Springhill Hospice (Rochdale)

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Inspection report

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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?	Good ●
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Good ●

Summary of findings

Overall summary

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

- 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.
- Staff provided emotional support to patients, families and carers to minimise their distress. Staff recognised and respected the totality of people's needs. They always took people's personal, cultural, social and religious needs into account, and found innovative ways to meet them. People's emotional and social needs were seen as being as important as their physical needs.
- Staff saw people, who were approaching end of life, and those close to them as active partners in their care. Staff were fully committed to working in partnership with patients, families and carers to make this a reality for each person.
- 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.
- Patients could access the specialist palliative care service in a way and at a time when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.
- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them 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.
- Leaders ran services well using reliable information systems 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 engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Outstanding ☆	The main service provided at this location was hospice services for adults. We rated this service as outstanding overall, with a rating of outstanding for caring and responsive and a rating of good for safe, effective and being well-led.

Summary of findings

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Summary of this inspection

Background to Springhill Hospice (Rochdale)

Springhill Hospice (Rochdale) is a charitable organisation located in Rochdale, Lancashire and provides a range of hospice services for adults residing in the Heywood, Middleton and Rochdale area who are over 18 years of age and have a life limiting illness.

The hospice is purpose built and provides accommodation on the inpatient ward for up to 16 patients. The hospice also has a specialist palliative care community service, a day therapies service, and a hospice at home service. The hospice also provides a counselling and bereavement service for patients and their relatives. In addition, the hospice offers a 24 hour, 7 days per week telephone advice line for professionals, people who use the service and their families.

The hospice is close to public transport routes and is situated in a residential area of Rochdale, not too far from the town centre. It is set in large well-maintained gardens with adequate parking and clearly defined parking areas for disabled visitors. Services are free to people, with Springhill Hospice receiving some NHS funding and the remaining funds achieved through fundraising and charitable donations.

During the period between April 2022 and March 2023:

- There had been 291 admissions to the inpatient ward. There were 213 patient deaths and 72 patients discharged.
- There had been 734 patients admitted to the specialist community services. The community teams carried out 4,415 visits during this period. There were 531 patient deaths and 163 patients discharged from the service.
- There had been 274 patients admitted to the hospice at home service. The team carried out 1,815 visits.
- There had been 39 patients admitted to the night sitting service. The team carried out 359 night sits.
- There had been 56 patients admitted to the day therapy service.
- There had been 136 patient referred to the bereavement service and 99 patients referred to the counselling service.

Springhill Hospice (Rochdale) has been registered since 1 October 2010. The director of clinical services has been the registered manager for the service since 5 October 2022.

The service is registered to provide the regulated activity, treatment of disease, disorder or injury.

We previously inspected Springhill Hospice (Rochdale) during August 2016. The report was published in December 2016. We rated the hospice as good overall. We rated safe as requires improvement, effective and caring as outstanding and responsive and well-led as good following the inspection. We reported one regulatory breach for Regulation 12 safe care and treatment following the inspection relating to the safe management of medicines. We followed up to check if improvements had been made.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. The inspection was unannounced (the service did not know that we were coming). We carried out the on-site inspection on 4 and 5 July 2023.

During the inspection visit, the inspection team:

Summary of this inspection

- Inspected the day therapy areas, patient quiet rooms, communal garden areas, the viewing room, the cold room and the inpatient ward and supporting areas.
- Spoke with 18 staff, including the ward sister (manager), the quality and development lead, the volunteer coordinator, the community services manager, the medical director, medical staff, inpatient ward staff, therapies unit staff, the maintenance lead (steward), reception staff, the director of finance (company secretary), the psychological and supportive care manager, the chair and the chief executive officer. We also spoke with the director of clinical services (also the registered manager) by telephone following the inspection as they were not present during the on-site inspection.
- Looked at the training and recruitment files for 3 trustees (directors), 7 employed staff and 3 volunteers.
- Spoke with 4 patients and 7 patient relatives in the inpatient ward and day therapy areas.
- Looked at 9 patient records.
- Looked at a 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:

- We found numerous examples to show how staff went the extra mile for patients and their care and support exceeded their expectations. We identified this as outstanding practice.

Areas for improvement

We did not identify any areas for improvement as part of this inspection.

Our findings

Overview of ratings

Our ratings for this location are:

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

Outstanding ☆

Hospice services for adults

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

Is the service safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. The service had a mandatory training schedule which detailed the requirements for mandatory training for clinical and non-clinical staff.

Mandatory training covered key topics such as health and safety, fire awareness, information governance, medicines management, nutrition and hydration, mental capacity, infection prevention and control, equality and diversity, manual handling and adult and children's safeguarding training.

Staff were also required to complete dementia awareness, learning disability awareness and autism awareness training as part of their mandatory training.

Mandatory training for core staff was delivered through face to face training and e-learning modules at least every three years, depending on the training topic.

The hospice had a quality and development lead in place to oversee the mandatory training process. Managers monitored mandatory training and alerted staff when they needed to update their training.

Mandatory training compliance was reported on a rolling annual basis and training for the current calendar year was in progress and due for completion by December 2023. Mandatory training compliance for all staff for the previous full year (2022) was 91.7%, which showed most staff had completed their mandatory training.

The hospice had an aspirational target of 100% training compliance. However, the registered manager reported they were in the process of implementing a formal mandatory training compliance target for future reporting.

Outstanding ☆

Hospice services for adults

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 service 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.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The medical director was the safeguarding lead for the service and had completed children and adults safeguarding training (level 3). The safeguarding lead and the director of clinical services were responsible for the review, investigation and external referral for any safeguarding concerns that had been raised by staff.

Staff had completed training specific for their role on how to recognise and report abuse. The training was in line with current intercollegiate guidance for adults and children. Staff also completed prevent (counter-terrorism strategy) training as part of their mandatory training.

Records showed 95% of eligible medical and nursing staff had completed level 3 adult safeguarding training, 89% of care staff had completed level 2 adult safeguarding training and 87% of non-clinical support and administrative staff had completed level 1 adult safeguarding training.

The service did not provide any care and treatment for patients under 18 years of age. However, staff and volunteers were required to complete safeguarding training for adults and children. Records showed 80% of all staff across the service had completed at least level 1 children's safeguarding training.

The director of clinical services reported that all nursing and medical staff had also completed the 'think family' safeguarding training during the past year, which included elements of both adult and children safeguarding training.

