

# Wakefield Hospice Company

# Wakefield Hospice

## Inspection report

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## Ratings

### Overall rating for this service

Good 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Outstanding 

Is the service responsive?

Good 

Is the service well-led?

Good 

## Overall summary

This inspection was carried out on 29 and 30 October 2014 and the inspection was unannounced. We previously visited the hospice on 19 September 2013 and we found that the provider met the regulations that we assessed.

The service is registered to provide nursing care, including transport services, triage and medical advice provided remotely. The hospice has 16 in-patient beds

and we were told that occupancy levels were usually between ten and 12 patients. Accommodation is provided in eight single rooms and two single-sex, four-bedded bays.

The provider is required to have a registered manager in post and on the day of the inspection there was a manager who had registered with the Care Quality Commission (CQC) in January 2011. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

# Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us that they felt safe whilst using the hospice. There were sufficient numbers of clinical and non-clinical staff on duty and staff were well supported by doctors and consultants. Staff had been recruited following robust policies and procedures that ensured only people suitable to work with vulnerable people had been employed. Staff had undertaken training on safeguarding children and adults from abuse and other training that provided them with the skills to carry out their role safely and effectively.

The management of medicines was safe and people told us that their pain was being well managed. Patient's nutritional needs were met and they told us that they were offered choices and that they could have snacks outside of meal times and during the night.

People's individual circumstances and lifestyle had been taken into account when their care or treatment plan had been devised. In addition to this, people who were important to the patient had been consulted. Relatives and friends were able to visit the hospice at any time; they told us that they were always made welcome.

People told us that their privacy and dignity was respected by staff and that they felt staff really cared about them. Relatives also told us that they were also well supported; this included the bereavement counselling service. Health care professionals who we spoke with described the bereavement counselling service provided by the hospice as being very effective.

Liaison with other health care professionals was described as being effective, including the plans for patients to be discharged home.

There were clinical governance systems in place that monitored people's satisfaction with the service and ensured that the policies, procedures and practices in place were followed so that people received the service they needed. Staff told us that they were well supported by the hospice and that their views were listened to.

The service was responsive to people's needs and continually looked for ways to improve. They had taken part in pilot schemes that were aimed at improving care and treatment for people with chronic illness or who were recovering from illness, and had introduced a variety of support groups for people and their relatives / carers.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service provided by the hospice was safe.

There were sufficient numbers of staff, both nurses and non clinical staff, to ensure that patients received their care and treatment in a timely way. Doctors were either present at the hospice to support staff, or 'on call' over a 24 hour period, seven days a week.

Staff had been recruited following robust policies and procedures, and were clear about their responsibility to promptly report any concerns or abusive behaviour.

There were robust systems in place for the management of medicines.

Good



### Is the service effective?

We found staff were provided with the training needed to carry out their work safely and effectively. This included learning about mental capacity and recognising people's rights.

Liaison with other health care professionals were effective, including the arrangements made for patients to be discharged home.

Patient's nutritional needs were met and efforts were made to ensure patients received ample hydration. Patients had a choice of meals and special diets were catered for. Patients were aware that snacks were available outside of mealtimes.

Good



### Is the service caring?

The hospice was caring.

We only heard compliments about the staff and the care. We found that staff displayed warmth and compassion and a genuine desire to care for patients.

Patient's privacy and dignity was respected by staff and patients could put a sign on their bedroom door to indicate they did not wish to be disturbed.

Patients were encouraged and supported to make decisions about their care and given time to make their own choices; this included their end of life care. Patients told us that their treatment meant they were free of pain. The hospice provided a bereavement service to patients families and this support was not time limited.

Outstanding



### Is the service responsive?

The hospice was responsive to people's needs.

Patient records included information about life histories and family trees; this ensured that staff knew about patient's individual lifestyles, wishes and needs.

Efforts were made to meet patient's specific wishes, including taking them out to significant events and providing special food and drink.

In response to demand, the hospice had initiated drop-in sessions within the Day Therapy Unit. People could access a variety of therapies and were able to arrange to meet health care professionals during these sessions.

Good



# Summary of findings

## Is the service well-led?

The hospice was well-led.

There was an experienced registered manager in post who people described as approachable, and who clearly knew the staff and the care and treatment patients were receiving.

Managers and staff carried out regular checks on how the service was operating and the Board of Trustees was updated continually. The hospice consulted with patients and others to get their views about their satisfaction with the service provided.

There had been various initiatives to provide services when gaps had been identified and this had resulted in an improved service for patients and other people who used hospice services.

Good



# Wakefield Hospice

## Detailed findings

### Background to this inspection

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

The inspection was carried out on 29 and 30 October 2014 and was unannounced.

