likes and dislikes were recorded. The chef confirmed catering staff were provided with information about people's dietary needs and preferences. People chose their meals every day from a four weekly rolling menu; alternatives were available if people did not want any of the meals on the menus. The kitchen was open between 7.30am and 5pm and outside of these times a selection of snacks was available. Staff told us they would go to the local shop if people wanted something in particular which was not in stock.

The hospice had a team of hostesses who provided people with hot and cold drinks throughout the day. Visitors had the option of pre-ordering meals for a small fee, bringing their own food or ordering a take away. There was a relative's kitchen which had a fridge, microwave and facilities for making hot drinks.

The provider told us they were able to provide food to meet people's cultural and religious needs. This was confirmed by the chef who told us they could also cater for a range of specialised diets such as diabetic, low fat and vegan.

Staff told us when people reached the last days of life they were supported to eat and drink as much as they wanted. Each person was assessed individually and medical interventions were provided if appropriate and in line with the person's wishes. The hospice had access to dieticians and SaLT (speech and language therapy) services from the local hospital.

The hospice provided in- patient care, day care and community services. They employed a range of staff which included specialist doctors, nurses, social workers, therapists and a Chaplain. There were three palliative care consultants and medical cover was provided 24 hours a day, seven days a week. This meant people could be admitted over the weekend if necessary.

One person we spoke with told us they had gone into the in-patient unit for a short stay because they were having difficulty getting the right pain management regime in place. They said while in the hospice they had spoken with the doctors every day. They said the doctors had "looked at it from every possible angle and come up with the perfect package". They told us this had made the world of difference to their quality of life.

Everyone who used the community services spoke in glowing terms about the support they received from the community nursing team. One person said, "I cannot praise them enough, they have been brilliant." Another person said they were "marvellous" and another person said, "They all do a marvellous job."

They all told us their nurses kept in regular contact with them. One person said to us one of the best things about their community nurse was that they always did what they said they were going to do. They went on to say if this involved arranging another service they always followed up to check it had happened.

People we spoke with who used the community services told us they had contact information for the out of hour's services. They told us they were very impressed with how well co-ordinated the services were. They said whenever they had needed to use the out of hours services the staff on the other end of the phone were well informed about their individual circumstances. They said they found this very reassuring not least because it spared them the distress of having to repeat their story to lots of different people. They told us they and/or their cares had access to a full range of services co-ordinated by the community nurses. Examples included visits from occupational therapists to help with the management of fatigue, visits from befrienders and access to complementary therapies when they attended the day services or clinics.

We contacted the local Healthwatch branch. They told us they had received very little feedback about Manorlands over the past two years but what they had received was positive with people describing the care as "superb" and "faultless".

In the hospice there was a rack of information leaflets on subjects such as managing breathlessness, cancer, radiotherapy, lymphedema, sexuality and cancer, preventing falls and complementary therapies. This meant that useful information was available for people who used the service and relatives should they wish to read it.

Is the service caring?

Our findings

We received consistently positive feedback from people and their relatives. A person who was receiving care and treatment on the in-patient unit told us, "Staff always knock on the door when it is closed." They went on to tell us they had spent time with the doctor discussing the options for their future care and where this would be delivered. They said they had not felt rushed and felt the whole approach was geared to their individual needs.

Another person on the in-patient unit told us the staff were approachable and described the care as "excellent". They said they felt they were experiencing "one to one" care.

A relative we spoke with told us how much they appreciated the emotional support they had received from the hospice staff. They were very happy with the care their relative was receiving and felt they were kept well informed and fully involved in all decisions about care and treatment. They said the doctors provided regular updates and added they felt comfortable approaching staff with any questions or concerns they had. They told us staff respected their relative's privacy and dignity while at the same time checking regularly to make sure they were comfortable.

Another relative told us how staff had supported them when they became upset. They said, "They just gave me a hug and it made all the difference." The same person described the staff approach as appropriate. They said staff were serious when they needed to be but jovial as well.

We saw a feedback card from a relative in which staff were commended for their, 'caring attitude, kindness and understanding'.

The provider told us all clinical and non-clinical staff undertook Sage & Thyme communication skills training which focuses on teaching staff how to listen and respond to people who are distressed or concerned in a way that is empowering. In addition registered nurses were supported to undertake advanced communication skills training. We observed staff were polite, helpful and courteous and the general atmosphere was warm and welcoming.