The hospice had reported 5 safeguarding concerns relating in the past 12 months. These were not directly attributable to the care and treatment provided by the hospice and we found staff had taken appropriate actions to protect patients, including referral to the local authority and other health and social care professionals involved in the patient's care.

Staff told us that any reported safeguarding incidents would be discussed as part of routine risk management committee meetings and operational management team meetings to identify trends and look for improvements to the services.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients on wards and transporting patients after death.

The hospice had infection prevention and control policies which provided guidance for staff and the staff completed mandatory infection prevention and control training. The hospice had an infection control lead nurse in place.

The hospice had not reported any healthcare-acquired infections or outbreaks during the past 12 months.

The inpatient ward, sluice room, treatment room, day therapies area and patient and relatives communal rooms and dining areas were visibly clean and had suitable furnishings which were clean and well-maintained.

Cleaning schedules and daily checklists were in place and up to date, and there were clearly defined roles and responsibilities for domestic, housekeeping and ward staff when cleaning the environment and cleaning and decontaminating equipment. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff used alcohol wipes and chlorine-based disinfectant to clean and decontaminate surfaces and equipment.

Personal protective equipment, such as masks, gloves and aprons, were readily available across all the areas we inspected. Clean linen was stored in a dedicated storage cupboard to minimise risk of contamination from air-borne particulates. There were enough hand wash sinks and hand gels. Staff we saw were compliant with hand hygiene and 'bare below the elbow' guidance.

Unused water outlets were flushed regularly to minimise the risk of Legionella. Patients with a known infection could be isolated in single rooms with use of universal precautions signage to minimise risks for staff and visitors.

Staff carried out carried out an infection control audit at least every 12 months to check compliance against national infection prevention and control guidelines and to monitor the cleanliness of the general environment and equipment. The audit included checks for hand hygiene compliance.

The most recent audit was completed in March 2023 and showed the service was compliant with most of the indicators covered by the audit. There was an action plan in place to improve compliance in areas such as completion of cleaning checklists.

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. There was secure access to clinical areas. Patients could reach call bells and staff responded quickly when called.

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 and staff used disinfectant wipes to clean and decontaminate equipment surfaces.

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 and this was overseen by the maintenance lead (steward). 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. Staff told us equipment needed for care and treatment was readily available and any faulty equipment could be replaced promptly. The hospice had access to specialist equipment, such as bariatric equipment or specialist pressure relieving equipment.

Single-use, sterile instruments and consumable items were stored appropriately and we saw these were within their expiry dates. Staff handled, stored and disposed clinical waste (and sharps) safely.

Staff carried out daily safety checks of specialist equipment. The hospice had an emergency defibrillator and this was checked by staff at least once a week.

Outstanding ☆

Hospice services for adults

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 an updated periodically on a weekly basis or sooner if there had been any change to the patient's condition.

The staff we spoke with understood how to identify patients with suspected sepsis, including neutropenic sepsis. Staff told any patients with suspected sepsis would be immediately transferred out to the local NHS acute hospital by emergency ambulance. There had not been any instances in the past 12 months where a patient required transfer to hospital for suspected sepsis.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff knew about and dealt with any specific risk issues. Patients had person-centred care plans in place so they received the right level of care. Staff carried out frequent patient observations so any changes to the patient's medical condition could be promptly identified. We looked at four patient records and these showed that patients were reviewed regularly and escalated appropriately for medical input when required.

Records showed 100% of medical staff and 95% of clinical staff on the inpatient ward had completed basic life support training.

If a patient became unwell and required hospital admission for an acute event that required investigation or treatment that the hospice was unable to provide, then they would be transferred to an NHS acute hospital by emergency ambulance.

Shift changes and handovers included all necessary key information to keep patients safe. Staff also carried out daily safety huddles at the start of the day to discuss key patient risks.

The hospice had fire safety risk assessments 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. The patient records we looked at showed each patient on the inpatient ward had a personal emergency evacuation plan in place and staff told us they carried out routine simulation exercises to assess staff response times.

Nurse staffing

The service had enough nursing and support 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 and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. The areas we inspected had sufficient numbers of trained nursing and support staff with an appropriate skill mix.

Nurse staffing levels were based on the 'safer staffing' acuity tool. 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 managers could adjust staffing levels daily according to the needs of patients. This included putting in place additional staff for patients with higher acuity requiring 1 to 1 care.

At the time of the inspection, the inpatient ward had 9 patients. The staffing establishment on each shift was for at least 3 nurses and 5 nursing assistants on the morning shift, at least 3 nurses and four support staff on the afternoon shift and at least one nurse and 2 nursing assistants on the night shift. The ward also had additional supernumerary staff present such as trainee staff, patient companion volunteers and care staff for 1 to 1 support.

The day therapies service was staffed with 2 registered nurses and a nursing assistant. The hospice at home service consisted of a registered nurse and one nursing support staff that were supplied by the inpatient ward on a rotational basis.

The community service team had 10 specialist palliative care nurses, 2 assistant practitioners (band 4), a physiotherapist, a dementia specialist nurse. The team also had a team of 'night sitter' care assistants that stayed with a patient overnight if required. The team consisted of 3 substantive staff and 4 bank staff.

The hospice had a pool of approximately 70 volunteers that supported the clinical and non-clinical areas (such as fund-raising and gardening support) of the hospice. Volunteers involved in any patient care underwent recruitment checks and had appropriate induction and training . Volunteers provided companionship and provided assistance to patients at the hospice such as during mealtimes and when visiting the garden or other communal areas.

The inpatient ward, day therapies, hospice at home and specialist palliative community teams were fully established with no clinical staff vacancies at the time of the inspection. The ward had recently recruited two newly qualified nurses that were due to commence employment in September 2023. The community services manager told us they had 1.5 whole time equivalent vacancies for night sitting staff and were in the process of recruiting a physiotherapist as a replacement for a member of staff that was due to leave the organisation.

Staff cover for leave and unplanned absences was provided by the existing staff working additional hours and through the use of bank staff. Where bank staff were used, managers made sure they staff had a full induction and understood the service. Bank staff received the same level of training as substantive staff. Managers limited their use of agency staff and requested staff familiar with the service.

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.

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

The team was led by the medical director, who was the responsible officer for the organisation and also worked clinically within the hospice. The medical director was supported by a team of 4 specialist grade doctors that supported the inpatient ward and the community based teams.

There were at least 2 doctors present on site between 9am and 5pm on weekdays and at least one doctor on site between 9am and 5pm on weekends. There was an on-call process for medical cover during out of hours service.

The hospice had one existing medical staff vacancy that had been recruited to, with planned a start date in October 2023.