The inspection team consisted of an Adult Social Care lead inspector, two Adult Social Care second inspectors, a pharmacy inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had

received from other stakeholders. On this occasion we did not request a provider information return (PIR) from the registered provider. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

On the day of the inspection we spoke with ten patients who were using the in-patient unit and the day service, four relatives or friends, five members of staff, the director of clinical services and the registered manager / chief executive officer. We spoke with a further three people after the inspection; a member of the service user group and two health care professionals.

We spent time observing the interaction between patients who were staying at the hospice, relatives and staff. We looked at all areas of the hospice, including bedrooms (with patient's permission) and office accommodation. We also spent time looking at records, which included the treatment records for four patient's in the in-patient unit, staff records and records relating to the management of the hospice.

# Is the service safe?

## Our findings

We observed on the day of the inspection that there were sufficient numbers of staff on duty to respond promptly to meet patient's needs. The registered manager told us that agency staff were not used, as the hospice had their own bank staff. The patients we spoke with told us that staff responded to call bells promptly, including during the night. One patient said, "They respond immediately" and another told us, "They usually come straight away and if they are busy, they come and tell you that they are busy and will be with you as soon as they can."

Staff told us that there were six staff on duty in the morning (three qualified and three unqualified), four staff on duty in the afternoon / evening (three qualified and one unqualified) and four staff on duty overnight (three qualified and one unqualified). The registered manager told us that they were in the process of recruiting additional night staff. On occasions this had caused staffing levels to fall to three during the night. If this had occurred, no admissions had been accepted during the night to ensure that staff were concentrating on caring for the people who were already an in-patient at the hospice.

The registered manager told us that occupancy levels were at 70% but that staffing levels were based on full occupancy. However, the hospice had recently made the decision that they would take referrals over a 24 hour period on seven days a week. They anticipated that this could increase occupancy levels to 100%. The hospice currently took referrals from hospital consultants, GP's and clinical nurse specialists. The exception to this was during the night, when they might take a referral from a district nurse.

On the day of the inspection we saw that there was a mix of staff on duty, including nursing sisters and health care assistants, and that these staffing levels were being consistently maintained. The registered manager told us that there was a doctor on duty each day, Monday to Friday, and a doctor on call overnight and at weekends. We saw a copy of the rota for the month of October 2014 and saw that the names of the doctors on duty during the day and the names of the on-call doctor were recorded. A list of the home and telephone numbers for each doctor was attached to the rota so that staff could easily access telephone numbers if needed in an emergency. Two consultants were responsible for overseeing the duties of

medical staff; the registered manager said that they supervised the doctors and were in daily contact with the hospice. In addition, both consultants aimed to attend the weekly multi-disciplinary meetings.

We saw that there were staff recruitment policies in place. The policy on Disclosure and Barring Service (DBS) checks recorded that a DBS check should be in place prior to a person's start date. If this was not possible, the person would not be allowed unsupervised access to vulnerable people until the necessary disclosure checks had been received and seen to be satisfactory. A member of staff told us that some posts did not require staff to undertake a DBS check, such as administrative posts. However, we noted that the policy did not clearly define which posts these were. Also, we noted that the policy still referred to Criminal Records Bureau (CRB) checks and these have been replaced by DBS checks.

We checked three staff personnel files. These included a completed application form, interview questions and responses, education and training certificates, ID (including photographic ID), two employment references and evidence that the person was physically fit to carry out their role. These were recorded on an employment checklist. We saw that, when all of the required checks had not been received, people had not commenced work at the hospice.

Child protection training was considered to be mandatory training by the hospice, although we noted that adult protection was not included on the list of core training modules. However, we saw some training materials that indicated adult protection was included in this training, and this was confirmed by the staff who we spoke with. Staff were clear about their responsibility to promptly report any concerns or abusive behaviour and to whistle blow poor practice. Any safeguarding alerts that had been submitted by the hospice were retained with patient records.

Every patient we spoke with told us that they felt safe and a relative told us that they had never seen anything at the hospice that concerned them. We saw that one patient's bed was pushed against the wall so that they were not able to get out of bed at that side. There was a sensor mat on the other side of the bed that alerted staff if they got out of bed. The director of clinical services told us that had been

## Is the service safe?

agreed with the patient, as they could not walk safely when unaccompanied. This allowed the patient to get out of bed when they wished, but the risk was alleviated as staff were able to be with the patient quickly to assist them.

Accidents and incidents were recorded in detail and analysed. This information was included for discussion in the quarterly clinical governance incident reporting and the health and safety committee meetings. Health and safety checks of the premises were conducted during monthly 'walk rounds' undertaken by the registered manager.

We saw there were clear notices within the premises for fire evacuation and fire exits were kept clear. The fire officer had made an unannounced visit earlier in the year and the registered manager said the outcome of the visit was satisfactory. Fire extinguisher appliances had recently been serviced and assessed to be in working order. However, the most recent fire risk assessment was dated 2008 and was due to be updated.

