Pendleside Hospice

Pendleside Hospice

Inspection report

Pendleside
Colne Road, Reedley
Burnley
BB10 2LW
Tel: 01282440100
www.pendleside.org.uk

Date of inspection visit: 24 to 25 October 2023
Date of publication: 21/02/2024

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Overall summary

Our rating of this location improved. We rated it as outstanding because:

- The service had enough staff to care for patients and keep them safe. Staff had dedicated mandatory training for volunteers and staff, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well and managed medicines safely. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided exceptional care and treatment, ensured and actively supported patients to have enough to eat and drink. Staff effectively managed pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff exceeded expectations in treating patients and carers with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers to minimise their distress.
- The service proactively planned its services and provided care in a way that took into account and, quickly and responsively, met the preferences and needs of local people and the communities it served. The service was inclusive and responsive in its tailored care to meet the individual and complex needs of its patients.
- Leaders ran services professionally and extremely well using reliable information systems. They proactively encouraged and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service went to extra lengths to engage well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The hospice should ensure any equipment not intended for use is clearly labelled as decommissioned until disposed of to prevent accidental use.
- The hospice should continue to create a more dementia friendly environment as detailed within their action plan.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	**Outstanding** ☆	See main summary

Summary of findings

Contents

Summary of this inspection

Background to Pendleside Hospice

Pendleside is a registered charity providing specialist palliative care services to adults over 18 but in exceptional circumstances patients between the age of 17 and 18 will be allowed to access Hospice services. Pendleside cares for over 1700 people each year, across several services. These include in-patient care, day services, hospice at home, family and bereavement support (including bereaved children), Health, Wellbeing and Rehabilitation service including outpatients.

The in-patient unit provides assessment and symptom control, rehabilitation and end of life care, along with access to a range of holistic complimentary therapies and spiritual care. The hospice has 10 single bedrooms with en-suite toilets.

The in-patient service includes access to the facilities and therapies on day services. There are separate facilities for day services.

Services available include occupational therapy, physiotherapy, aromatherapy, massage, reflexology, art therapies, exercise classes and presentations from outside speakers.

The hospice at home service offers personal care and assistance, respite for carers, emotional support/advice, spiritual care and a night sitting service.

The Hospice is registered to provide the following regulated activities,

- Treatment of disease, disorder or injury.
- Diagnostic and screening procedures.
- Transport services, triage and medical advice provided remotely.

There was an established registered manager in post.

We inspected the hospice unannounced as part of our regulatory priority as it was last inspected by the commission in 2015.

How we carried out this inspection

We inspected the hospice using our comprehensive inspection methodology. The inspection was unannounced (they did not know that we were coming). We carried out the on-site inspection on 24 and 25 October 2023 and a further offsite staff focus group for community staff via teams on 26 October 2023.

During the inspection the inspection team inspected the day therapy areas, the inpatient ward and community hospice at home.

We spoke with a range of staff (22) including the registered manager, senior leaders and a trustee. We also spoke with ward, therapy and medical staff. We went out on a home visit with the hospice at home team and held a focus group via teams to give other community staff the opportunity to tell us about the service. Staff were offered the opportunity to speak to us individually should they not want to speak up in the group.

Summary of this inspection

We spoke with 14 people including carers in the day service, inpatient areas and in their own home.

We looked at the training and recruitment files for staff including 2 trustees (directors) and 2 senior managers. We also Looked at four patient records and a wide range of policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

- Outcomes for people who used the services were consistently better than expected when compared with other similar services. Evidence and feedback from people using the service supported this and were incredibly strong. The service demonstrated strong analysis and oversight of a persons preferred place of death and used data to look at how they could improve the service.
- We found numerous examples to show how staff went the extra mile for patients and their care and support exceeded their expectations.
- The staff survey was exceptional about the service and benchmarked above other similar services.
- The service had a very strong outreach offer and had developed a blueprint for other hospices to follow nationally to support those who were dependant on drug and alcohol or had shelter insecurity.
- The service had provided significant support to the NHS and was above national benchmarking for access. The service was able to respond within 2 hours to people at a time of crisis negating the need for admission to hospital or enabling people to be discharged from hospital care sooner.
- There service had gone the extra mile to proactively engage and understand the local area ethnic minorities. This had resulted in an increased understanding of what the service could offer and increased volunteer diversity. The service demonstrated that it went above and beyond to look at how to reach everyone that would benefit from the service and improve their outcomes and end of life experience.
- The hospice had established a meal on wheels service for anyone in the geographical area who may benefit from it and not just those using the hospice services. The service not only provide meals but acted as an additional welfare check. Drivers were trained to identify and escalate any welfare concerns.
- The hospice had written a policy to enable them to support people experiencing end of life conditions with drug and alcohol addictions that made it difficult for them to access other services including health and housing.
- The hospice actively sought seldom heard groups, such as the homeless and those with housing insecurity, to access support with end of life conditions.
- Clinical effectiveness was very professionally managed and governance was also very professional and robust. The service had also developed a strong board. The service had demonstrated it was outstanding by design and dedication.
- The service had extensively implemented quality improvement methods including dashboards and had used the data to consistently monitor and improve the service.

Areas for improvement

Areas for Improvement

Summary of this inspection

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

We did not find any required actions the hospice MUST take to comply with its legal obligations.

Action the service SHOULD take to improve:

- The hospice should ensure that fire doors are completely unobstructed by equipment. (Regulation 12)
- The hospice should ensure any equipment not intended for use is clearly labelled as decommissioned to prevent accidental use. (Regulation 12)
- The hospice should continue to create a more dementia friendly environment as per their action plan. (Regulation 09)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospice services for adults	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Overall	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding

Outstanding ☆

Hospice services for adults

Safe	Good
Effective	Outstanding ☆
Caring	Outstanding ☆
Responsive	Outstanding ☆
Well-led	Outstanding ☆

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

All staff including volunteers and fundraising staff, had access to mandatory training. In October 2023 the overall percentage for the completion of mandatory training, which included all clinical and non-clinical staff, volunteers and charity shop staff was above the hospices target of 90%. Mandatory training compliance was reported on a rolling annual basis.

Mandatory training was comprehensive and met the needs of patients and staff. All staff (relevant to their roles) undertook basic life support (BLS) both adult and paediatric and had BLS practical training including anaphylaxis for medical and nursing staff. New staff including bank staff received a comprehensive induction pack incorporating mandatory training and essential skills requirements. Volunteers also received a comprehensive mandatory training and induction pack. From September 2023 the volunteer mandatory training booklet was updated and all volunteers had to complete the training in the new booklets to ensure they had up to date records.

A breakdown of training compliance per staff group such as inpatient, hospice at home, health, wellbeing and rehab services showed all staff were up to date with their mandatory training.

Oliver McGowan learning disabilities and autism training level one had been introduced at the hospice with a completion rate of 65%. Managers said this was below the target of 90% but all staff had been scheduled to undertake the training and could book an additional supernumerary day to complete training. Since the inspection, all staff had now completed this training. The hospice was planning to put staff on the level two face to face training for the same course.

All staff had completed training for dementia awareness.

Additional mandatory requirements specific for the service included blood transfusions, safe use of insulin and syringe pump training for nurses. Information provided showed over 90% compliance in all staff groups.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers and staff said they were supported to complete their training with a non-clinical day to complete training if they were struggling to complete it when at work. Extra sessions had been put on for nurses to complete the blood transfusion updates. Staff induction booklets were comprehensive and clearly identified what learning was required.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The hospice had a safeguarding policy, which provided guidance for staff on how to identify and report any safeguarding concerns. The policy included instructions for staff for making referrals to external agencies, such as the local authority safeguarding team. All staff including medical staff, received training specific for their role on how to recognise and report abuse and staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could give clear examples of when they had raised safeguarding concerns and the action taken to keep people and children safe.