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

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. Records were stored securely.

Staff used paper-based patient records for recording risk assessments, consent, discharges, care plans, patient assessments, and observations and for daily medical and nursing notes. When patients transferred to a new team, there were no delays in staff accessing their records.

Records for patients receiving community based care were kept within their homes or places and 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 paper-based records for standardised nursing activities, such as for daily vital observations and nutritional care. We saw that observations were well recorded, and the observation times were completed at regular intervals depending on the level of care needed by the patient.

We looked at the records for 3 patients based in the ward, 3 community patients and 3 hospice at home patients. These were structured, legible, complete and up to date. Patient records showed that nursing and clinical assessments were carried on admission to the services. Patient risk assessments were reviewed and updated at least one a week unless there were any changes to patient needs. Multidisciplinary staff interventions were recorded in daily notes and these were up to date.

We found that patient's 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, urinary catheters, smoking management, nutrition and hydration and personal care. The records we looked at included care plans that were up to date and had been reviewed at least once a week.

Staff carried out routine audits of patient records to check for accuracy and completeness. We looked at a selection of patient record audits from November 2022 to June 2023 for the inpatient ward, community services, hospice at home service and counselling service records.

The audits were based on a sample of between 5 and 13 records each. Audit results showed compliance was achieved across most audit indicators, indicating high levels of compliance for accuracy and completeness of patient records. The audits identified areas for improvement such as entries not always being signed and dated and audit records included remedial actions taken such as retraining staff and raising staff awareness.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The community and ward-based staff stored and managed all medicines and prescribing documents safely and securely, in line with the provider's medicines management policies.

We identified shortfalls in medicines management processes during our previous inspection in August 2016. During this inspection we found improvements had been made.

During our previous inspection we found staff did not always escalate correctly when fridge temperatures exceeded the recommended range. We found during this inspection that medicines that required storage at temperatures between 2ºC and 8ºC were appropriately stored in medicine fridges. Fridge temperature logs showed that these were checked daily and the medicines we checked were stored at the correct temperatures. Log sheets also showed that staff monitored the temperature of the clinic room where medicines were stored on a daily basis.

Staff reported that a new fridge had been purchased since the last inspection. There was a system in place for staff to notify the maintenance or pharmacy teams where medicine fridge or treatment room temperatures exceeded the maximum temperature range. The fridge temperature log sheets we looked at showed there had been one instance in the past month where the temperature had exceeded the maximum range and this had been appropriately escalated by staff.

During our previous inspection we found maximum doses and minimum dose intervals had not been stated by the prescriber on four prescription charts for 'when required' medicines. During this inspection, we looked at 5 prescription charts for 'when required' medicines and found the medical prescribers had clearly recorded information around dosage and dose intervals on each prescription chart.

During our previous inspection we found that not all ward staff were aware of the location of emergency medicines and oxygen. During this inspection we found emergency medicines and oxygen were safely stored in the treatment room. Emergency medicines were checked on a weekly basis to check for expiry dates. The staff we spoke with were aware of how to access emergency medicines and oxygen.

During our previous inspection we found there was no log of prescriptions received into the service as set out in national guidance. During this inspection we found the hospice had developed a protocol for ordering, receipt, storage, issuing and retention of prescription pads. Staff completed a log sheet to record when prescription pads were ordered, stored and issued for use and we saw this was complete and up to date.

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 director of clinical services was the controlled drugs accountable officer for the service.

The hospice had an arrangement with an external pharmacy provider for the supply and disposal of medicines. An external pharmacist was on site one day each week to provide guidance and support for staff. The external pharmacist also attended routine medicines management committee meetings.

The hospice used electronic prescribing and medicines administration records on the inpatient ward and paper-based prescribing for community based patients. Staff completed medicines records accurately and kept them up-to-date. The service did not use any patient group directives and all medicines were prescribed by the medical staff and four qualified non-medical (nurse) prescribers.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. We looked at the medicine administration records for four patients and saw these were complete and up to date. Information such as patient allergy status was documented.

Medical gases were appropriately and securely stored in the areas we inspected. The medicine records also showed patients who required oxygen treatment had oxygen prescribed and this was appropriately documented.

Staff carried out a range of routine audits on medicines management processes, including for the storage, administration and disposal of medicines, management of syringe drivers, non-medical prescribers and management of prescription pads. We looked at a selection of recent audits and these showed compliance across most audit indicators had been achieved. Audit records showed remedial actions had been taken where audit indicators had not been fully met, such as staff training and awareness to reduce documentation errors or omissions.

Incidents

The service managed patient safety incidents well. Staff recognised and reported 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

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. All incidents, accidents and near misses were logged on a paper-based incident reporting system. Incidents were reviewed and investigated by staff with the appropriate level of seniority, such as the director of clinical services and the medical director.

There had been no unexpected patient deaths, never events or serious incidents reported by the service during the past 12 months.

A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. The event has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.

The service had reported 348 incidents between July 2022 and July 2023. All incidents were graded as low or no patient harm. Most incidents related to the inpatient ward. The most frequent reasons for incidents were for documentation errors in medicines reconciliation and medicine administration records and for patient falls (with low or no harm).

We saw evidence incident records were completed appropriately and remedial actions had been put in place to minimise the risk of reoccurrence.

The director of clinical services reported remedial actions taken to reduce medicines management incidents included an update of the medicines management policy to provide guidance for staff and additional training for staff. A reflection form had also been introduced so staff could offer any extrinsic factors in the event of medicine errors and to identify any learning for the staff member or team to prevent recurrence.

Outstanding ☆

Hospice services for adults

Staff received feedback from investigation of incidents, both internal and external to the service. The senior managers told us any reported incidents would be reviewed and discussed at daily huddles, routine risk management, audit commitee and operational management team meetings so shared learning could take place. We saw evidence of this in the meeting minutes we looked at.

The staff we spoke with were aware of their responsibilities regarding duty of candour legislation. There had been no incidents reported by the service that met the threshold for implementing the duty of candour.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

The senior managers were aware of their responsibility to report notifiable incidents to the Care Quality Commission (CQC) and other external organisations. There was a system in place to ensure safety alerts relating to patient safety, medicines and medical devices were cascaded to staff and responded to in a timely manner.

Is the service effective?

Good

Our rating of effective went down. We rated it as good.

Evidence-based care and treatment

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

Staff followed 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), Royal Colleges and other bodies such as the North West Palliative Care Audit Group.