We found that medicines were safely handled. We spoke with hospice managers, two doctors and two nurses. Staff we spoke with were knowledgeable about their patients and could clearly describe the approaches being used to improve individual patient symptom control. One patient told us, "They closely monitor my drugs and I feel I am involved with decision making and my confidence has increased since coming here."

In common with many hospice's some licenced medicines were used in a different way to help relieve symptoms; this is described as 'off licence'. This was explained to patients in a hospice leaflet and by hospice staff.

We observed part of the lunchtime medicines round. Medicines administration was completed by two nurses. The nurses took time to ask patients how they were feeling and to observe if patients were experiencing any problems with taking their medicines. One patient had recently arrived at the hospice; nurses explained that the doctors were reviewing their medicines and checked that the patient was not in any pain. A relative of a second patient

explained how much better their relative was since the hospice had reviewed and changed their medicines. We saw that all medicines were safely stored and that patient consent was obtained before any medicines were disposed of.

A doctor showed us how information about people's medicines and healthcare needs were shared and assessed prior to and on admission to the hospice to help ensure their needs would be met. All medicines were prescribed by hospice doctors and administered by experienced nurses. Nurses completed annual medicines competency assessments and up-to-date medicines information and reference sources were available to staff.

The hospice had informal arrangements in place with a local hospital pharmacy for medicines supply, including a full medicines out-of-hours service. Telephone pharmacist support and advice was also provided by the local hospital but weekly involvement of the specialist pharmacist in the hospice multidisciplinary team meetings had recently stopped. This meant that there was less pharmacist support and advice about the safe, effective use of medicines for individual patients. We noted that the responsibilities of the pharmacy service had not been agreed under a service level agreement.

The discharge nurse spent time with patients and their families explaining their medicines before they left the hospice and all patients were provided with a contact number should they have any queries about their medicines after discharge.

We saw that all areas of the hospice were visibly clean and free from odours. Staff used personal protective equipment (PPE) where appropriate and there was a plentiful supply of antibacterial hand sanitiser for people, staff and visitors to use. Visitors were seen to routinely use this on arrival and exit, minimising the risk of infection. Cleaning staff were seen to be engaged in frequent routine cleaning tasks during our visit.



# Is the service effective?

## Our findings

We saw that staff training was monitored on a regular basis. Each member of staff was given a training needs analysis questionnaire and the results were collated within each department. The analysis document recorded, "The above results will be discussed with the two ward sisters and an action plan will then be formulated." This work was on-going. The management team told us that the training provided by the hospice met the National Institute of Health and Care Excellence (NICE) guidelines.

Staff who we spoke with told us that they were happy with the training opportunities provided by the hospice. We spoke with a member of staff who worked in the education facility; they were a specialist in palliative care and end of life care. They told us that there was an electronic system that tracked all individual training activity and we saw this on the day of the inspection. They said that mandatory training consisted of manual handling, safeguarding (e-learning), the Mental Capacity Act (MCA) and first aid / cardio pulmonary resuscitation (CPR). They told us that nine clinical staff had attended training on CPR on 17 October 2014. They explained that the period from 2.00 to 3.00 pm was devoted to education for clinical staff; this was confirmed by some of the staff who we spoke with. The registered manager told us that all staff were expected to attend refresher training annually.

We checked the records for four clinical staff and these evidenced that they were working from Level 5 (competency) to Level 6 (proficiency). Topics included in training were symptom management, medicines management, syringe drivers, blood transfusion and palliative care. A competency framework had also been developed for non clinical staff and we checked two files for non clinical staff that showed records of the training they had completed.

The hospital physiotherapist provided moving and handling training for staff, including the use of hoists and other mobility equipment. This was provided to new staff, with an annual update.

A healthcare professional who we spoke with told us that they had attended training sessions at the hospice. They said that the lectures were 'very current' and that hospice staff took part along with people outside of the hospice; they described them as being very skilled.

The hospice was well supported by volunteers and we saw they were enthusiastically involved in their roles. One volunteer described themselves as 'only a volunteer', yet they were seen to have an integral part of the teamwork within the hospice. Each head of department was responsible for the volunteers in their unit / area and training was provided for volunteers.

We observed a weekly meeting that was held to discuss the needs of patients who used the service or may be in need of the service. Staff shared good practice information with the visiting MacMillan Team Palliative Care Team Leader, which illustrated the effectiveness of the service. For example, how people's end of life wishes had been achieved and how the service facilitated follow-up care for families. It was clear from the discussion that staff were very knowledgeable about patient's clinical and social needs. This meant staff effectively provided for and anticipated people's changing needs.

The registered manager told us that, when people were first referred to the hospice, they contacted their GP to confirm the details of the person's diagnosis. She also said that Macmillan nursing was a separate service but that they worked closely with them.