Managers and clinical staff completed safeguarding children level 3 training. All staff, appropriate for their roles, completed safeguarding children and child sexual exploitation level 2 and adults safeguarding. Data provided indicated completion rates were above the 90% target.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Depending on staff responsibility, staff said they would inform their immediate shift manager and would receive support to complete the referral forms to the local authority if this was needed. Most staff knew who the safeguarding lead was for adults and who it was for children. There were safeguarding flow charts and contacts visible to staff. Staff said they knew how to access the safeguarding policy online.

Staff also completed Prevent (counter-terrorism strategy) training as part of their mandatory training.

Cleanliness, infection control and hygiene

Staff used infection control on the ward and when transporting patients after death.

The hospice had infection prevention and control (IPC) policies which provided guidance for staff and the staff completed mandatory infection prevention and control training.

All areas seen were clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The domestic teams had daily and monthly checklists for cleaning which we noted were all completed and dated. We spoke to domestic staff who could talk us through the process of a room if the patient had required additional IPC measures such as Covid-19. We observed the correct disposal of disposable mop heads and cleaning products.

Staff followed infection control principles including the use of personal protective equipment (PPE) when this was required. We observed good infection prevention and control practices by hospice

staff including appropriate hand hygiene measures and bare below the elbows. The service scored consistently above 95 to 100% compliance for technique, bare below the elbows, short, clean nails and no jewellery.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

The hospice screened patients routinely for methicillin resistant Staphylococcus aureus (MRSA) and C. difficile infections (CDI). We reviewed the hospice's MRSA and CDI records for a 12-month period Oct 2022 - Oct 2023 and noted 4 patients who tested positive either on admission and one within the first few days of admission They were treated appropriately and barrier nursed as required to prevent the spread of infection. None were acquired from care in the hospice.

The hospice used a national audit tool throughout the service to review data for IPC. The standards included a wide range of audits such as, the environment, bathrooms, clinic rooms, sharps bins, PPE, uniforms and hand hygiene. Compliance was consistently above 97% from data derived to April 2023 in the audit report 2023 to 2024.

The hospice had recently added a laundry service on site with the domestic team having responsibility of this.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design and layout of the hospice promoted accessibility in all areas. All the areas we inspected were well maintained, free from clutter and suitable for providing safe care and treatment for patients. Patients said they could reach call bells and staff responded quickly when called.

All visitors had to sign into reception and were issued with a photographic identification badge which had to be submitted on departure. There was secure keycode access and exit to clinical and office areas.

All the equipment we saw (such as hoists and syringe pumps) were clean, well maintained and were within the service and calibration due dates. Equipment such as trolleys and stands were visibly clean.

We noted some syringe drivers in a store cupboard had not been serviced for several months. Following the inspection, we were told these were old syringe drivers waiting to be disposed of that had been decommissioned and replaced with new ones in September 2023. Staff had been trained to use the new equipment and it was said they would not have needed to use the old ones. However, it was not clear that they should not be used. There was a planned maintenance schedule in place that listed when equipment was due for servicing. Equipment servicing, calibration and portable appliance testing was carried out by external contractors under a rolling service level agreement contract. This also included oxygen servicing and fire equipment. The hospice had its own maintenance team on site who also supported with transport duties such as meals on wheels. We saw portable electrical equipment were within date for the required testing as were fire extinguishers.

The hospice had piped oxygen in patient rooms and portable oxygen cylinders were stored in a secure designated room. A further three outdoor storage areas were locked and secure. An emergency shut off point was situated on the main corridor.

We looked at the equipment schedule and this showed all equipment was within service and calibration due dates. The service had enough suitable equipment to help them safely care for patients. The hospice had access to specialist equipment, such as pressure relieving equipment.

Staff carried out appropriate safety checks of specialist equipment. The hospice had an emergency grab bag for resuscitation including anaphylaxis and bleeding which was checked by staff weekly. The hospice also had two defibrillators one of which was used for events that occurred outside the hospice. These were checked weekly which check logs confirmed.

Staff carried out monthly audits for department health and safety checks including fire safety, portable equipment testing, machinery, fire extinguishers and clear fire exits.

A fire safety policy and procedure was in place and staff understood their roles in the event of a fire. Fire sheets and evacuation slides were situated on the upper floor to evacuate patients if the need arose. All staff were up to date with their fire safety training.

We noted one fire door was part obstructed by a standing aid, however all fire exits were clear. The manager said they undertook a daily walk round to check fire escapes and would raise with staff following the inspection to keep these doors fully clear.

The service had suitable facilities to meet the needs of patients' families with a designated kitchenette to make drinks, a seating area and conservatory overlooking the garden. All patients' rooms were ensuite and single occupancy with patio doors opening on to the garden. There was accommodation for close family to stay overnight where patients were at their end of life.

Staff disposed of clinical waste safely. We observed sharps bins were used correctly and not overfull. Comprehensive audits were undertaken by staff to ensure the correct management and disposable of sharp clinical objects. Waste disposal bins were stored in an outside designated area and locked. Contract arrangements were in place for the safe disposal of clinical waste.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff completed risk assessments for each patient on admission to the ward and community services, using a recognised tool, and reviewed this regularly, including after any incident. Patient records included risk assessments such as for pressure ulcers, nutritional needs, risk of falls, moving and handling and infection control risks and these were reviewed and updated periodically on a weekly basis or sooner if there had been any change to the patient's condition. We reviewed four patient records and found appropriate risk assessments and care plans were in place for each patient, for example risk of bleeding, water low assessment, fall risk, nutrition and hydration. All had allergies recorded.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately considering the patient's wishes and advanced care plan. The frequency of observations was dependant of patient specific needs assessments. We saw evidence of a transfer to hospital of a patient of suspected sepsis whose wishes were for treatment. Staff said if they had any concerns about a patient deteriorating, they would escalate this to the doctor or call for an ambulance in the event of a collapse in accordance with the patient's wishes. If patients had an advanced 'do not attempt cardiopulmonary resuscitation' (DNACPR) this would be taken into consideration. The hospice had emergency equipment on site, defibrillators and first aid kits. All staff had received basic lifesaving training.

Staff knew about and dealt with any specific risk issues such as pressure ulcers and falls. Most pressure ulcers were non-inpatient acquired. Appropriate risk assessments and management for mitigating falls were carried out. In records, we saw evidence that increased observations were undertaken for patients whose risk score had increased, such as following a fall.

Shift changes and handovers included all necessary key information to keep patients safe and included.

The hospice had a fire policy and procedure in place. Evacuation and assembly points were clearly signposted. The fire alarm systems and fire extinguishers were routinely checked as part of the planned maintenance programmes.

Staff said they carried out routine simulation exercises and were aware of their roles and responsibilities in the event of a fire. All staff had completed mandatory fire safety training and the nurse in charge had responsibility to cut off the oxygen supply in the event of a fire. The service was said to be a 2 to 3 minute response time from the fire service. A silent alarm was tested weekly and twice-yearly fire evacuation drills were completed.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The number of nurses and healthcare assistants matched the planned numbers. Staff said they were always safely staffed and there was always a registered nurse on shift with the palliative care qualification. At the time of the inspection, the inpatient ward had 9 patients. The staffing establishment on each shift was for 3 registered nurses on an early shift with a shift coordinator and 2 healthcare assistants (HCA). The staffing establishment on the late shift were 2 nurses and 2 HCA and at night 2 nurses and 1 HCA, all of which were fully staffed.

We reviewed audits of staffing for the inpatient ward, health wellbeing and rehabilitation and hospice at home services from March to September 2023 and found they were appropriately staffed. Where there was increased demand in a service staff were redeployed to support.

The hospice at home service was independently staffed with a manager, 3 team leaders, 3 registered nurses and 30/35 health care assistants (HCA's) (dependent on hours worked). In addition to its day time support, it was providing a charitable Night Sitting service.

The hospice had also been commissioned to provide a further Night Sitter service and act as a single point of access for 'Fast Track' care for Burnley, Pendle and Rossendale since March 2023. A hospice at home coordinator is employed to coordinate the service.