Staff gave us examples of how they provided care in a dignified and respectful way. For example, keeping people covered as much as possible when providing personal care, closing blinds and curtains, always explaining what they were doing and seeking consent. They told us they got to know people well and found out about their preferences.

People who used the community service were similarly positive in their feedback about the service. They told us they had regular contact with the community nurses and when we asked one person if they were happy with the service they replied they were "ecstatic".

Some people told us how the community nurses had arranged for them to visit the in-patient unit to look around and meet people to help allay their fears about having to go into a hospice. One person said they

had been "quite nervous" but had lost their fear as soon as they had arrived.

Carers of people receiving support in the community were equally complimentary in their feedback about the service. One person told us they were kept well informed about what was happening but stressed the community nurse always obtained their relative's permission before information was shared.

Another person said whenever the community nurse spoke with the doctor about their care they always reported back on what they had discussed. The person said they found this reassuring because it meant they were kept fully informed about their care and treatment.

The hospice had a multi faith room which was referred to as the 'room for reflection'. This provided a quiet and calm place where people from any faith background and people who did not hold any religious beliefs could have time on their own or with families and friends. Within the faith room we saw there was a selection of prayers, a leaflet which explained the services provided by the Chaplain and a prayer mat for people of the Muslim faith. Staff told us they also sometimes used the room when talking with bereaved relatives because people felt more comfortable in a less clinical environment.

The hospice had a befriending service that utilised volunteers to befriend patients in their own homes, often providing companionship and a break for the carer. One person we spoke with told us they had found the befriending service helpful.

The hospice had a family support team which consisted of social workers, a Chaplain, bereavement support counsellors and a psychologist. They provided practical and emotional support for people who used the service, their carers and children. Relatives were provided with a bereavement folder which included practical advice and information about further support which was available after their loved ones death. The bereavement team offered people support in a variety of ways which included telephone calls, counselling and a drop in service. We also saw leaflets on display about the range of bereavement services offered and this included support for bereaved children. One relative we spoke with told us they had been involved with the hospice before when another relative had passed away. They said they and their children had been offered bereavement support and had come back to visit the hospice every year. They said they were always met with a warm welcome.

The provider told us the hospice worked in partnership with the Carers' Resource and had family link workers who provided support to the carers of people who used the community and day therapy services. The Carers' Resource is the local, specialist carers' centre for the Bradford and Airedale, Harrogate and Ripon, and Craven districts of Yorkshire.

Is the service responsive?

Our findings

We found the hospice services were responsive to people's individual needs. For example, two people we spoke with told us how they had been supported to visit the hospice and look around in preparation for a time in the future when they might need to use the in-patient services. There was an information leaflet about complimentary therapy which told people about the range of treatments available. The carer of one person who used the community service told us how much they benefitted from the massage therapy which they were able to access when they accompanied their relative to their clinic appointments.

People were referred to the hospice from hospital services or community based health care professionals such as GPs, district nurses and community matrons. If people made contact with the hospice directly staff told us they advised them how to get in touch with a health care professional who could then make the referral on their behalf.

Daily referral meetings were held during the week, Monday to Friday. The referrals were reviewed and decisions were made about admissions. This included looking at the availability of beds and resources, the urgency of the referral and the suitability of the referral. For example, confirming the person was in need of palliative care or had a life limiting illness. At weekends urgent referrals were reviewed by the nurse in charge and the on-call doctor and if necessary the on-call consultant. The registered manager told us they tried whenever possible to make sure a bed was kept available for emergencies.

People received care and treatment from a multi-disciplinary team which was made up of palliative care consultants, specialist doctors, nurses, nursing assistants, physiotherapists, occupational therapists, physiotherapists, occupational therapists, counsellors, a psychologist, complimentary therapists a Chaplain and a befriender.

Staff told us the daily routines were flexible and depended on people's needs and preferences. For example, they said they never woke people in the morning, waiting until people woke up naturally before offering support with personal care or food. This was confirmed by people we spoke with who told us staff helped them to maintain their independence. For example, one person said they liked to wash themselves as much as possible and staff helped with the rest, they stressed staff were always willing to help them when needed.