The hospital employed a qualified bereavement counsellor, an art therapist, a physiotherapist, an occupational therapist and a social worker and we saw that patients could make appointments to see these professionals during the drop-in sessions. One patient told us that they could have access to health care professionals whenever they wanted, such as the counsellor and the doctor. Another patient who was visiting the drop-in service said, "I can see the social worker or the doctor if I want to."

One person told us, "My sore areas are treated every day, they deal with discomfort straight away." Another patient told us, "Since I came here from another service, balls have started rolling. My therapy and pain management have improved and I am less worried now, less anxious. I can see light at the end of the tunnel."

We spoke with the MacMillan Team Palliative Care Team Leader, who told us there was strong cohesive partnership working between their team and the hospice and as a result, care of patients was highly effective. They gave praise for the way in which the hospice communicated with their team to meet patient's needs. The registered manager acknowledged that the hospice could not be specialists in



## Is the service effective?

every area and told us that they linked with the local NHS hospital for advice / appointments for people with diabetes, chronic obstructive pulmonary disease (COPD) and Motor Neurone Disease. We were told that referrals were made to health care professionals outside of the hospice when needed, such as to the speech and language therapy service (SALT).

The hospice employed a specialist nurse (family care) who coordinated all discharges; discharge letters were sent electronically to the patients GP and other health care professionals. A GP who we spoke with told us that they received discharge summary letters on the day before discharge or on the day of discharge and that these were very helpful, as they also included any changes in the patient's medication. Another health care professional told us that the discharge planning officer always rang them to discuss a patient's discharge from the hospice.

People's nutritional needs were assessed and there was evidence people had been offered regular drinks. For example, daily notes stated "Encourage fluids" and "Regular hydration offered". One patient's record stated they liked to eat sweets and use mouthwash to help them feel hydrated. Another patient's record showed they liked 'lemonade pop' to quench their thirst.

We saw patients were supported to eat and drink according to their individual needs and preferences. On the day of the inspection, we saw patients were asked what they would like to eat and drink and had meals in their rooms, brought to them by staff.

We saw staff updated the cook with people's choices and they discussed alternative ideas for people who did not have much appetite. Staff made suggestions to help people decide what they might like if they did not want what was on the menu. The hospice had achieved the Gold Eatwell Award in 2014 for healthier choices and good standard of food hygiene. All establishments that gain the award had been assessed by Wakefield Council environmental health and the food and health team.

We spoke with the cook, who told us they tried to accommodate people's wishes at all times. A whiteboard in the kitchen was updated regularly with people's individual dietary needs listed clearly. The cook said if people slept through a meal time or did not want their meal, an alternative was always available and freshly made, such as an omelette. The cook told us people could have food and

drink at any time of day or night. We spoke with one person who told us they were very happy with the quality of the food. They said: "I don't always feel up to eating, but that's not because of the food, that's just how I feel. The food is lovely, but if I don't want it they'll [the staff] bring me a sandwich or something. I know I can have anything at all, both to eat and to drink." One person said that they had a sore mouth and they told us, "They will cook me anything" and another person said, "It's like a hotel. Care is second to none. I asked for coleslaw and they made it straight away."

We saw there were laminated notices in people's rooms to inform them they could ask for something to eat and drink outside of meal times. This had been implemented following a survey in which it had been identified not all people were aware of this. We saw people had drinks within their reach and staff regularly offered people drinks throughout the day. People also told us that staff would make them a snack during the night if they wanted one.

We saw that training on nutrition and hydration were included on the list of core training modules for nursing staff and health care assistants. In addition to this, dysphagia was also on the list of core training. This meant that staff had received training that would assist them to recognise when people were at risk of malnutrition or swallowing difficulties.

We saw four people's care records and saw people's mental capacity had been discussed and assessed. Staff told us there was a flowchart used where people's mental capacity fluctuated so that decisions could be made in the person's best interests. We saw people had nominated family members to help them make decisions where they were unable to do so. It was clear from people's care records consent was sought for all aspects of their care. Where treatment or support was refused, the relevant discussion was documented and retained in the person's care record.

We saw that staff attended a study day on the Mental Capacity Act; this was considered to be mandatory by the hospice. We saw that this training explored issues in respect of capacity and the role of Independent Mental Capacity Advocates (IMCAs). These are independent professionals who can help people with decision making when they are not able to make decisions for themselves and do not have representatives do help them with decision making. In addition to this, we saw that guidelines about Deprivation of Liberty Safeguards (DoLS) were on display and available to staff.

## Is the service effective?

They said that staff dealt with some difficult situations and had undertaken training on communication skills, advanced care planning and mental health / capacity to assist them in managing these situations. The hospice also held de-briefing and reflection sessions each week, led by

the hospice social worker. They looked back on difficult family situations and poor outcomes of death, for example, emotional distress and looked at strategies to support doctors and nurses.