Patients had an individualised care plan which, if the patient was at end of life, was supported by the individualised care and communication record for a person in the last days or hours of life. This was in line with NICE guidelines and quality standards, such as QS13 (End of life care for adults) and NG31 (Care of Dying Adults in the Last Days of Life).

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.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. The weekly multidisciplinary safety huddle was attended by bereavement counsellors and chaplaincy representatives to review and discuss patients' spiritual, psychological and emotional needs.

Changes to clinical practice, national guidance and policies were reviewed and developed through routine monthly clinical standards committee meetings and shared with staff.

Policies and procedures reflected current guidelines and staff told us they were easily accessible in electronic and paper format. We looked at a selection of the policies and procedures and these were up to date and based on current national guidelines.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

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 at least weekly. Where patients were identified as at risk, staff fully and accurately completed patients' fluid and nutrition charts where needed.

Patients with specific dietary needs (such as diabetic patients) were identified and routinely monitored by staff. Staff told us could be referred for dietitian or speech and language therapist support if needed. Staff told us dietitians usually responded within 48 hours of referral and were available during routine hours on weekdays.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered. The hospice had menus with options available for patients with specific requirements, such as vegetarian, halal and kosher meals. Staff also offered to cook food for patients that was not on the menu if required.

The assessment of patients nutritional status audit (February 2023) was based on a sample of 5 patient records. The audit results showed compliance across all 10 audit standards had been achieved. This included patients receiving a nutrition and hydration assessment within 24 hours of admission, having a care plan in place and monitoring and nutritional status checks in place.

Pain relief

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

The ward and community staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used pain assessment tools to monitor pain symptoms at regular intervals. Communication charts were used for patients unable to communicate verbally.

Patients received pain relief soon after requesting it. The patients we spoke with told us they received good support from staff and their pain symptoms were appropriately managed during and after their care.

Staff prescribed, administered and recorded pain relief accurately. The records for inpatient and community based patients showed that patients received the required pain relief and they were treated in a way that met their needs and reduced discomfort.

Patient outcomes

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

Hospice services for adults

Outcomes for patients were positive, consistent and met expectations, such as national standards. During the period between April 2022 and March 2023, the hospice reported there had been 599 patient deaths, of which 565 patients had a documented preferred place of death. The hospice achieved the preferred place of death for 525 (92.2%) of these patients. This showed the hospice was able to meet the wishes of most patients who had specified a preferred place of death.

The director of clinical services reported they routinely used the Australia-modified Karnofsky Performance Status (AKPS) scale and Phase of Illness (POI) elements of the Outcome Assessment and Complexity Collaborative (OACC) suite for patients on inpatient ward. The hospice had a plan in place to introduce the Integrated Palliative Care Outcome Scale (IPOS) on the inpatient ward by the end of this year. The OACC a suite of outcome measures that is aimed to measure, demonstrate, and improve care for patients and families.

The counselling team also used specific tools such as patient health questionnaires (PHQ) and generalised anxiety disorder (GAD) to measure patient outcomes.

An audit of IPOS scores for 10 patients from the day therapies unit between November 2022 and February 2023 showed 4 patients had improved outcome scores after using the day therapy services and the remaining 6 patients reported outcome scores which were either similar or lower than prior to using the day therapy services.

The director of clinical services reported they planned to implement a new electronic system by the end of 2023 and conduct staff training to enable them to report outcome measures more effectively.

The service did not participate in any national clinical audits. However, the medical director told us they routinely participated in clinical audits as part of the North West Palliative Care Audit group (NWAG).

The hospice had recently participated in an NWAG audit of pharmacological management of newly diagnosed neuropathic pain. Th audit showed overall good compliance with most indicators in the NICE clinical guideline CG173; Neuropathic pain in adults: pharmacological management in non-specialist settings (2020 update). Audit findings had been presented to staff to aid learning and improvement.

Competent staff

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

Managers gave all new staff a full induction tailored to their role before they started work. Newly appointed staff had an induction for up to 5 weeks and their competency was assessed before working unsupervised. Bank and locum staff also had inductions before starting work.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us they received an annual appraisal including a mid-year review. Records showed appraisal completion for clinical staff was approximately 98% for the current year, which demonstrated most staff had completed their annual appraisal.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The medical staff had specialist training and additional qualifications in palliative care medicine. The counselling team were all registered with the British Association for Counselling and Psychotherapy (BACP). The hospice reported there were no outstanding queries relating to General Medical Council (GMC) and Nursing and Midwifery Council registrations and revalidations.

Managers recruited, trained and supported volunteers to support patients in the service. Volunteers involved in any patient care underwent recruitment checks and had appropriate induction and training prior to working with any patients.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff undertook competency based training and attended specific training and workshop sessions covering a range of topics, such as for wound management, oral care for head and neck cancer patients, medicines management, use of specialist equipment and for patient symptom management, such as pain, breathlessness and advanced care planning and communication.

We looked at the training records for 5 staff from the ward and specialist community teams and these showed they had undertaken induction and routine role-specific training and development. Staff were positive about on-the-job learning and development opportunities and told us they were supported well by their managers.

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 regular and effective multidisciplinary meetings to discuss patients and improve their care. There was effective daily communication between multidisciplinary teams across the hospice. Staff handover meetings took place during shift changes and 'safety huddles' were carried out on a daily basis to ensure all staff had up-to-date information about risks and concerns.

There were routine team meetings that involved staff from the different specialties. The patient records we looked at showed there was routine input from nursing and medical staff and allied health professionals.

There were daily safety huddles to identify and resolve any issues relating to the patient risks and admission, discharge and death of patients. A weekly multidisciplinary team (MDT) safety huddle included medical and nursing representatives from the hospice, including the inpatient, day therapy unity and community services teams as well as physiotherapy, bereavement and counselling and spiritual and pastoral staff. The weekly MDT team was also attended by representatives of the local community, such as social workers and local healthcare service providers (such as from the NHS acute trust).

The ward staff told us they had a good relationship with the medical staff and that they received good support from stewards, volunteers, porters and catering staff. We saw there was effective team working and communication between staff across all disciplines.

Staff worked across health care disciplines and with other agencies when required to care for patients. There was routine multidisciplinary working between the medical staff and external NHS hospital staff and general practitioners (GP's) to discuss the patient's care and treatment. The medical director told us they routinely attended MDT meetings for cancer and respiratory patients admitted to the service. The ward staff and specialist community teams also liaised with a number of different services when co-ordinating patient care. This included GP's, adult social care providers, district nursing teams, hospitals, community services and social services.