One person who used the service told us they had been able to have a bath for the "first time in ages" when they moved into the hospice. They said staff used a hoist to help them and made it a "good experience". The same person told us they felt very much involved in making choices about their care and treatment and this was echoed by their family.

The provider told us medical cover was available 24 hours a day, seven days a week. One person we spoke with told us any medical issues or decisions were dealt with "more or less immediately"

We asked a visitor if they felt their relative was involved in making decisions about their care and treatment. They said, "Yes, totally in control." Another relative told us the doctors regularly provided updates and said

they felt very comfortable approaching staff with any concerns or queries.

The hospice had a family room where people could make refreshments. The hospice did not have the space to provide a separate bedroom for relatives who wished to stay over but they were able to offer people 'put up' beds or recliner chairs.

The provider told us people were supported to develop personalised care plans and to complete Advanced Care Planning. They also said people were encouraged to document their wishes for their preferred place of care and preferred place of death.

The hospice used multi-disciplinary care records which meant that all the information about their care and treatment was held together in one place. However, we found the care plans we viewed were generic and had not been personalised to reflect people's individual needs and preferences. For example, one person had a care plan about supporting them to manage fatigue and the action was to provide a copy of the 'managing fatigue leaflet'. This did not tell staff what particular interventions the person had found helpful.

The provider had carried out an audit of the service in June 2016 and one of the actions from the audit was for the service to develop more person centred care plans. The ward manager explained the work they were doing to address this.

We saw people's records had information about their social and spiritual needs and wishes which helped staff to understand their individual needs. This information was also used to make sure people were referred to the right services for support.

We saw information displayed throughout the hospice inviting people to share their views and raise any concerns they might have. This included a 'comments' box and a leaflet which explained the complaints process. The leaflet included contact details for other organisations which people could contact for help and support if they had concerns about the service.

Everyone we spoke with told us they had been given information about how to raise a concern or make a complaint. They all added they had never had any reason to complain about the service.

We found complaints were recorded and dealt with effectively in line with the provider's procedures. People were given full written feedback and their level of satisfaction was recorded when the process was completed. There were no complaints in progress at the time of the inspection.

Compliments were also recorded and information from compliment cards was collated and reported on at senior management meetings. We looked at some of the compliments. One made special mention of the housekeeping staff and thanked them for, "The lovely food and making sure he had lovely fresh sheets each day". The same person praised the community team particularly for the equipment they had provided and the work they had done to help the person maintain their independence for as long as possible. The letter finished by saying, 'You all took great care of [person's name] while he was with you. Not only making sure he was as comfortable as he could be but you also took care of me.'

Is the service well-led?

Our findings

There was a clearly defined management structure and staff told us they felt well supported at both ward and senior managerial level. However, we found some staff were not clear about the requirements or arrangements for clinical supervision.

The provider's clinical supervision policy stated there was an expectation that clinical staff would seek clinical supervision at least four times a year either in organised groups or in one to one sessions. The registered manager told us the provider's expectation was for staff to have up four clinical supervisions a year if they wanted it. We found external clinical supervision had been removed due to financial constraints. However, senior management told us supervision was still available internally in group or one to one sessions and reflective sessions were run at least once a month by the Chaplain. When we spoke with staff we found they were not clear about the supervision procedure. One member of staff told us they thought clinical supervision was no longer available. Another staff member said, "I haven't had clinical supervision for a while. I think it is optional." A third member of staff said, "I don't have supervision, I have never had it. I can just go if I need it [supervision]."

We looked at the minutes of the SMT and QIG (Quality improvement group) and found action planning was varied with no actions being recorded for some items. For example, the SMT minutes showed that although training sessions had been provided to support nurses with the NMC revalidation process the sessions had been poorly attended. There was no action plan in place to address this. Following our inspection the provider informed us they felt the lack of attendance at revalidation support sessions had been due to the fact individual nursing staff had received appropriate individual support. However, this had not been recorded as such in the SMT minutes.

We saw in the notes of the SMT meetings a service user group was to be developed. This had been on the agenda since May 2016. However it had not been developed at the time of the inspection.

We also saw the SMT minutes referred to the use of 'You said, we did' to tell staff what actions the provider had taken in response to their feedback. However, we found these notices were no longer displayed. Following the inspection the provider told us it was their policy to display this information for a period of three months only.