# Is the service caring?

## Our findings

A GP who we spoke with told us that hospice staff focussed on providing good nursing care. Staff demonstrated they were very caring in their approach and delivery of the service. We found there was a genuine care for people, illustrated by staff who showed warmth and compassion. For example, we saw staff spent time with one person, patiently speaking with them and using reassuring body language and facial expression. Staff engaged in friendly banter with people where appropriate; one person told us: "They make me smile, it does me good." Another patient told us 'caring' was not a good enough word to describe the staff. They said: "They are just fantastic. I would give them 110% for how much they care." A relative told us, "I have nothing but praise for the service."

We observed quiet and pleasant interactions between staff and clients. We saw staff were observant without being intrusive when people were trying to rest. We were told by one client's relative that staff are intuitive and caring. They told us "(My relative) gets upset naturally at their condition and sometimes takes it out on their spouse. One such time, the nurse came to help (my relative) and sent us out of the room. She calmed (my relative) and when the nurse came out of the room to us, she lightened the situation, without taking sides, in an understanding way."

Patients and relatives who we spoke with had nothing but praise for all of the staff at Wakefield Hospice. One patient said, "(The staff) are skilled and very patient" and another told us, "I have a sore mouth and the nurse offered me a mouth spray, without me asking." A member of the service user group told us that the staff had the right kind of skills to work in a hospice, including their communication skills when speaking with patients and relatives.

The service was highly supportive of families who were bereaved and offered follow up contact, counselling and support. Staff were sensitive to families' individual circumstances. The director of clinical services told us the bereavement support co-ordinator made sensitive contact with families at intervals following their bereavement. She explained support was always individually needs led and there was no time limit for families to access this. A GP who we spoke with told us that the hospice provided excellent

support to families as well as patients. They said that the social worker, nurses and medical staff (including consultants) were willing to speak to family members to provide advice and support.

There was no named dignity champion within the service, although the registered manager told us all staff were up to date with best practice about people's rights to dignity and privacy. We saw staff were respectful of people's privacy at all times. Staff knocked on patient's doors, waited for an invitation to come in before entering and explained why they had come in. For example, we saw one staff member say, "Sorry for disturbing you, I wonder if you would like a drink or if there is anything you need?" We saw there was a 'patient time out' notice available for people to put on their doors if they did not want to be disturbed. One patient told us, "My dignity has been restored since I came here" and another said, "I cannot believe how good they are. They want to do it (the job). They treat me with dignity – they draw the curtains round." We saw that bedrooms had plenty of room and curtains around their beds to ensure privacy and dignity.

The hospice's patient information leaflet recorded, "If you would prefer to have a nurse of the same sex as yourself to give you personal care, or chaperone you during intimate procedures, please make a member of the nursing team aware and we will endeavour to comply with your wishes." This evidenced that it was made clear to patients that staff understood both their rights in terms of diversity and equality and for their need for privacy and dignity to be respected.

Patients were encouraged and supported to make decisions about their care and given time to make their own choices. We observed staff encouraged this by saying, "It's up to you, you decide".

We asked patients if they were consulted about their care and treatment. One patient told us, "We've talked about everything, I'm in charge for the first time in my life." A patient and their spouse told us, "They listen, they respond, we feel involved with everything. They are angels, they care, they are absolutely brilliant and they have all the time in the world for us." Other comments from patients were, "Nothing is too much here, people listen, my daughter has been involved with my care. Staff are gentle, really



## Is the service caring?

professional and there are enough staff” and “I was scared about the word hospice. I didn’t realise that people come here who don’t have cancer, they have restored my quality of life.”

A health care professional told us that patients who had attended the hospice for respite care had been happy to return. They felt that this indicated the treatment and support they had received was good. They also said that family members had told them that they were consulted and felt very supported.

There was a ‘dream tree’ in the entrance for families to record and place happy thoughts and we saw this was full of hopeful and positive comments which reflected the caring ethos of the hospice.

We asked patients and their relatives if they were involved in decisions about their end of life care. One patient told us, “I am involved with decision making. I asked for honesty and they are honest. I can talk to anyone about my concerns, the staff are lovely, you can’t fault them. When I need them (in the night), they come, just like that. Since coming here, nothing worries me, it’s perfect, no-one snaps at me and they are marvellous.” A health care professional said that, if people were at the end of their life, hospice care was the most appropriate environment in catering for these needs. They said that Wakefield Hospice provided a very valuable service.

We saw a record that would be included with patient details when a person was on end of life care, although

there was nobody at the time of our visit with such a record on file. This record included information for the person and their families about what to expect and how the hospice would support their care at the end of their life. The plan contained information and a flowchart that was in keeping with the Mental Capacity Act 2005. There was also a leaflet for families about what they could expect in the person’s terminal phase of life and how the hospice would meet their needs.