Staff told us they received good support from pharmacists, dietitians, physiotherapists as well as the pastoral, counselling, and bereavement teams. The medical director told us they had an arrangement with local NHS hospitals to provide prompt diagnostic support such as for x-rays and scans if needed.

The hospice also had service level agreements in place for a number of services such as laundry services, equipment maintenance and waste disposal.

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 led daily ward rounds on the inpatient ward, including weekends. There was on-site medical staff during routine working hours on weekdays and on weekends, with on-call support available during out of hours service. Patients could be admitted to the ward 7 days per week, including during out of hours service with support from on-call medical staff.

The community specialist teams and hospice at home operated 7 days per week during days, with a night sitter service available for patients requiring overnight support. 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 day therapies unit provided sessions four days per week during routine working hours. The bereavement and counselling teams operated during normal working hours on weekdays.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. The hospice had a range of information leaflets to provide support and advice for patients around healthier living.

Staff assessed each patient's health when admitted to the ward or community services and provided support for any individual needs. Staff told us they routinely discussed health promotion and lifestyle choices with patients. For example, patients identified as being overweight, patients at high risk due to high alcohol consumption or patients that were smokers were given advice and support, including on how to refer or gain access to external NHS services.

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 or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty. However, do not attempt cardiopulmonary resuscitation records were not always fully completed by staff.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff understood how to obtain informed verbal and written consent from patients before providing care or treatment. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. We looked at 9 patient records which showed that patient consent had been obtained and planned care was delivered with their agreement.

Outstanding ☆

Hospice services for adults

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) training was incorporated into the adult safeguarding (level 3) training. The hospice reported there had been one instance in the past 12 months where a Deprivation of Liberty Safeguards application had been made. This related to an end of life care patient living with dementia and staff had taken appropriate actions to safeguard the patient.

We looked at 'do not attempt cardiopulmonary resuscitation (DNACPR) orders' in 5 patient records and reasons for DNACPR order were documented and relevant for the patient. Where patients lacked capacity to make their own decisions, medical staff had completed mental capacity assessments. However, 3 of the records we looked at did not clearly document if discussions with patient's relatives or carers had taken place.

The provider submitted further information following the inspection in relation to these 3 patient records. This information had not been made available or seen by the inspection team during the on-site inspection. However, the additional information from the provider showed that for each of the 3 patients, discussions with patients and/or their relatives had taken place and had been documented within the patient records.

During the inspection, the medical director told us they had identified similar concerns from routine audits and had raised awareness with the medical staff. The medical director told us not all discrepancies were attributable to hospice staff because a significant number of patients had pre-existing DNACPR orders in place at the time of their admission.

A DNACPR records audit in January 2023 the inpatient ward sampled 13 patient records and found they were compliant across most indicators. The audit identified some errors and omissions and action plans were put in place raise staff awareness around documenting discussions held with family members.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The medical staff were trained to carry out mental capacity assessments, in order to determine if a patient had the capacity to make their own decisions. We saw evidence of capacity assessments undertaken in the patient records we looked at and the assessments were complete and up to date.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. If a patient lacked the capacity to make their own decisions, staff told us they sought consent from an appropriate person that could legally make decisions on the patient's behalf.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could seek advice and support from the safeguarding link nurses and the medical director, who was the safeguarding lead for the service. Staff also told us they could seek advice from external organisations such as the local authority safeguarding teams when needed.

Is the service caring?

Outstanding ☆

Our rating of caring stayed the same. We rated it as outstanding.

Outstanding ☆

Hospice services for adults

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

We observed staff across the inpatient ward and the day therapy services and saw patients were consistently treated with dignity, compassion and empathy.

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. Staff followed policy to keep patient care and treatment confidential.

We saw that patients were treated with dignity, compassion and empathy. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. 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 health needs.

We spoke with 4 patients and 7 relatives. They were all overwhelmingly positive about the care and treatment provided. The comments received included "nothing is too much for the staff, they are so welcoming and have done wonders for me", "staff are so helpful, amazing and kind, can't think of anything they can do better", "the care has been absolutely excellent" and "my dignity has been given back to me whilst I have been here".

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 that demonstrated how staff went the extra mile for patients and their care and support exceeded their expectations. This included: -

- A patient had died at home having previously been admitted as an inpatient and was known to staff. Ward staff took time out to personally attend the patient's home and provide personal care so their privacy and dignity could be maintained.
- A patient became unwell and had insufficient medicines at home. Some of the medicines required out of hours medical support which would have led to a delay. The specialist palliative care nurses took some water for injections from the ward and completed syringe driver authorisations ensuring the patient was able to receive their medicines sooner.
- A patient on the ward liked the garden and birds. The gardener ensured the bird feeder outside the patients room was always full and talked to the patient about the various birds it was attracting. The patient's family donated to the hospice to ensure each patient has a bird feeder for the window so other patients could enjoy this as their loved one did.
- A patient told us a member of the medical staff went to hospital personally to deliver patient samples when a porter had been unavailable to avoid delays in their care and treatment.
- The specialist community palliative nurses delivered anticipatory medicines to a patient at home because their relatives were unable to.

Hospice services for adults

Feedback from patients and their relatives was continually positive about the way staff provided care and treatment. Staff sought feedback from patients and their relatives about the quality of the services provided through feedback surveys and feedback cards.

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 survey results showed patients and their relatives were very positive about the care and treatment they received and most of the responses showed the care they received exceeded their expectations.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. Staff recognised and respected the totality of people's needs. They always took people's personal, cultural, social and religious needs into account, and found innovative ways to meet them. People's emotional and social needs were seen as being as important as their physical needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. 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. Patient's emotional and social needs were seen as being as important as their physical needs. We observed staff providing reassurance and comfort to patients.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Patients told us they were supported with their emotional needs and were able to voice any concerns or anxieties. The comments received included: "my emotional and mental health has improved so much since I came to the hospice, the staff and the physiotherapist have been encouraging and have provided good emotional support", "staff are lovely, [the hospice is] very calm and relaxing place" and "I was very poorly, I am much better having been on the ward for 2 weeks and am ready to be discharged home".

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. A patient requested spiritual support and wanted to be baptised. This was arranged within a few days and 20 family members also attended. Staff told us patient approaching end of life care planned to get married later in the year and the staff arranged for their marriage ceremony to take place at the hospice promptly and in accordance with their wishes.

Patients or their relatives could be referred for access to counselling and bereavement support if required. A patient we spoke with commented; "I have had counselling service, my mood is much better and I feel brighter".