Healthcare assistants could be requested to provided night sits to patients who are within the last 3 months of life. The team consisted of 4 substantive staff with a further 2 posts recruited to. Recruitment was in progress for additional HCAs.

The hospice had a large pool of volunteers that played a key part of the of staffing and support in clinical and non-clinical areas and income generation. All volunteers underwent the same recruitment checks as substantive staff and had appropriate induction and mandatory training. There were clear policies and procedures for the recruitment of volunteers all of which were managed by the volunteer manager and human resources.

Staff cover for leave and unplanned absences was provided by existing staff working additional hours and using established bank staff. Bank staff had a full induction, understood the service and received the same level of training as substantive staff. We spoke with bank staff who said they feel part of the team. Managers did not use agency staff which was confirmed by staff we spoke to.

There were no established staff vacancies, but some new roles had been created due to service expansion. Leaders and staff said staff sickness and turnover rates were low with many staff having worked in the service for several years.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. The areas we inspected had enough suitably qualified medical staff to provide timely and safe care and treatment.

Consultant cover is provided through the local acute trust. Agreement had been finalised for the trust to appoint a medical director, either consultant or associate specialist, who will be funded by based at the hospice. It has taken some time (around a year) for the trust to agree the terms of the service level agreement which is due for final sign off in November. The medical director post has now been advertised. One of the consultants also covered the inpatient ward and an outpatient clinic.

The medical team consisted of a hospice and community consultant who was employed by the local trust, 4 specialist grade doctors and 2 advanced clinical practitioners (ACP) employed by the hospice.

Patients admitted to the Hospice inpatient unit came under the direct care of the hospice medical team, and consequently hospice physician on duty on the day or on call out of hours.

The hospice medical team, alongside the hospice and community consultant provided out of hours medical provision to the inpatient unit, they were supported also by the hospital palliative medicine consultant and a general practitioner (GP).

Patients being cared for within the community, health, wellbeing and rehabilitation service and outpatients remained under the care of their local General Practitioner.

A medical position had recently been filled following the retirement of a long standing hospice physician and a further retirement was planned by the end of the year. The new medical director post will support cover in the medical team.

Medical staff and leaders told us medical staff sickness and turnover rates were low and the existing team was able to cover for leave or unplanned absences.

Hospice services for adults

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily.

When patients transferred to a new team or information sharing was required, there were no delays in staff accessing their records. The hospice had integrated their electronic records with local NHS records such as the acute hospital and GP services. Staff used electronic systems to ensure continuity of care.

Records were stored securely. We observed staff logged in and out of electronic records over the course of the inspection and all paper records were locked away. All staff had completed data security training.

Records for patients receiving community based care were kept within their homes or places of residence and shared with other health professionals, such as district nurses. The hospice maintained electronic records for community based patients detailing patient information such as contact details, risk assessments and care plans.

The ward staff used minimal paper based records except for bedside standardised nursing activities, such as for daily vital observations and nutritional care and falls risk assessment and monitoring. All paper records were uploaded onto the electronic record base for storage and data monitoring.

We looked at 4 patient records and found them legible, complete, signed and up to date. Patient records showed that nursing and clinical assessments were carried out on admission to the services.

Patient risk assessments were all completed and recorded electronically such as allergies, falls and pressure ulcers. They were reviewed and updated according to changes in patient needs.

We found that patients' care plans were person-centred and were completed to a good standard. Person-centred care plans were in place, such as for falls management, pressure care, pain management, medicines management, nutrition and hydration and personal care.

Staff carried out routine audits of patient records to check for accuracy and completeness. They also monitored recording of a range of required documentation for example, risk assessments, care plans, DNACPR and pain assessment for hospice at home and the inpatient unit records. Data provided showed paper based records were scanned and monitored.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Data provided after the inspection showed all staff had completed mandatory medicines management training relevant to their role.

People we spoke with did not raise any issues around support with their medicines.

In the last 12 months, data showed 99.96% of the medicines were administered as prescribed and at the correct time. There had been 33 medication incidents between April to September 2023, all low and with no harm to patients out of a total of 31804 medicine administered.

It was noted there had been a small increase in the number of prescribing errors from the previous year which was attributed to e-prescribing following its implementation.

The main reported incidents for medication were due to individual staff errors such as, missed or late administration of medications, medication chart not signed or errors in documentation.

There were 3 incidents of a controlled drug being given higher than the intended dose. All doses were within the prescribed range and there was no harm to patients. All patients and their relatives had received an explanation and an apology under the duty of candour.

The hospice had oversight of medication errors and took action to mitigate risk through investigations, sharing learning and feedback to staff. Introduction of an electronic prescription (e-prescription) had been identified for some of the incidents reported as staff were embedding in the new system.

Staff carried out daily checks on controlled drugs and routine medicine stocks to ensure that medicines were reconciled correctly. We looked at a sample of controlled drugs and found the stock levels were correct, and the controlled drug registers were completed correctly.

The clinical services manager was the controlled drugs accountable officer for the service. The hospice had an arrangement with two external pharmacy providers for the supply of patient own and stock medication. The pharmacist undertook quarterly stock checks of controlled drugs in clinical areas. We saw recommendations from the checks and the date for followed up. Disposal of controlled medicines was carried out on site by the pharmacist and quality assurance manager and disposed as part of the clinical waste management.

We saw records of syringe drivers being correctly used and monitored.

Stock and patients own medications were delivered from two local pharmacies and controlled drugs were delivered from a local NHS hospital. Medications were checked before being stored.

The hospice had arranged for an external pharmacist to visit site three days each week to go through all prescription charts, controlled drugs and support with medication audits.

The hospice undertook quarterly antimicrobial point prevalence audits to monitor antibiotic prescribing and target specific areas for non-compliance to ensure appropriate support was provided if required.

Staff stored and managed all medicines and prescribing documents safely. We observed staff following the procedure for managing controlled drugs and recording them.

Fridge temperatures were checked and recorded daily.

Incidents

The service consistently managed patient safety incidents well. Staff recognised and reported all incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Outstanding ☆

Hospice services for adults

Staff raised concerns and reported incidents and near misses in line with the provider's incident reporting policies. Staff knew what incidents to report and how to report them. Managers said they had seen an improvement in incident reporting since the implementation of champions for a range of areas such as syringe drivers, falls, food and nutrition etc. Champions looked at an incident where it involved their area of expertise and disseminated information to improve practice and care. All incidents, accidents and near misses were logged on the electronic incident reporting system. Incidents were reviewed and investigated by staff with the appropriate level of seniority, such as the director of clinical services and senior medical staff.

There were processes in place for oversight of incidents with a monthly clinical management meeting, quarterly clinical governance subcommittee and a clinical governance report which was shared to the executive committee. From the clinical governance report it was clear medication and falls incidents had not increased in the October 2023 monthly report from the same reporting timeframe for 2022-23.

There had been no unexpected patient deaths, never events or serious incidents reported by the service since the last inspection.

The service had reported 152 incidents between April 2023 and September 2023. All incidents were graded as low or no patient harm. The hospice used a 'learning through action' Root Cause Analysis (RCA) tool to support staff to learn from incidents. Most incidents related to the inpatient ward. The most commonly reported incidents were for patient falls, medications administration/documentation, and pressure ulcers (with low or no harm).

We saw evidence incident records were completed appropriately, investigated, actions had been taken and lessons learned. Staff reported there were weekly incident feedback emails which required signing to acknowledge they had been read. Managers reviewed reports to ensure staff were reading emails. This was part of staff performance measures. We also saw in staff meeting minutes that incidents and learning was discussed and shared.

In addition, information boards displayed learning from incidents and were also displayed in staff rooms. Dashboard incident summaries were available for staff to access easily. However, not all staff could give examples of how lessons learned had been shared with them or how this had impacted on practice.

A significant events discussion group was also held bimonthly so teams could discuss an incident there was learning from.

Managers debriefed and supported staff after any serious incident.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Is the service effective?