We spoke with the head of support services about health and safety related issues. Audits were carried out such as an annual quality and safety visit. We reviewed the report from the most recent visit in June 2016. We found an action plan had been developed following the visit which was to be followed up in September 2016. The action plan covered a range of areas such as infection control, fire safety and activities on the in-patient unit. Actions were colour coded using a RAG system (Red, Amber, and Green) which determined the timescale for completing the actions.

We found some actions were still outstanding. For example, the action plan indicated a fire evacuation drill should be carried out and reviewed within one month. The support services manager advised us this had not been completed due to staff shortages. We saw the last recorded fire drill had taken place on 4

November 2015.

We found the provider had a detailed business contingency plan in place. However, although the head of support services told us desk top testing was done we found no records of these tests was available during our inspection.

When we looked at how people's medicines were managed we found that although regular checks of the medicines charts were made by the pharmacist these were not audited to assess if themes were occurring.

We found that although people told us they were satisfied with the way their pain was managed there was an inconsistent approach to the use of pain assessment tools. The provider had a pain assessment tool but the nursing staff we spoke with during the inspection told us they did not routinely use a formal pain assessment tool. This created a potential risk of people experiencing unnecessary discomfort.

We concluded the providers systems and processes for assessing; monitoring and improving the quality of the services provided were not as effective as they should be.

This was a breach of regulation 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were opportunities for staff to give their views about the care provided at the hospice. One staff member told us there were monthly team meetings. They said, "We can give views and opinions." One staff member told us they had suggested providing a laminated list of toiletries in each room as a prompt for staff to ensure people had everything they needed. This suggestion had been adopted.

There was a staff forum and the minutes showed it was well attended. Senior management were not routinely invited to these meetings but specific issues were escalated to the senior management team (SMT) meetings. Feedback was then delivered to staff at the next forum meeting. Staff told us they valued the opportunity to escalate any concerns and were positive about the speed of responses from the SMT.

There was a process of written feedback in place to obtain the views of people who used the service and relatives. Notices were clearly displayed in many areas indicating that people's views were welcomed and valued. Feedback forms were available in several areas which could be placed in a sealed box. If feedback was anonymous it was reported to the staff via email from the ward manager. If a name was placed on the feedback form a written response was made by the nurse manager directly to the relative. Feedback was reported at SMT meetings and evidence of this was noted in minutes.

The hospice obtained real time feedback on people's experiences; this was done by volunteers and recorded electronically. The registered manager provided us with a summary of the feedback received between September 2015 and August 2016. Within that timeframe 85 responses were recorded and 93% of people stated they would be 'extremely likely to recommend' Manorlands. Some of the reasons cited were, 'Because of caring and helpfulness provided by all concerned.' 'Because the before and after treatment is second to none'. 'Cared for well and good food.' 'For the kindness and compassion shown'. 'The care is wonderful.' 'Attention to detail, nothing left to chance.' 'Because they remove any worries and the care is so compassionate'. 'I've been put at ease and been given confidence.' 'Such good care and sensitive treatment.' 'I feel loved and cared for at Manorlands.'

The hospice had taken part in a national bereaved relative's satisfaction of End of Life care audit undertaken by the Association of Palliative Medicine. Documents were available which showed the hospice had received positive feedback from this survey.

Quality initiatives were led by Sue Ryder central office and the registered manager provided us with a copy of the audit programme for 2016 – 2017. The areas covered included pressure ulcers, falls, documentation, infection control, medicines management, information governance and the Mental Capacity Act.

The provider shared with us examples of recognition of good practice and partnership working. Manorlands is part of a managed clinical network working across Bradford, Airedale, Wharfedale and Craven. The network partners work together to ensure equity of quality end of life care. As part of the managed clinical network the hospice won a BMJ (British Medical Journal) award for their 'Last year of life' project. Other examples included nursing staff from the hospice rolling out the 'Five Priorities of Care' at Airedale Hospital and the Manorlands rehabilitation therapy team being highly commended in the Pride of Airedale awards for their physical and functional gym.

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 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 The providers systems and processes to assess, monitor and improve the quality of the services provided were not consistently effective. Regulation 17(2)(a)