Understanding and involvement of patients and those close to them

Staff saw people, who were approaching end of life, and those close to them as active partners in their care. Staff were fully committed to working in partnership with patients, families and carers to make this a reality for each person.

Staff talked with patients and their relatives and carers in a way they could understand. Staff ensured that people's communication needs were fully understood. Patient's individual preferences and needs were consistently reflected in how care was delivered. Relationships between people who use the service, those close to them and staff were strong, caring, respectful and supportive.

Outstanding ☆

Hospice services for adults

The patients we spoke with told us they were kept informed about their care and treatment and staff were clear at explaining to them in a way they could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Survey feedback from patients and their relatives also showed patients and their relatives were involved in all aspects of their care and the care and treatment provided was in accordance with their wishes.

Staff fully informed patients and their relatives and supported patients to make advanced decisions about their care. Staff gave an example where they carried out a visit to the home of a patient to discuss palliation and end of life care. The patient and their relatives were initially reluctant and apprehensive, but opened to discussions around advance care planning, resuscitation and inclusion on gold standards framework register on subsequent visits as a result of staff clearly explaining the care and treatment options that were available.

Staff also gave an example where the husband of an end of life patient had been providing care at home did not want to sit and watch the patient dying. Staff provided additional support to the patient's husband and also provided encouragement and positive support for the quality of care that had been provided by the husband of the patient.

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 worked with others in the wider system and local organisations to plan individualised and highly responsive care that promoted equality, including for those with protected characteristics.

Facilities and premises were appropriate for the services being delivered. The design and layout of the 16-bedded inpatient ward promoted accessibility in all areas with most patient rooms facing out to the gardens which surrounded the hospice.

The hospice grounds had extensive gardens and open communal and quite areas to provide patients and their relatives with a calm and relaxing environment. The garden areas were well-maintained to a high standard by a head gardener who was supported by a team of 7 volunteers.

The hospice provided a range of services including the inpatient ward unit, day therapies services, hospice at home and specialist palliative community services.

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.

Hospice services for adults

Managers planned and organised services, so they met the needs of the local population. There were daily safety huddles so patient flow could be monitored and maintained and to identify and resolve any issues relating to the admission, discharge and death of patients. The hospice had an admissions coordinator that reviewed patient referrals and admissions on a daily basis.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The inpatient ward had a mixture of bays and single rooms and the ward layout enabled same sex accommodation with appropriate segregation. There had been no mixed sex accommodation breaches reported by the service in the past 12 months.

The hospice had an education team that formed part of the hospice team but was located off site. The education team provided specialist palliative care training and support for hospice staff and to professionals across the local area. The team provided the accredited Springhill specialist palliative care education passport (SPCEP) to a range of professionals across the local area, as well as specific palliative care training for in-house staff and other professionals, such as general practitioners (GP's), care home staff and NHS staff.

The service had systems to help care for patients in need of additional support or specialist intervention. The inpatient ward and specialist community teams were led by medical staff and supported by the nursing teams. The hospice offered a counselling and bereavement service and also had in-house specialist support such as from the multi-faith spiritual and pastoral team, physiotherapy team, the creative therapist, the complementary therapist and the dementia specialist nurse. Patients could 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 specialist palliative community nurse teams had caseloads that were linked by GP catchment area, and they worked closely with district nurses, adult social care providers and GPs to provide care and treatment for community based patients referred to the hospice.

There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that meets these needs, which was accessible and promoted equality.

Staff across the hospice routinely engaged with the local community, including ethnic minority groups (such as the local South Asian and Eastern European communities), lesbian, gay, bisexual and transgender (LGBT+) groups and other vulnerable groups such as homeless people and the local traveller community. The hospices engagement team provided a range of specialist training to staff across local acute NHS services, primary care service providers, adult social care providers and local community members to raise awareness of the services provided by the hospice.

8-10% of all patients admitted to the hospice inpatient and community services were from an ethnic minority background, which was reflective of the local demographic.

Meeting people's individual needs

The service 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. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Outstanding ☆

Hospice services for adults

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 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.

The hospice had a pet-friendly environment and encouraged patients and their relatives to bring pets to the hospice. This was well received by patients and their relatives.

The service had suitable facilities to meet the needs of patients' families. The hospice had a number of quiet rooms that were suitably furnished to a very good standard and could be used by patients and their relatives. The hospice had two separate suites that could be used for overnight accommodation by relatives. Staff told us they had recently applied for funding to purchase 'cuddle beds' to enable partners to stay overnight with patients. There was also a play area and toys, books and computer games available for children attending the hospice.

The hospice had a dedicated viewing room, and an adjoining relatives' room. This meant that families and carers could spend time with their deceased relative. Staff told us the viewing room was arranged in accordance with the preferences of the patient and their relatives, such as flower petals, bouquets and religious materials. A separate door from the viewing room enabled the staff or the undertaker to move the patient out of the hospice or to the hospice's cold room discreetly. Deceased patients could be stored in a cold room whilst awaiting transfer out of the hospice. The cold room area had restricted access and had a temperature controlled environment that was monitored by staff.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff made reasonable adjustments for patient with a learning disability, such as allowing them to be accompanied by a carer.

Staff mandatory training included dementia awareness and autism and learning disability awareness. The hospice had a dementia specialist nurse in place who had been involved with providing specialist guidance and support for staff, patients and their relatives. Staff also supported patients living with dementia and learning disabilities by using the 'my life story' passport document, which detailed their preferences.

The hospice had recently created a dementia-friendly garden space with input from the dementia specialist nurse. This was designed to provide a sensory, activity based environment where patients living with dementia could participate in gardening activities such as planting flowers and where they could look and touch plants of various types and colours. Staff told us this had been received positively by patients.

The hospice planned to undertake inpatient ward refurbishment activities over the current year and the dementia specialist nurse had also provided input into refurbishment plans to implement dementia-friendly measures.

Hospice services for adults

During the inspection, staff gave several examples of how they supported patients with mental health needs and also provided support (such as counselling) for their relatives if they were in crisis. This included providing end of life care for a patient that was admitted to the inpatient ward following an attempted suicide and examples where patients in the community were given suitable support to help calm them when distressed or anxious.

The service had information leaflets available in languages spoken by the patients and local community. Information leaflets in different languages or other formats (such as braille, large print or 'easy read' format) were also available or could be printed upon request.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed and staff knew how to access them.

The hospice had facilities available for patients living with a disability. All the hospice's services were on the ground floor and services, including the garden areas, were accessible for patients with a wheelchair. The hospice had specialist equipment available, such as equipment to support bariatric (obese) patients.