Outstanding ☆

Our rating of effective stayed the same. We rated it as good.

Outstanding ☆

Hospice services for adults

Evidence-based care and treatment

The service consistently provided care and treatment based on national guidance and evidence-based practice. Managers always checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

The Hospice had developed and embedded a quality improvement programme throughout the organisation, since the last inspection, based on best practice evidence and research. There was significant evidence provided in reports demonstrating improved performance and winter pressures outcomes that had had a positive impact. In particular, identifying how the Hospice had improved patient services and outcomes for individuals accessing Hospice services and in collaboration with other organisations.

Staff followed effective and up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies and procedures were based on national guidance, such as from The National Institute for Health and Care Excellence (NICE) and quality standards which were reviewed monthly. The hospice was part of the NICE user engagement group.

We reviewed a wide range of polices and found these were up to date with review dates set and based on current national guidelines.

Staff could easily access current policies and procedures electronically. The staff page was set up to have the most needed links first in a tile format with words and a picture of what was inside the folder. Staff confirmed they knew where to find policies and procedures. Hospice at home staff carried portable electric devices and could access information remotely.

Volunteers did not have access to electronic records but reviewed policies relevant to them with team leaders and signed to say they had read them.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Patients and their relatives were supported by the counselling team for psychotherapy and emotional support. Patients could also be referred to local specialist NHS mental health services for advice and support if required.

At handover meetings, we noted staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff always ensured patients enough food and drink to meet their needs and improve their health where this could be achieved. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs and monitored patient satisfaction.

Staff always made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. Patients and families reported food and drink preferences were respected and support provided to ensure patients had enough to eat and drink. One person reported 'staff would get anything you want eat' and would never say they cannot provide it. People said the quality of food was 'homecooked' and of 'good quality'. All efforts were made to encourage patients where possible to eat and drink and staff were said to go above and beyond to achieve patients' nutritional wishes.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We looked at four patient records which showed staff carried out an assessment of patients' nutritional requirements on admission and this was updated as required.

Where patients were identified as at risk, staff fully and accurately completed patients' fluid and nutrition charts where needed. We also looked at special diets in the hospice kitchen to understand how nutritional needs were met for patients with special dietary requirements.

We noted in records, patients received specialist support from staff such as dietitians and speech and language therapists for those who needed it.

The hospice had recently improved menu choices following feedback from the patients and families. Meal times were protected at the hospice with only essential activities taking place when needed.

Senior leaders audited the quality and timeliness of nutrition assessments and care planning. Where improvements were identified this was acted on.

Pain relief

Staff always assessed and monitored patients regularly to see if they were in pain and gave effective pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice and patients received pain relief soon after requesting it. We saw in patient records, and patients and family confirmed, that 'pain relief was provided quickly' when needed.

Staff prescribed, administered and recorded pain relief accurately. Staff said doctors were very quick to prescribe pain relief and always used patients own pain score assessment to determine appropriate pain relief as required.

Leaders audited pain assessments with data showing a 100% compliance by staff assessing patients' pain on admission to the inpatient unit.

Patient outcomes

Staff continually monitored the effectiveness of care and treatment. They used the findings to make improvements and consistently achieved good outcomes for patients.

Outcomes for patients were positive, consistent and often exceeded expectations, such as national standards. During the period between April 2023 and September 2023, the hospice reported there had been 167 patient deaths, of which 142 patients had a documented preferred place of death (PPD). The hospice achieved the preferred place of death for 132 of these patients. (93%) This showed the hospice where possible, was able to meet the wishes of most patients who had specified a preferred place of death. Where the PPD was not met the hospice reviewed why this had not occurred. This was identified on some occasions where records had not been updated when the PPD had changed or the patient was too poorly to be asked or moved if at home. In the majority of these instances hospice at home provision was provided to ensure patients received the care needed.

Managers and staff continuously used the results to improve patients' outcomes. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. For example, the hospice used the

Australia-modified Karnofsky Performance Scale (AKPS) which is a gold standard scale within palliative care and allows patients to be classified as to their functional impairment and performance status. This can be used to compare effectiveness of different therapies and to assess the prognosis in individual patients. The lower the Karnofsky score, the worse the survival for most serious illnesses. Leaders used audits to evaluate the Karnofsky scores of patients who were discharged from the inpatient unit, either to their own home or a nursing home and evaluate the change in score compared to that on admission. Data showed, on average, for the first two quarters of 2023/24 that scores on admission to the inpatient unit for symptom management and stabilising a condition, did not have any detrimental effect of functional status on the patient and in many cases it either improved or was maintained at discharge.

The counselling team also used specific tools such as patient health questionnaires (PHQ) for depression and generalised anxiety disorder (GAD) to measure patient outcomes. The lower the score the greater the positive impact of the therapy intervention. Clinical audit results for April to June 2023 showed 100% (31) of patients had a lower PHQ score for both depression and generalised anxiety demonstrating the positive impact of the therapy intervention.

Managers effectively used information from the audits to improve care and treatment. A baseline audit highlighted pain assessment was variable and documentation inconsistent in May 2022. Since implementing a systematic process of pain assessment and recording and supporting staff to embed it, data showed an improvement month on month from implementation.

The hospice undertook performance improvement projects to improve patient outcomes. For example, falls prevent project had just been agreed to analyse and reduce inpatient falls as they were identified as the second most reported incident.

Managers shared and made sure staff understood information from the audits for example, a review of the electronic template for recording a patient's preferred place of death (PPD) was undertaken to ensure all patients receiving care had this documented in their records.

There was extensive evidence from the inspection and data provided that the hospice had processes in place to audit and implement actions to improve the service. Improvements were continually checked and monitored.

The service did not have any ISO accreditations which was said to be due to the additional cost involved but they did participate in numerous national clinical audits such as, Hospice UK: Hospice Activity and Contracting Data Collection, Hospice UK: Patient Safety Data, National Care at the End of Life Case Note Review and Association for Palliative Medicine.

Competent staff

The service made sure staff and volunteers were competent for their roles. Managers appraised staff's work performance and held effective supervision meetings with them to provide additional support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Medical staff had specialist training and additional qualifications in palliative care

medicine. Regular checks were made for revalidation and competencies for medical staff and consultants working in the service. The hospice contributed to consultant appraisals.

Hospice services for adults

The hospice did not currently have any newly qualified nurses with less than 18 months experience working in the hospice.

Managers gave all new staff a full induction tailored to their role before they started work. All new staff had a six month induction and probationary period. We saw a comprehensive induction pack for staff including the hospice vision and strategy, required induction standards and expected behaviours.

Managers supported staff to develop through yearly, constructive appraisals of their work with all staff groups achieving more than the required 90% overall target rate of completion by October 2023 at 96.7%. The hospice was undergoing a review of appraisals and involving staff to ensure it was effective.

The hospice had a designated clinical educator who was also an advanced clinical practitioner (ACP) who supported the learning and development needs of staff.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers made sure staff received any specialist training for their role, identified any training needs staff had and gave them the time and opportunity to develop their skills and knowledge. All registered nurses were encouraged and supported to complete the palliative care course with a pay enhancement award on completion. Staff confirmed they were encouraged to undertake training and against future plans of the hospice such as nurse prescribing. Health care assistants (HCA) were trained to give oral (pain relief) medication if patients could not administer it themselves. We saw training and competencies were completed in the staff records we reviewed.

Staff said they had the opportunity to discuss training needs with their line managers and were supported to develop their skills and knowledge. All staff had completed training for new syringe drivers which were replacing older models in the hospice. Nurses undertook additional training for verification of deaths, advance care planning and 'react' for pressure ulcer prevention.

In the 2023 staff survey 91% staff agreed they received the training and development to do their job well compared to 73% against hospices national benchmarking. 75% compared to 58% nationally agreed they felt supported to develop their career.

Managers identified poor staff performance promptly and supported staff to improve. The hospice employed an external company to manage human resources matters.