All the patients we spoke with said they were not in any pain and that their pain was well managed. We saw a copy of a specific end of life care plan; this was a plan that was used by a number of hospice services. The plan included a copy of the patient charter for the care of the dying, and consisted of a clinical initial assessment, an individualised end of life care plan, medical review forms, care plan evaluation forms plus directions for staff (in the form of a flow chart) for treating specific conditions. These included respiratory tract secretions, nausea and vomiting, terminal restlessness/agitation and the management of seizures. Patient’s pain assessment was done regularly through the day and night and pain relief was recorded when given. One patient told us, “I’m not in pain, I am comfortable” and another said, “They respond to needs and explain everything in a way that we understand. They talk in a way that we can understand because we don’t know about drugs.”

# Is the service responsive?

## Our findings

Staff made frequent reference to patient's care records and during our visit we saw these were used as working documents. We looked at four patient's care records and found there were clear plans for how patient's individual health and care needs were met. We saw staff made updates to these as they carried out people's care. We also noted that the topic of 'personalised care planning' was a core training module for both nursing staff and health care assistants.

Nursing assessments were documented on the patient's day of admission and included mental capacity information and individual risk assessments for each aspect of care. Patient's religious and spiritual needs, life histories and family trees were completed; it was evident through observing the weekly meeting staff knew this information well. Care plan notes were updated regularly and in detail. For example, where patients had pressure care areas these were assessed and a pressure ulcer management chart was implemented. Treatment was noted daily in care records such as creams and dressings. Where a patient refused pressure care this was documented.

Whilst care records were kept up to date, we found some minor aspects of documentation that lacked clarity. For example, one person had a 'Do Not Attempt Cardiopulmonary Resuscitation' form in their file, yet there was no review date on this. Another patient's property disclaimer was unsigned, and on one patient's 'advance care planning' some questions were marked as 'ask again later' but it was not clear if this had been followed up. On one patient's core care plan for pressure care area the person's consent 'yes/no' section was not completed. This could have resulted in staff not having up to date information about patients and could potentially have affected the care they received.

We saw that visitors were made welcome and were free to visit at any time of day or night. A relative told us, "As soon as you come through the door, you feel welcome; there is a lovely sense of peace."

We asked the registered manager if they had been able to meet people's specific wishes. She gave us examples of how they had taken people out to special events, organised

events in the hospice and how they had provided special food and drink for people. This indicated to us that staff "Went the extra mile" to meet people's needs, especially when they were close to receiving end of life care.

We asked a patient what they liked to spend their time doing and whether they could do it at the hospice. They said that they liked bingo and they could play it at the hospice. Another person told us that they could go out for a walk if they wanted to.

The service included a Day Therapy Unit where there were twice weekly drop-in opportunities for patients living in the community to access activities and support. The hospital employed a qualified bereavement counsellor, an art therapist, a physiotherapist, an occupational therapist and a social worker and we saw that people could make appointments to see these professionals during the drop-in sessions. The drop-in drop facility provided a calm and welcoming environment where chronically ill patients could meet others on a regular basis. Patients could 'tap into' the support and activities offered and access therapies such as massage. We spoke with three patients in this room who had been taking part in an art activity. One patient said, "The support I receive here has helped me a lot. The staff are second to none and I can forget my troubles when I'm here."

Various therapies were available at the drop-in service. These included complementary therapies / relaxation, music therapy, art and craft therapies. The registered manager told us that this service was very successful and they often had approximately 25 people attending at various times of the day. She felt that this was because the service was informal; people could call in any time that suited them, and take part in any activity of their choice.

The registered manager told us that the hospice also operated a 24/7 advice line for patients, professionals and carers. Staff had attended workshops on 'active listening' so were able to offer bereavement support to relatives. However, more expert support was provided by a team of specialists in palliative care. If relatives experienced a 'complicated' bereavement, they could be referred to a psychologist or psychiatrist if they were felt to need this level of support. The bereavement service offered within the day therapy unit was available from 1.00 – 7.00 pm. This allowed people to visit the unit after work if this was more convenient. One group was specially for younger people who had been bereaved and another was for pre-grief

## Is the service responsive?

work. One person who we spoke with said they had attended for bereavement counselling and that the service was excellent. They said, “Staff are very good listeners.” This indicated that the hospice had responded to the needs of patients and their families by providing support for friends and relatives and for people following bereavement, as well as in-patients.

The chief executive officer told us there had been no complaints received since 2011 and records we looked at verified this. However, they had been aware of one family’s dissatisfaction with the care of their relative, yet had not regarded this as a complaint and therefore not applied the complaints procedure. However, the chief executive officer told us that they had held meetings with this family in an attempt to resolve their concerns.