The day therapy service provided themed sessions which included arts and crafts, singing and music, quizzes, games and activities (such as armchair bowling and gardening) and exercise and relaxation sessions. Complementary therapy services included reflexology and massage. There was also a weekly therapy sessions for patients living with dementia. Patients usually attended one day per week as part of a 12 to 16 week programme. The service also offered similar activities as part of the virtual wellbeing group programme that was live streamed one day each week for patients that were unable to attend the day therapy unit.

The hospice had a prayer and reflection room, which could be combined with the adjacent quiet room to enlarge the space if required for a specific event, such as a wedding. Multi-faith pastoral support was available for patients and their relatives.

The hospice conducted a remembrance service every 3 months for patients who had passed away during that period. Staff told us this was well attended with up to 60 people attending and bereavement counsellors were available to support attendees.

The 'Makin Memories Foundation' was funded by relatives of a patient who had passed away at the hospice and supported the families of terminally ill patients with young families up to the age of 18 with mementos such as memory boxes, soft toys made out of the patient's clothes and recordings of a patient's voice in soft toys.

Access and flow

Patients could access the specialist palliative care service in a way and at a time when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice. There were processes in place to ensure urgent admission and rapid discharge when needed.

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

Staff carried out a formal assessment to prioritise patients for admission to the inpatient ward so that patients requiring end of life care would be prioritised for admission over patients requiring respite care or psychological support.

Managers monitored waiting times and made sure patients could consistently access services promptly when needed and received treatment within agreed timeframes and national targets. Patients referred to the hospice did not experience significant delays or waiting times for their care and treatment.

The average patient waiting time from receipt of referral to admission into the service between April 2022 and March 2023 was 1.9 days for the inpatient ward, 2.4 days for the specialist community service, 1 day for hospice at home and 14 days for the day therapy service.

Managers and staff worked to make sure patients did not stay longer than they needed to. The hospice reported the average length of patient stay on the inpatient ward every three months as part of the commissioners report. The average length of stay ranged between 8.6 days and 14 days between April 2022 and March 2023.

Managers monitored the number of patients whose discharge was delayed and took action to reduce them. The Inpatient ward was a short-stay facility and patients and staff reported there were minimal delayed discharges. Patient admissions and discharges were monitored daily by the admissions coordinator discussed during daily safety huddles to facilitate patient flow.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Managers and staff started planning each patient's discharge as early as possible. We saw evidence of early discharge planning in the patient records we looked at.

Managers monitored patient transfers and followed national standards. The hospice facilitated rapid discharges of patients who wished to die at home. A rapid discharge checklist was in place to ensure all relevant needs were considered and documented. Staff provided relevant information such as summaries of care plans, risk assessments and medicines when patients were discharged or transferred to another service.

Managers worked to keep the number of cancelled appointments to a minimum. Staff told us patients or their relatives rarely missed counselling or bereavement appointments or day therapy sessions. Managers ensured that patients who did not attend appointments were contacted.

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.

Patients, relatives and carers knew how to complain or raise concerns. Patients and their relatives were given information leaflets on admission to the service detailing how to complain or raise concerns.

Staff understood the policy on complaints and knew how to handle them. The director of clinical services oversaw the complaints process and managers were responsible for investigating complaints in their areas.

The hospice's complaints policy stated that complaints would be acknowledged within 48 hours and responded to within 2 weeks for routine formal complaints. Where this was not possible (such as for complex complaint investigations), staff were required to send a letter explaining the reason for the delay to the complainant.

Where patients were not satisfied with the response to their complaint, they were given information on how to escalate their concerns within the organisation or to external organisations such as the Parliamentary and Health Service Ombudsman.

There had been 4 complaints received by the service in the past 12 months. One complaint related to a query about services from a member of the public, one complaint related to a complaint from a volunteer and 2 complaints related to poor communication and care and treatment provided to patients on the inpatient ward. We looked at complaints records which showed these had been investigated appropriately and responded to in a timely manner.

Managers shared feedback from complaints with staff to aid staff learning. Staff told us that information about complaints was discussed during daily safety huddles and at routine team meetings to aid future learning. Complaints performance was reported to routine operational management and governance and audit committee meetings by the director of clinical services.

Is the service well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The hospice had a board of trustees, which consisted of 8 trustees including the chair. The chief executive officer reported to the board of trustees and was supported by the quality and development lead, the director of clinical services, the medical director, the director of corporate services and the director of finance.

The director of clinical services was supported by the ward manager, psychological and supportive care manager, the admissions coordinator and the community services manager.

The ward manager (ward sister) oversaw the day to day running of the inpatient ward, the psychological and supportive care manager oversaw the day therapy team, bereavement and counselling team and the spiritual and pastoral care service. The community services manager was responsible for the specialist palliative care team, physiotherapy, hospice at home team, education team and night sitting service.

The medical director was responsible for the management of the medical team across the hospice.

The director of corporate services was supported by the head of income generation and marketing and the corporate services manager, who oversaw the stewards, catering teams, volunteers, IT support and HR teams. The director of finance oversaw the finance team.

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

The staff we spoke with told us they understood their reporting structures clearly and described the managers as approachable, visible and who provided them with good support.

Vision and Strategy

The service had a 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's vision was 'Every adult in HMR (Heywood, Middleton and Rochdale area) with a life limiting condition is supported to live and die well, according to their wishes'.

The hospice's mission statement was 'Making every moment count; working collaboratively to provide the highest standards of physical, psychological and spiritual care to our patients and those who love them'.

The vision and mission statement was underpinned by 6 core values that were based on inclusivity and diversity, dignity and respect, encouraging creativity, encouraging positivity, supporting staff, patients and their loved ones and to support patients to find joy wherever possible.

The hospice's 5 year strategy (2022-2027) outlined the strategic objectives for the service. The chair and the chief executive officer told us the strategy had been developed with involvement from all relevant stakeholders, including staff, volunteers and other relevant local healthcare services involved with the service.

The strategy consisted of 6 strategic objectives that were based on staff recruitment and retention, improving efficiency and digital transformation, raising the profile of the service, financial sustainability, environmental sustainability and reduction of carbon emissions and continual innovation of services to meet changing needs.

The chief executive officer and chair told us the strategic objectives were underpinned by key performance goals and measurable targets and each subcommittee of the board was responsible for specific objectives. Progress against key objectives was reviewed as part of routine subcommittee meetings and reported to the board of trustees.