There was a dedicated team to recruit, train and support volunteers to support patients in the service. Compliance for volunteer training was included in the overall staff figures but was not provided separately. Volunteers received the following mandatory training, Health & Safety, Infection Prevention & Control, Equality & Diversity, Safeguarding, Confidentiality, Data Protection & Information Governance, Security, Communication & Customer Service.

Volunteer drivers for the meals on wheels service also received additional training during an annual driver forum specific to their role.

In the last twelve months a selection of clinical and patient facing volunteers had also undertaken additional Last Days Matter Training to enhance their skills further. This was a Lancashire and

South Cumbria wide initiative through the Compassionate Community network, delivered by Pendleside Hospice Quality Improvement Lead.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held weekly multidisciplinary team (MDT) meetings to discuss patients and improve their care. Weekly MDT discussions were recorded into patient records. Patient records showed there was routine input from nursing and medical staff and allied health professionals.

Six monthly MDT meetings, more frequently if required, were held to review any significant incidents or review patient care cases. We observed a multidisciplinary meeting which included a palliative care consultant, the hospice palliative care team, and hospice at home staff. The current and future needs of those using the service were discussed and the possible need of home care patients requiring inpatient attendance.

Staff said they could refer patients for mental health assessments when they showed signs of mental ill health. The hospice had its own psychology service supporting people using the service with symptoms of depression and generalised anxiety.

Staff handover meetings took place during shift changes. We observed all relevant information was shared.

There were routine monthly staff team meetings for each part of the service.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff and specialist community teams also liaised with a number of different services when co-ordinating patient care. This included the patient's primary care team and general practitioner, adult social care providers, district nursing teams, hospitals, community services and social services.

Staff shared case studies where the hospice had worked well with other services including care homes and following lengthy hospital stays to improve patients' quality of life. This was attributed to by a collaborative approach with external staff and services.

Seven-day services

Key services were available seven days a week to support timely patient care.

The inpatient ward operated 24 hours a day, seven days a week. The ward accommodated overnight patients 7 days per week and staffing levels were suitably maintained during out-of-hours and weekends.

The medical staff were rostered Monday to Friday on the inpatient ward. There was on-site medical staff during routine working hours on weekdays with on-call support available during out of hours service and weekends. Patients could be admitted to the ward 7 days per week including out of hours.

The community specialist teams and hospice at home operated 7 days per week during days, with a night sitting service available for patients requiring overnight support. Care could also be extended for patients requiring 24-hour care at times of crisis and for patients who choose to stay

at home for end of life care. There was a 24/7 emergency support helpline available for patients and their relatives if they required any support and guidance.

Physiotherapy support was available on site during normal hours on weekdays.

The bereavement and counselling teams operated during normal working hours on weekdays and could also offer support out of hours with specially trained volunteers.

Health promotion

Staff gave patients practical support to help them live well until they died.

The hospice had a dedicated health, wellbeing and rehabilitation service providing advice support and specialist management of patients and their carers who had advancing long term and life-limiting conditions. The service was provided by a multi-disciplinary team of nurses, physiotherapists, occupational therapists, health and well-being assistant, counsellors and a psychotherapist. Staff assessed each patient's health when admitted and provided support for any individual needs around living with a life limiting illness and advance care planning.

The hospice had relevant information promoting healthy lifestyles and support on inpatient areas. The hospice had a range of information leaflets to provide support and advice for patients with a life limiting illness.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes. The hospice provided an example from case review notes where staff had received support from medical staff to fulfil a patient's unwise choices around their care. Staff found this difficult as it did need meet their own high standards but worked with the patient and the family to listen to their wishes. There were examples of where the team explained their rationale to the patient to try to help her accept personal hygiene and wound care but they still refused. It was discussed using the Mental Capacity Act guidance that by providing care against the patient's wishes whilst they had capacity would have been classed as assault.

Staff gained consent from patients for their care and treatment and made sure patients consented to treatment based on all the information available. We saw this in the patient records we reviewed, and relatives confirmed this happened.

All staff and medical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Doctors made decisions and applied for Deprivation of Liberty Safeguards.

Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff knew where to find the hospices best interest document and completed it with the patient's family.

We looked in 4 patient records and found they all had advanced 'do not attempt cardio pulmonary resuscitation (DNACPR) in place. They also had documented discussion with patients and family and of obtaining consent. Audits for DNACPR recording and compliance were undertaken six monthly and demonstrated this was 100% completed.

Outstanding ☆

Hospice services for adults

Is the service caring?

Outstanding ☆

Our rating of caring improved. We rated it as outstanding.

Compassionate care

Staff always treated patients and relatives with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. There was a strong, visible person-centred culture that was promoted by service leaders. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Feedback from patients and those who are close to them was continually positive about the way staff treat people.

There was a culture across the hospice that encompassed compassion, privacy, dignity and delivering individual needs to palliative and end of life care patients. All the staff were caring and compassionate and were committed to providing the best patient care possible.

We observed and people using the service told us, staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Call bells were answered quickly which was confirmed by relatives.

Feedback was consistently very positive from people using the service with comments that 'staff and doctors were excellent'. People also reported that staff 'introduced themselves' and 'listened to their loved one's wishes'.

Patients and their relatives were very complimentary and full of praise when describing the care and support they received from staff across the hospice. We found numerous examples including case studies provided by the hospice team that demonstrated how staff went the extra mile for patients and their care and support exceeded their expectations. Some examples included: -

- Supporting a vulnerable patient to find and reconcile with an estranged loved one before dying working with other charitable organisations.
- Supporting a couple with care and compassion who were receiving end of life care who experienced a challenging relationship. Working with the safeguarding team, and without judgement, a coordinated and individualised care plan was implemented.
- Numerous examples of patients with behaviours that challenged becoming calmer once admitted from hospital to the hospice as staff built up a trusting relationship and showing compassion and kindness.
- Respecting and supporting patients preferred wishes even when this was not always easy for the family members to reconcile with.
- Working with other faith sector organisations supporting people who were homeless to access end of life support when they cannot access other services.

Staff followed policy to keep patient care and treatment confidential. Patients and carers confirmed that privacy and confidentiality had been maintained without restricting information when required.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental ill health.

Staff sought feedback from patients and their relatives about the quality of the services provided through feedback surveys and feedback cards. The hospice also undertook a 'first impressions challenge' in February 2023 based on the NHS 15 steps. This is a nationally recognised tool to explore healthcare settings through the eyes of patients, families and the public accessing the service. All feedback which was predominantly positive was shared with staff and an action plan drawn up where some areas for improvement were identified.

We looked at a selection of surveys and feedback comments relating to the inpatient ward, specialist community palliative service, day therapy services and the bereavement and counselling services from the last 12 months. The feedback was overwhelmingly positive with only one feedback suggesting some improvement could be made. The survey results constantly showed patients and their relatives were very positive about the care and treatment they received. All service users who responded to surveys would recommend to family and friends.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. The hospice had a range of additional support for patients and their loved ones including talking therapies and a bereavement service. Feedback reviewed showed 100% of family and people accessing psychological support clients were very Satisfied with the service.

We were told by one relative the whole family had been supported and offered bereavement support even though not all family members lived close by. Staff were said to have 'gone out of their way' to find out of area support for those relatives.

The hospice had a chaplaincy service and could access different faith groups when required.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. All patients completed a document called 'All About Me' and were supported to implement an end of life advanced care plan to ensure their wishes were known. Patients and carers confirmed completing the document and recording likes, dislikes and preferences.

From case studies shared by staff, we saw how day care activities and groups supported people emotionally, physically and enabled them to have some normality despite living with a life limiting condition. This had a positive impact on patients' experience.