We saw the hospital’s complaints leaflet. This gave the names of people who were responsible for particular areas of the hospice so that people could complain to a named person, and also gave the details of other organisations the complainant could approach, including the Care Quality Commission. One patient who we spoke with said if they wanted to make a complaint they would “Go straight to the staff”. However, they added: “I have nothing to complain about in here.” Two other patients told us that they would not know how to complain, but they had nothing to complain about. One of them said, “Why would I complain anyway when this place is perfect?”

The survey that was carried out with in-patients from July – September 2014 included a question “Do you know what to do if you want to make a complaint?” Two people responded “Yes”, one was not certain and one said “No”. One patient did not respond. However, we saw that the patient leaflet that was placed in each person’s bedroom included information about how to make a complaint, and that there was a specific leaflet about complaints. We noticed the complaints policy had a review date of December 2013, but there was no evidence this had been reviewed.

The hospice website did not have an area where people could give feedback. However, the email addresses of key members of staff were recorded so that people could email them directly. In addition to this, the service user group had their own page on the website and this enabled people to raise a complaint through the service user group.

The registered manager showed us the documents that were used to carry out professional development reviews for staff; they told us that these were carried out annually and were undertaken with non-clinical staff as well as clinical staff. The process required staff to submit a self appraisal form and included a face to face meeting where work related objectives and any training needs could be discussed. The outcome of these meetings had to be agreed by both parties.

However, the records we checked did not include information about up to date appraisals for staff. We checked the records for seven members of staff and saw that two people last had an appraisal in 2011, two people last had an appraisal in 2012 and three people had no appraisals on file. One of the clinical staff we spoke with told us that they had attended an appraisal meeting the previous week and two others said they had attended an appraisal during the last year. This indicated that staff were attending appraisal meetings but the records were not up to date.

Staff said that they could request a one to one supervision meeting with a manager but these were not routinely held. Although staff did not see this as a problem and told us that they were well supported in their roles due to ward meetings, weekly de-briefing sessions, regular training and their annual appraisals, we were concerned that they did not have the opportunity to have a regular discussion with their manager. The registered manager told us that this would be re-considered by the hospice management team following discussion with staff.



# Is the service well-led?

## Our findings

On the day of our inspection managers were very visible in the hospice and we saw they related well to staff. The member of staff we spoke with said managers were approachable and they felt comfortable and confident to question practice or to raise any matters with them.

The registered manager was also the Chief Executive Officer. She told us that she was supported by the Board of Trustees, as were other members of the senior management team. The main board meetings were held quarterly (including discussions about clinical governance) and monthly meetings were held in respect of finances and estate management. The board had an oversight of audits; some of these were undertaken by the registered manager and some were undertaken by other senior staff.

The registered manager told us that all heads of department attended a service governance meeting. If any breach of policy had been identified, this would be discussed at the service governance meeting, including how to prevent the breach reoccurring. This group reported to the management board and the audit and policy group. Information was then cascaded by heads of department to their team. The registered manager told us that all meeting minutes were shared with staff, apart from minutes of board meetings.

The registered manager told us that hospices in the Yorkshire region were independent but collaborated in respect of benchmarking and auditing. The hospice was currently involved in benchmarking programmes for falls, pressure care and nutrition; they were working with other hospices to prepare the data required. The registered manager said that they had never used the Liverpool Pathway, although they had used an amended version. They were working with community, hospice and hospital services regionally to put together a pathway that all services could use. She told us that this would include advice about appropriate hydration.

Hospice UK (previously known as Help for Hospices) is the national charity for hospice care and they work closely with hospice services throughout the country. They recently developed a tool to benchmark patient outcomes, and this information was provided to the local CCG by hospices. This benchmarking recently identified that the figures for pressure care management were slightly higher at

Wakefield Hospice. The registered manager said that they were investigating this and we saw a pressure ulcer analysis that had been undertaken by the hospice on 23 October 2014, plus previous audits. They believed that the figures were higher because they were recording Grade 2 pressure ulcers and other hospice services were not. The hospice had fed back to Hospice UK that it would be helpful for pressure ulcers to be categorised for benchmarking purposes to ensure that all hospices were using the same criteria and would therefore be measured against each other in a more equitable way.

We saw there were many policies and procedures which underpinned the practice within the hospice, but noted these were filed in abundance and it was not clear to see which had been updated and which needed revision. We saw some policies, such as manual handling and complaints, had passed their review dates.

We saw evidence of a variety of audits that were carried out by senior staff. These included audits for end of life care, nutrition, falls, the mental capacity act (MCA) and infection control. They all included details of any improvement actions that were needed. For example, a cleaning audit identified that improvements were needed and various actions had been taken; domestic staff were required to achieve National Vocational Qualification (NVQ) or equivalent Level 2 in Housekeeping, shift patterns were changed so that domestic staff were on duty until later in the day and further training was sourced for the domestic supervisor.