The vision, values and strategic objectives were clearly displayed on notice boards across the areas we inspected. They had been cascaded to staff across the services and the staff we spoke with had a good understanding of these. The strategic objectives were incorporated into individual staff appraisals.

Culture

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.

The staff we spoke with were highly motivated, patient-focussed and spoke positively about working at the hospice. They told us there was a friendly and open culture and that departmental and senior site managers were visible, approachable and provided them with good support.

The nursing, medical and support staff with told us they received regular feedback to aid future learning and that they were supported with their training needs by their line managers.

Staff felt confident to raise issues with line managers and felt managers responded positively when concerns were shared. The director of clinical services was the Caldicott guardian for the service. A member of the medical team was the freedom to speak up guardian for the service. They told us any concerns raised and actions taken would be reviewed at monthly risk management committee meetings.

The staff we spoke with were aware of the whistleblowing policy and understood how to contact the freedom to speak up guardian if needed. There had not been any significant whistle blower or freedom to speak up concerns raised by the service or received by the Care Quality Commission during the past 12 months.

Governance

Leaders operated 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 governance structures in place that provided assurance of oversight and performance against safety measures. The board of directors held board meetings every 3 months. The hospice had 4 trustee led sub-committees of the board that held meetings every three months. This included the governance and audit committee, finance and employment committee, remuneration committee and lottery committee.

There was a number of staff led sub committees and working groups that reported to the board sub-committees and board of trustees. This included the clinical standards committee, risk management committee, HR and IT committee, operational management team committee, audit committee and income services committee. The staff led sub-committees reported to the trustee committees, which reported to the board of trustees.

We looked at a selection of meeting agendas and meeting minutes for the board meetings and trustee and staff led committees over the past 6 months. These showed key discussions routinely took place around performance and quality, governance, incidents, complaints and audit performance. Meeting minutes showed action plans were in place and these were followed up at subsequent meetings.

The senior managers held routine departmental staff meetings every 3 to 6 months to manage patient risks, share learning and cascade governance and performance information to staff.There were daily hospice-wide multidisciplinary safety huddles to discuss day to day issues and patient risks.

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

The hospice had 8 trustees including the chair, who were all listed as company directors. We looked at the fit and proper persons files for 3 trustees and these included information relating their qualifications and disclosure and barring service (DBS) checks. The records also included any at least 2 references to show they were of good character as well as checks to confirm there were no concerns around past criminal or financial irregularities, in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5 requirements for fit and proper persons; directors.

We looked at the recruitment records for the chief executive officer, the director of clinical services and the medical director. We also looked at the recruitment files for 2 volunteers and 5 staff across the inpatient ward, community team

and medical staff team. We found evidence that suitable checks had been carried out prior to commencement of employment in the files we looked at. This included identification checks, proof of qualifications and mandatory training, at least two employment references, Disclosure and Barring Service (DBS) checks and professional body registrations and revalidations.

Management of risk, issues and performance

Leaders and teams used 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.

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 these 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, decontamination processes, incidents and audit results.

We saw that routine audit and monitoring of key processes took place to monitor performance against patient safety standards and organisational objectives. There was a programme of audit covering key processes such as infection control, patient records and medicines management. Information relating to performance against key quality, safety and performance objectives was monitored by senior managers and cascaded to staff through routine team meetings, information on notice boards and through general correspondence.

The service had a business continuity plan which included guidance for staff in relation to managing untoward and unexpected events.

We saw evidence 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 collected reliable data and analysed 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.

Senior managers collated and analysed information on performance to look for improvements and routine performance reports were in place detailing performance against key performance indicators.

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 for staff and could be easily retrieved. Electronic records were stored on computers with controlled access.

Staff completed general data protection regulation (GDPR) and confidentiality training as part of their mandatory training. The director of clinical services was information governance lead and was responsible for reporting to the Information Commissioner's Office (ICO). The director of clinical services confirmed there had been no reportable data breaches during the past 12 months.

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.

Engagement

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

Staff told us they received good support and regular communication from their line managers. Staff routinely participated in team meetings and took part in daily huddles across the areas we inspected. The senior managers also engaged with staff through newsletters, briefs and through other general information and correspondence that was displayed on notice boards and in staff rooms.

The hospice carried out routine staff surveys to gain feedback from various staff groups about their experiences. The findings from staff and volunteer surveys carried out over the past 12 months had been analysed to look identify and implement improvements. Feedback from staff was mostly positive. A number of improvements such as updated meal menus, ward refurbishment plans and staff well-being initiatives were implemented as a result of feedback from staff. A staff wellbeing group had been developed looking at ways to support staff and volunteers. A volunteer recruitment and retention working group had also been set up to look at improvements from feedback from volunteers.

Staff told us they received good personal support if they experienced a traumatic event. Counselling services were available and accessible to all staff. The hospice also had four mental health first aiders to support staff and volunteers.

The hospice routinely engaged with patients and their relatives to gain feedback from them. This was done informally and formally through participation in patient surveys and through patient and relatives focus groups.

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

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Hospice services for adults

Staff told us the service had a positive culture that was focussed on learning and improvement. We saw evidence of learning and improvement resulting from findings from audit results and incidents and shared learning was cascaded to staff to improve the services provided.

The director of clinical services had looked at incident trends and implemented actions such as updating policies and introducing staff reflection forms to reduce medicines management incidents.

We also identified concerns around medicines management processes during the previous inspection in 2016 and found improvements had been made during this inspection.

The hospice launched the quality, development and innovation project in October 2022. The scope of the project was to identify and implement improvement to a range of key areas, such as compliance with CQC standards, feedback from patients and relatives, staff development and engagement processes and learning from complaints, incidents and suggestions.

The quality and development lead worked alongside department managers to support the development of staff and services, including carrying out mock CQC inspections, conducting staff and patient surveys and analysing feedback to look for improvements and implementing staff development and support schemes such as staff reward schemes.

As part of the strategic objective around environmental sustainability and reduction of carbon emissions, the hospice planned to install solar-powered emergency power backup generator in the near future. The hospice had taken a number of initiatives as part of the green agenda, including the introduction of recycling schemes across the hospice, launch of a cycle to work initiative using a salary sacrifice scheme and installing thermostats to radiators.

As part of the hospice's strategic objectives around digital transformation, the hospice planned to install a new electronic incident management system over the next few months to enable better management and reporting of incidents and complaints.

The hospice reported the appointment of the dementia specialist nurse had led to improvements in the management of patients living with dementia. The hospice had installed a dementia-friendly garden area and planned inpatient ward refurbishments to make the ward environment more dementia-friendly.