Another example, from many provided, was the response to urgent referrals from families for loved ones approaching their end of life and unable to cope with care due to emotional distress. Where patients had chosen home as their preferred place of death the hospice at home team provided extended 24 hour service to meet all the patients care needs and supported the family with referral to the bereavement service.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Outstanding ☆

Hospice services for adults

Staff made sure patients and those close to them understood their care and treatment. Carers and family said, 'staff were amazing and kept family updated without them having to seek out information'. We saw in patient records discussions with patients and those close to them to understand their condition and make decisions about their options, care and treatment. Families and carers agreed that they had all been involved and confirmed this happened.

Staff supported patients to make advanced and informed decisions about their care. Feedback from patients, families and carers reported the same. Staff were said to be' very approachable, open and accommodating.'

Is the service responsive?

Outstanding ☆

Our rating of responsive improved. We rated it as outstanding.

Service delivery to meet the needs of local people.

The service proactively planned its services and provided care in a way that took into account and, quickly and responsively, met the preferences and needs of local people and the communities it served. It also proactively and consistently worked with others in the wider system and local organisations to plan individualised and highly responsive care that promoted equality, including for those who were seldom heard.

The Hospice was a member of the Lancashire and South Cumbria ICB Compassionate Community Network group, influencing the response of Hospices to people with palliative and end of life care needs and health and social care locally and regionally across the ICB. The Hospice enacted this at local level across Burnley and Pendle by having its own Compassionate Community Group, a group of both internal staff and key influencers in the local community, together they were working through an action plan for ensuring people were aware of Hospice and palliative and end of life services locally.

Managers planned and organised services, so they met the needs of the local population and proactively sought ways to support those who were seldom heard or in crisis.

The hospice had policies which outlined the admission criteria for patients. Most patients admitted for these services were palliative care patients (patients with a life-limiting illness), aged over 18 years of age and resided within the hospice's geographical catchment area.

The hospice monitored bed occupancy and was above the national bench mark of 77.6% for bed occupancy rate with an average of 88.6% for 2023-24. Admissions to the service were considered 7 days a week including out of hours.

The Hospice at Home Single Point of Access for the coordination of Fast Track care was unique to Pennine Lancashire. Urgent referrals in the community were responded to within 2 hours of the referral, working in collaboration with community services, other charities and domiciliary care providers to ensure patients got the appropriate care required in a timely manner. A case study example was provided which demonstrated the impact of this service at a time of crisis. A patient with a poor prognosis was fast tracked to home from hospital who was living alone and minimal family support. The patient could not be transferred into the Hospice due a positive COVID test and a home care package was

arranged for 4 day and night visits per week. However, the home assessment identified the patient was not safe at home due to being unwell with COVID. The Registered Nurse amended the Fast Track package to be increased to 7 nights which was immediately allocated by the Hospices single point of access to a domiciliary care provider on the fast track provider framework.

Information provided after the inspection showed 44% of patients referred to the home care team were assessed by a registered nurse on the same day as the referral and 76% of patients being assessed within 24hrs, A 100%of patients referred to the service were responded to in accordance with the referral criteria.

In addition, the hospice had implemented a 'meals on wheels' service to the wider community not just for people receiving end of life services. Provision of one or two meals a day including a hot lunch and the option of an afternoon tea was offered and delivered by hospice staff and volunteers. The service also provided social interaction and wellbeing checks.

The hospice had considered what additional services it could offer to alleviate winter pressure this year on the NHS as it had increased bed capacity during the pandemic. In addition, it moved its day and family support services to virtual and increased its hospice at home capacity. It had also delivered successfully on a winter pressures project 2022/23 commissioned by the NHS, increasing hospice at home support, education to care homes and support to palliative patients who were vulnerable. Unfortunately, there was no additional winter pressures funding for 2023/24 from the NHS. However, the Hospice still had plans to continue to support to care homes, the socially vulnerable and increase the hospice at home provision funded from charitable donations.

Facilities and premises were appropriate for the services being delivered. The design and layout of the 10-bedded inpatient ward promoted accessibility in all areas with all patient rooms pending out onto the hospice gardens.

There was no mixed sex accommodation as all 10 bedrooms were single occupancy with ensuite bathrooms.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Family and carers we spoke to confirmed there was 24/7 access to urgent mental health services.

The hospice had systems to help care for patients in need of additional support or specialist intervention. The hospice offered specialist support such as a counselling and bereavement service, physiotherapy, creative therapy, complementary therapy and spiritual care. Patients could also be referred for specialist care such as speech and language therapy, tissue viability nurses, dietitians and psychiatric support for patients with mental ill health.

The hospice at home team could provide extended crisis care in an emergency until care packages could be put in place if a patient either wanted to stay at home or there was no immediate bed available in the hospice. We saw examples of when the hospice at home team had been responsive and proactive to urgent requests for assessment from community professionals for assessment of 24 hour support and care with the night sitting service utilised to provide 24 hour support at home. Crisis care is often in place when the patient dies due to the short time frame for other care packages to be provided.

Managers monitored and took action to minimise missed appointments and ensured that patients who did not attend appointments were contacted. The hospice had recently introduced a text message reminder service for people attending the day service and family support to reduce the number of did not attend rates. Feedback from people receiving the text was positive but it was too early for audit data to confirm the overall impact.

The service relieved pressure on other departments when they could treat patients in a day. The hospice had purchased a bladder scanner enabling on site diagnostics rather than sending patients to hospital. This had proved useful in detecting urinary retention despite clinical symptoms suggesting other causes and providing effective control of symptoms.

Meeting people's individual needs

The service consistently put people's individual needs and preferences central to the delivery of its services. The service was inclusive and responsive in its tailored care to meet the individual and complex needs of its patients. This included people who faced significant barriers to accessing health and care services. Staff went above and beyond to help patients access services. They proactively and consistently coordinated care with other services and providers.

The Hospice proactively worked to meet the needs of people from the whole community reflecting diversity at local level. People's individual needs and preferences were central to the delivery of tailored services. Upon referral or admission to the service, staff developed detailed person-centred holistic care plans which took into account all aspects of the patient's care including end of life.

Each person's care plan was devised in discussions with the patient and their carers where relevant about what was important to them. The care plans were regularly reviewed and updated, and referrals were made to members of the multidisciplinary team according to each patient's needs. The hospice used a tailored individualised care and communication record to document each patient's care at the end of life. This included any advanced care plans, or advanced decisions to refuse treatment that had been put in place by the patient.

The hospice supported open visiting for relatives and carers seven days a week; however, the service had protected mealtimes. Patients told us visitors to the hospice were always offered refreshments, such as tea, coffee and cakes and there was access to a relative's kitchen.

The service had facilities for a couple of families to stay overnight with additional convertible space if needed.

The hospice supported patients if they wanted to withdraw from treatment such as non-invasive ventilation. Careful assessment of capacity and continued checking of wishes from a multi-disciplinary team was undertaken. This also included input from other professionals involved in patient care and treatment outside the hospice which ensured patients preferences were respected. Staff made sure patients living with mental ill health, learning disabilities and dementia, received the necessary care to meet all care and emotional needs. Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

The day service had piloted groups for people living with dementia and their carers before Covid. This had evaluated so well with positive outcomes that when the day services was reinstated post Covid, it was reintroduced as a permanent service within the new Health Wellbeing Programme (HWP) of activities. The hospice HWP manager is also a member of the leadership team for Dementia Positive Pendle with the hospice providing administration support to this group.

Staff completed dementia awareness and learning disability and autism training. The HWR manager was active in local dementia organisations, voluntary services and Vice Chair of Dementia Positive Pendle and internally in the Hospice. She disseminated learning, knowledge of services and ensured inclusive services for people & families living with dementia. She had forged links with local charities, supporting them with setting up their services.

Funding had been approved and an advertisement had gone out to employ an admiral nurse, who are registered nurses who specialise in dementia, helping family carers gain the necessary skills to assist with dementia care, promoting positive approaches in living well with dementia and improving the quality of life for everyone involved.

The hospice had plans in place to undertake refurbishment to create a more dementia friendly environment as identified within their improvement action plan.