Senior staff showed us that regular audits of the prescription charts and of controlled drug handling were completed. Additionally, they told us that the hospice had also recently enrolled on a national benchmarking audit of medication errors.

We saw that a quality account was completed and submitted to the local Clinical Commissioning Group (CCG). This is not a mandatory quality monitoring tool but the hospice chose to complete it. The quality account for 2013 identified areas for improvement; these included the development of a more robust service user group, improvements to the gardens and the employment of palliative care educator. The registered manager told us that they published this quality account. This was an example of the hospice being open and transparent. We noted that good progress had been made towards achieving these improvements.



## Is the service well-led?

One member of clinical staff told us that they were aware of the strategic direction of the hospice and that there was good team work. They said that they had time to provide quality care to patients and that there was positive medical support. One staff member said, “There is time to provide good quality care for patients – time to be available to do this.” One staff member described the best area of work as being able to admit and follow the patients pathway. Another member of staff mentioned a ‘no blame’ culture and positive management support.

We saw that the information leaflet for patients included the hospice philosophy, the philosophy of care, an organisational structure and an introduction to the staff team. We saw that one of the core training modules was called, ‘Being open’. This showed us that the hospice took openness and transparency seriously and ensured that staff were aware of these values.

We asked patients if the service was well-led. One patient said: “Staff give me their time, the managers obviously plan that. Staff are happy in their jobs, it goes all the way up to management. It’s due to them.” Another person told us, “This place is first class, top quality” and “The place is delightful, we’ve been treated well, my spouse has had first class care.”

We spoke with one member of non-clinical staff who described their role. The member of staff was very enthusiastic and committed to providing a good service for people and their families. They told us they had annual appraisals but no individual supervision. However, they said they felt very supported by their managers to carry out their work and felt management was approachable should they need to discuss any matters at any time. The staff member said they would be happy for themselves or their relatives to receive care at the hospice.

Staff meetings for nurses and health care assistants were not held on a regular basis although ward meetings were held. Meetings for other health care professionals were held; we saw the minutes of a meeting attended by the physiotherapist, occupational therapist and social worker on 2 October 2014 and previously on 31 July 2014.

We saw the outcome of an in-patient satisfaction survey that had been carried out between 1 July and 30 September 2014. Seventeen questionnaires had been sent out and five had been returned. The registered manager told us that they felt this was a low response rate as

questionnaires had been given to all in-patients on their discharge. Four of the five people said that they had been given an information leaflet whilst an in-patient at the hospice and one could not remember. The survey also asked questions about care planning, confidence in staff, individual needs being met and privacy and dignity; most responses were positive. Comments from people included “Hard to improve on excellence” and “Well pleased.” The responses had been collated by the director of clinical services and they had recorded in the action plan, “If response rates continue to drop, to consider other opportunities to obtain feedback from patients.”

Anyone who attended the drop-in service or for bereavement counselling also received a survey. A member of the service user group confirmed to us that they had recently completed a survey.

The registered manager told us that the results of patient surveys were displayed on their website. She told us that changes had been made following feedback received in patient surveys. For example, some patients asked if snacks were available outside of mealtimes. The hospice had ensured that snacks were available in the ward kitchen and had included this information in the patient information leaflet; we saw this on the day of the inspection.

A service user group had been established and monthly meetings were held in the day therapy unit. The leaflet recorded, “The group is for anyone who receives care and support from the hospice – patient, family member, carer or friend using in-patient, drop-in or bereavement services. You have a unique perspective on the work of the hospice and we value your ideas and recommendations.” People were also told that they could put any comments in the suggestion box in reception if they could not attend the meeting.

We saw the minutes of the service user group meeting in October 2014. The topics on the agenda included widening the membership of the group, fundraising and the hospice’s newsletter. This was mailed to all supporters of the hospice. There was a note to record that there were no suggestions in the suggestion box. This indicated that any comments received would have been discussed at the service user group. The minutes of the meeting in August 2014 explained that the Thursday drop-in session was to be changed to a bereavement service, where specialist support would be provided. It was felt that the drop-in service was to support people in coming to terms with their

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own illness, and it might be distressing to come into contact with people who had been recently bereaved. This indicated that people's opinions had been listened to and that issues were dealt with sensitively.

The registered manager told us that they periodically piloted new services at the hospice. For example, there was a 6 – 8 week programme for breast cancer survivors to help them to look forward, when statutory services were no longer involved. A programme for people with end stage

chronic obstructive pulmonary disease (COPD) was piloted by the hospice alongside the CCG and a local hospital. The feedback from patients was positive; there had been fewer hospital admissions and advanced care plans had been put in place. Some of the patients had also attended the day therapy unit at the hospice. Funding was secured from the CCG for a two year period following the pilot. This evidenced that the hospice had identified a gap in services and had taken positive action to meet patients needs.