An event called 'Launch of Memories on the Lake' was held this year to mark 35 years of the Pendleside hospice service. Hundreds of personalised, glowing floating lanterns were released on a lake in one of the local town parks by relatives paying tribute lost loved ones. More than 1,000 people attended, not only to pay tribute to their lost loved ones, but also to help mark the special 35th anniversary. This is now going to be an annual event.

The hospice also held an annual service called 'light up a life' and invited relatives and loved ones to remember those who have passed away. Bereavement support is offered to those who need it.

The hospice had an end of life educational facilitator, homeless outreach and drug & alcohol lead who went out with another charity to reach vulnerable people who were homeless and drug and alcohol dependant. Examples were shared how people were supported with life limiting conditions despite not engaging with other medical and statutory services. The quality governance lead had written a policy to enable the hospice to support people with drug and alcohol addictions and enable uptake of services such as symptom management, rehousing and inpatient care.

Managers had undertaken actions to understand a lower than expected uptake of ethnic minorities of the hospice service despite high ethnic diversity in some areas than other primary care neighbourhoods (PCN). Some of this was attributed to a much lower percentage of people registered with GP in high areas of ethnicity who were under 65 years. A member of staff, supported by the Hospice Quality Assurance lead, was nominated for Inclusivity Champion Hospice UK 2023 for the work undertaken to raise awareness of the hospice services amongst the minority ethnic community in Burnley and Pendle. This led more diversity in volunteer roles including at board level and in increased engagement event inclusivity.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients' loved ones and carers could get help from interpreters or signers when needed. Staff could also access an online language translation service. Staff also said they used iPad, picture cards and communication tools to support interaction.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Menus and choices had recently been updated with input from service user feedback.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

Patients could be referred to the service by health professionals and self-referral within the local area for end of life care, symptom control, unplanned respite care and for psychological support.

Hospice services for adults

There had been an increase in overall demand for all services across the hospice from the previous year. For example, over 100 more service users attended the Health Wellbeing and Rehabilitation Service face to face contacts than the previous year. The number of patients accessing outpatient and community services had increased by 47% and 39%, respectively, compared to the previous year. There had also been an increase in carers and children accessing bereavement services by 9% compared to the previous year.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Senior leaders and managers looked at maximising inpatient bed capacity to ensure patients could access the specialist palliative care service when they needed it. Audits had identified that patients using the inpatient ward stayed on average 17.78 days compared to a national average of 14 between 2021 to 2022. Figures for January 2022 to March 2023 showed discharge figures remaining static whilst referral numbers were increasing over the same period following the pandemic.

Managers monitored waiting times and were able to offer the hospice at home and night sitting service to patients where a bed could not be offered immediately. This had sometimes meant that once fully supported at home, patients chose not to take up the offer of an inpatient bed and changed their preferred option to home. Patients did not normally have to wait long for a bed with an urgent admission criterion being followed.

Managers were reviewing how to start planning each patient's discharge as early as possible and a discharge project was being undertaken to review how access and flow could be improved without pressuring patients to leave the inpatient service until they felt ready to do so.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs and demonstrated how they worked closely with other services.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint however complaints about the service were very rare.

Patients, relatives and carers knew how to complain or raise concerns and the hospice clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. Data showed an increase in feedback received about the services over a 2 year period. The hospice also looked at ways it could continue to improve and capture feedback from a wide range of service users.

Managers investigated complaints and identified themes and staff knew how to acknowledge complaints. However, there was only one formal complaint in the last 12 months with feedback overwhelmingly positive.

Managers shared feedback from suggestions and complaints with staff and learning was used to improve the service. All feedback was analysed and shared including positive feedback so staff could understand what was going well. Any comments no matter how minor, such as 'mashed potatoes were too lumpy' was reviewed for any possible improvements, in this instance this was shared with the kitchen staff.

Is the service well-led?

Outstanding ☆

Hospice services for adults

Outstanding ☆

Our rating of well-led improved. We rated it as outstanding.

Leadership

Leaders consistently demonstrated they had the right skills and abilities to run the service. They clearly understood and managed the priorities and issues the service faced. They were very visible and approachable in the service for patients and staff. They positively encouraged and supported staff to develop their skills and take on more senior roles.

The hospice had a clear and robust management structure with lines of responsibility and accountability. The chief executive officer (CEO) reported to the board of 11 volunteer trustees who had a collective wealth of experience. The board was led by a chair who was also the nominated individual for the hospice. The CEO, also the registered manager, was supported by a clinical services manager, quality assurance manager, quality improvement lead, finance and business manager and head of income generation.

The clinical services manager was supported by the medical team, and managers and leads for the hospice clinical and therapeutic areas including the community services manager. Clinical effectiveness was very professionally managed.

The senior managers had the relevant skills and abilities to manage the hospice services effectively and professionally. They understood the risks to the services and had clear oversight on patient safety, governance and performance issues through daily involvement and quality monitoring. Governance structures were robust.

Most leaders had more than one role in the organisation and worked well together for the benefit of the service.

Staff knew the reporting structures and said all managers, leaders and the CEO were very approachable and visible throughout the service. Manager and team leaders in the hospice also reported they were supported by senior leaders out of hours where this was required.

Vision and Strategy

The service had a clear and ambitious vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The hospice had a clear vision underpinned by 'The 5 Pillars of Pendleside' strategy (2021 to 2025). The hospice was committed to ensuring effective leadership to enhance services and recognised it could not achieve it alone. The 5 pillars, 'proud to be Pendleside', consisted of community collaboration, care delivery, governance and sustainability were underpinned by their core values of care, compassion and support.

The vison and strategy was developed taking account of staff, service user and stake holder feedback, local and national guidance and legislation for health and social care particularly palliative and end of life care. Each year, an annual review was undertaken, mapping the progress the hospice was making in achieving its strategic aims and updating if required.

Staff said they were involved in the vision, strategy and behaviours and have annual employee engagements to share ideas and review the strategy. The vison and strategy was also included in the induction pack for new staff. A staff survey said 95% of staff knew about the behaviours underpinning the strategy.

Culture

All staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff said managers and senior leaders were approachable and had an open door policy. They reported feeling listened to, valued and supported. Most staff had worked at the hospice for a number of years and said they 'would recommend' it as a 'good place to work'.

All staff demonstrated and provided examples on how they were focussed on the needs of patients receiving care and their families. Service users also confirmed this with many people accessing services over a number of years.

Staff said they felt safe to raise concerns and knew how to do it. The service had a whistleblowing policy which was available to all staff and information on how to raise concerns was available within this document. 2 board members, with relevant training, have just been appointed as the freedom to speak up guardians (FTSUG) for hospice staff and volunteers. There had not been any whistle blower or freedom to speak up concerns raised or received by the Care Quality Commission during the past 12 months.

Service users also knew how to raise concerns such as approaching staff directly. Feedback was that they had 'never had to'.

The hospice had developed a Health and Wellbeing Committee and the role of Health and Wellbeing Champions across each department. The Health and Wellbeing Champions had undertaken additional training to fulfil their role. The group had developed a health and wellbeing calendar including a menopause policy, menopause café and menopause champion to support staff as part of their well-being commitment.

Staff could also benefit from a private healthcare package and a health and well-being service in partnership with a local hospital. Alongside other benefits on offer staff received subsidised meals when on duty. Staff also received mental health first aid and well-being training.

In the last staff survey the hospice benchmarked higher overall for staff satisfaction in every category compared to other hospices with 96% of staff proud to work at Pendleside.

Governance

Leaders operated robust and effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were clear and robust governance structures in place that provided assurance of oversight and performance against safety measures. The board of directors (trustees) held board meetings every 3 months. The hospice also had 4 trustee led sub-committees of the board. Trustees on subcommittees were chosen for their area of expertise and heads of hospice at home and inpatient services also attend these groups. A clinical governance subcommittee meeting was held quarterly to review audit reports, performance reports, case studies and adverse incidents. There were effective

processes and systems of accountability to support the delivery of good quality and sustainable services. These were regularly reviewed, and improvements made as required. We reviewed audits and minutes of monthly or quarterly meetings where staff discussed these and other topics. When audits for compliance fell below the provider's accepted levels of 90%, action plans were implemented to make improvements. For example, a fall in venous thrombosis risk assessment completion was noted and investigated. This was found to be due to reporting errors rather than care. Actions were taken to support staff to complete the new electronic records correctly to ensure clear oversight.

Leaders operated effective governance processes and systems were in place to ensure these were effective throughout the service. For example, when polices were approved they went to a review group for quality control and then through to the board for oversight and signoff. New polices were accessible online for staff to read in each area and sign to say they had read it. A hard copy was also printed off for reference to ensure accessibility.

The hospice had undertaken quality improvement measures to improve the flow of information from the ward to the board and back again. A board development programme had been undertaken with support from human resources and the university. Trustees got a full induction and review all areas of the service. They have a visiting rota to review patient areas and write a report to feedback their findings to the senior leadership team.

Senior managers held routine departmental staff meetings to manage patient risks, share learning and cascade governance and performance information to staff.

The hospice submitted a formal report detailing performance key indicators to local service commissioners every 3 months.

We looked at the fit and proper persons files for 1 trustee and three directors and found them to have all the relevant checks in place. The hospice was reviewing the use of a new form for appointing volunteer board trustees to ensure they were in line with employee recruitment forms.

Management of risk, issues and performance

Leaders and teams made good use of systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There was a risk management policy and procedure in place that outlined the process for identifying, assessing and mitigating risks to the service.

The key risks relating to the services were incorporated into the organisational risk register and board assurance framework. The risk register showed that key organisational and patient safety risks were identified and control measures were put in place to mitigate risks. A risk scoring system was used to identify and escalate key risks and each risk had a review date that was regularly updated.

Meeting minutes showed key risks had been reviewed and discussed at routine board meetings, risk management meetings and governance and audit committee meetings.

Routine staff meetings took place to discuss day-to-day issues and to share information on performance, patient safety, incidents and audit results.

The hospice was part of a hospice collaborative to share lessons and learning from the patient safety investigation reports framework (PSIRF).

The hospice had continuity plans in place to deal with unavoidable circumstances such as utility failure with an action plan in place on the risk register. The hospice building did not have a backup generator in the event of a power failure. They had an agreement with their energy provider to provide a generator at short notice in an emergency to keep the service running.

The hospice had a utility failure policy which included systems and contact details in the event of a utility failure and a business continuity policy for information technology. Hospice smart devices could access to patient information via 4G connections if necessary.

Staff maintained up to date risk assessments in relation to premises and equipment, health and safety risks and Control of Substances Hazardous to Health (COSHH) assessments.

Information Management

The service enthusiastically collected reliable data and scrutinised it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

There were systems in place for the safe storage, circulation and management of electronic and paper-based records such as patient records, audit records and meeting minutes. Patient records were accessible to staff and stored securely.

Staff completed general data protection regulation (GDPR) and confidentiality training as part of their mandatory training. The CEO and registered manager was the information governance lead and was responsible for reporting to the Information Commissioner's Office (ICO). The clinical service manager was the Caldicott guardian.

Staff could access information such as policies and procedures in paper and electronic format. The policies we looked at were version-controlled, up to date and had periodic review dates.

The hospice had invested in creating meaningful live information dash boards to support meeting their ambitions of care. This was just part of the measures undertaken by leaders to understand and analyse all information available to them to understand and consistently improve the service.

Engagement

Leaders and staff proactively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They sought out collaboration with partner organisations to help improve services for patients.

The hospice proactively engaged with patients, carers, family members and clients in a variety of ways including, informally, patient surveys, feedback forms and community events. Information was reviewed with themes and trends identified to improve the service where this was indicated. Feedback was overwhelmingly positive. They also participated, contributed and led on system wide meetings and task and finish groups to improve the palliative care offer and support the NHS. For example, they were contributing to, 'Ambitions for Palliative and End of Life Care: national frame work, Delivering Outstanding Care. Other examples included, Hospices Together, which is a provider collaborative.

The hospice was attending the local and regional, care, faith and social enterprise assembly (VCFSE) feeding into the integrated care board. They were also part of the Lancashire and South Cumbria Clinical Network and ICB Strategic Hospice Forum aimed at delivering sustainable palliative and end of life care across Lancashire and South Cumbria.

In addition, the hospice had a "Pendleside Together" group with, terms of reference and a committee, to seek out the voice of patients, families, local community and health and social care professionals. The group meet quarterly and produced reports with agreed action plans for any potential improvements which fed into the overall feedback. For example, the hospice undertook a survey 'Rate my Plate', following comments about food. Small feedback forms were put next to meals and feedback invited. The overall score was positive. Despite this any comments that indicated anything could be better was shared with the kitchen. An additional survey was undertaken to understand patients night time experience on the ward following feedback about noise on nights. Again, this was reviewed and acted on.

The hospice also undertook a volunteer survey (2021) which overwhelmingly showed all volunteers felt proud to work at the hospice, reported a great sense of purpose and achievement, were happy being a volunteer and most all volunteers felt valued and would recommend it as a place to volunteer. Regular events were held for volunteers throughout the year to thank them for their valued support.

The hospice had a volunteer representative group with volunteer representatives across the service. Members of the committee had been involved in the review of the volunteer policy, mandatory training, volunteer guides and recruitment processes.

The hospice also employed a community engagement officer who had recently been awarded the national accolade of inclusivity champion by Hospice UK out of all hospices nationally.

We saw evidence of routine formal and informal engagement with stakeholders, commissioners and other healthcare providers as part of local and regional integrated care systems and regional palliative care collaboratives. The hospice was actively looking at ways of engaging with ethnic minorities and was working with other organisations to achieve this.

The hospice also held regular public engagement events attended by members of the general public and local community representatives to promote the service.

The service actively engaged with staff with an annual staff survey, team meetings, bulletins and a face group page to ensure collective participation in the planning and delivery of services and shaping of the culture.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had an exceptional understanding of quality improvement methods and the skills to use them. Leaders actively encouraged and innovation and participation in research to improve the end of life offer across the system.

The hospice had been awarded Burnley Employer of the Year 2022, a local business award and short listed in the 'Not for Profit and Employer of the Year Red Rose Business Awards 2023 for Lancashire. In 2022 they received 'highly commended' awards in both categories.

The hospice facilitated a 'board away day' to look at the strengths of their trustees and identify any areas that could be improved. This was said to be very successful and had improved overall accountability and understanding at all levels.

Outstanding ☆

Hospice services for adults

The hospice had used research and evidence to procure the introduction of a portable bladder scanner at the hospice providing enhanced symptom control and preventing admission to hospital.

The hospice also had developed competency of staff to undertake intravenous infusion, intra venous antibiotics and tracheostomy care for patients to enable them to be discharged from hospital to the care of the hospice. There were plans to develop this competency further.

A new position had been advertised to employ an admiral nurse specialising in dementia to complement and enhance the hospice offer.

As part of the hospice strategy 'to build a compassionate community involving, influencing and working in partnership with all stakeholders to enhance palliative and end of life care', the hospice undertook a homeless project. This has enabled them in partnership, to raise the profile of palliative care services and the challenges for the homeless & vulnerably housed community with accessing these services. It has also increased the confidence in other organisations to support vulnerable groups with support from the hospice and a multidisciplinary approach. The hospice wrote a new policy and reviewed addictions in relation to end of life care following a regional university review of a substance misuse policy. The policy promoted looking holistically at patient needs. This policy was sent back to the university and is now shared on the hospice UK website.

The hospice had established a meals on wheels service for anyone in the geographical area who may benefit from it and not just those using the hospice services.

A sustainability group had been developed and was working on improvements that could be made to reduce the hospices impact on the environment which was shared with staff in the weekly bulletin.

The hospice had implemented digital transformation with live dash boards creating live collection of data and oversight of the service which had enhanced and improved data collection and reports to monitor and improve the service.