

Hospice Care for Burnley and Pendle







Hospice Care for Burnley and Pendle

Inspection report

Pendleside
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Ratings

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

Overall summary

We carried out an inspection of Hospice Care for Burnley and Pendle on 11, 12 and 13 March 2015. The first day of the inspection was unannounced.

Hospice Care for Burnley and Pendle is a registered charity providing specialist palliative care services to adults with cancer and other life-limiting illnesses. Services include in-patient care, day services, hospice at

home and family support. Pendleside is located in Reedley near Burnley. There are accessible gardens and car parking spaces available. The entrance hallway includes a staffed reception desk and separate shop.

The in-patient unit provides assessment and symptom control, rehabilitation and end of life care, along with access to a range of holistic complimentary therapies and

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spiritual care. There are 10 single bedrooms with en-suite toilets, all rooms overlook the gardens. There is day lounge with conservatory and a dining room. There are specialised bathing facilities, including a wet room/shower and an assisted hydrotherapy bath with optional sensory lights and music. The in-patient service includes access to the facilities and therapies on day services.

There are separate facilities for day services, this includes a communal lounge and dining room, several therapy/counselling rooms, a gym, conservatory and quiet room. Services available include: occupational therapy, physiotherapy, aromatherapy, massage, reflexology, calligraphy, creative writing, art therapies, exercise classes and presentations from outside speakers.

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

The service was managed by a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the previous inspection on 21 November 2013 we found the service provider was meeting the legal requirements.

People using the service and their relatives had no concerns about the way people were cared for or treated. We found arrangements were in place to help keep people safe and secure. Risks to people's well-being were being appropriately assessed and managed.

Robust processes were in place to manage medicines safely. None of the people spoken with raised any issues around support with their medicines.

Staff were aware of the signs and indicators of abuse and they knew what to do if they had any concerns. Staff confirmed they had received training on safeguarding and protection.

Proper character checks had been carried out before new staff started working at the service. New employees were

recruited on a probationary period, this meant their suitability and competence in the role was monitored and considered, prior to a permanent contract being offered or declined.

Arrangements were in place to maintain appropriate staffing levels. We found there was no formal process in place to assess staffing arrangements, to make sure there were always enough suitable staff. However the registered manager agreed to address this matter.

Effective processes were in place to maintain a safe environment for people who used the service, visitors, volunteers and staff. We looked around the premises and found all the areas seen were safe and well maintained. The service had defined contingency procedures to be followed in the event of emergencies and failures of utility services and equipment.

People we spoke with indicated they were satisfied with the services they received. They made positive comments about the skills and abilities of the staff team. All new staff completed an initial induction training programme to a nationally recognised standard. There were systems in place to ensure all staff received regular training as part of a comprehensive 'mandatory training framework'. All relevant staff were supported to access palliative and end of life care, tailored to their individual experience and qualifications.

The MCA 2005 (Mental Capacity Act 2005) and the DoLS (Deprivation of Liberty Safeguards) sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. We found appropriate action had been taken to apply for DoLS and authorisation by local authorities, in accordance with the MCA code of practice and people's best interests.

We observed staff involving people in routine decisions and consulting with them on their individual needs and preferences. People were involved with their initial assessment, the care planning processes and they had consented to care and treatment.

People made positive comments about the meals provided at the service. Arrangements were in place to provide people with an interesting, nutritionally balanced and varied diet. People's individual dietary needs, likes and dislikes were provided for. Doctors and dieticians

Summary of findings

were liaised with as necessary. Various drinks were readily available and regularly offered. People were supported to eat their meals wherever they wished, including dining areas, or their own rooms.

People spoken with gave us examples of how their health care needs had been recognised and sensitively managed. Healthcare needs were monitored and effectively responded to. We observed people being supported and cared for by staff with kindness and compassion. We saw people were treated with dignity and respect and consideration was given to their privacy. Processes were in place to respond to people's individual faith and cultural needs.

We found people who used the service were made aware of and encouraged to engage with, other support networks which could have a positive impact on their quality of life. People's needs, preferences and abilities were assessed taking into account their views and opinions. There were detailed care and treatment plans in response to identified needs and preferences, with clear directions for staff to meet people's needs.

People spoken with told us how much they appreciated the various therapies and counselling sessions which were available to them. We found the counselling and massage therapies were also offered to family members and friends of people using the service. There were various therapies and activities available which included: occupational therapy, physiotherapy, aromatherapy, massage, reflexology, calligraphy, creative writing, art therapies, exercise classes and presentations from outside speakers.

Effective processes were in place to support and encourage people to raise any concerns and make complaints. The service had systems in place for the recording, investigating and taking action in response to complaints.

There was an effective management team to provide strategic direction and support the day to day running of the service. There were governance systems in place to monitor and develop the service in consultation with the people who used it.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

Arrangements were in place to keep people safe and secure. Processes were in place to maintain a safe environment for people who used the service, visitors, volunteers and staff.

People were treated and cared for safely, they were protected from avoidable harm and potential abuse. Risks to people's safety were appropriately assessed, managed and reviewed.

The service had policies and procedures to support an appropriate approach to safeguarding and protecting people. Staff were trained to recognise any abuse and knew how to report it.

Staff recruitment included all the relevant character checks and probationary periods. There were enough staff available to provide safe care and treatment for people who used the service.

We found there were robust processes in place to safely handle and manage medicines.

Good



Is the service effective?

The service was effective.

People indicated they were satisfied with the service. They told us staff were 'dedicated and professional.'

Systems in place to ensure all staff received regular training as part of a wide-ranging ongoing programme. All new staff completed an initial induction training programme to a nationally recognised standard. Processes were in place to ensure all volunteer staff received appropriate training.

People were encouraged and supported to make their own choices and decisions. The service was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People made positive comments about the meals provided at the service. Processes were in place to ensure people's individual dietary needs, likes and dislikes, were known and catered for. People were offered an interesting, nutritionally balanced and varied diet.

Arrangements were in place for people's healthcare needs to be monitored. People spoken with gave us examples of how their health care needs had been recognised and sensitively managed. Doctors and nurses appropriately shared information around people's individual symptoms and needs.

Good



Is the service caring?

The service was caring.

All the people spoken with expressed an appreciation of care, treatment and support they received at the service. One visitor told us, "The staff here are devoted to the work that they do and the patients that they care for." We observed people being supported and cared for by staff with kindness and compassion.

Good



Summary of findings

People were sensitively involved with their care and treatment. They felt that both the medical and nursing team in the in-patient unit were very informative when explaining ways of responding to their needs. One visitor told us, their relative was “Fiercely independent but the staff managed this in a very tender and respectful way.”

The domestic, maintenance and catering staff spoken with also showed compassion and kindness within their roles.

Processes were in place to respond to people’s individual faith and cultural needs, including relatives, friends and staff.

There were suitable rooms to promote privacy, dignity and confidentiality. Accommodation was available for relatives who wished to stay close to people on the in-patient unit.

Is the service responsive?

The service was responsive.

The service had strategies in place to integrate and share its services within the community. People were encouraged to access other support networks which may enhance their quality of life.

People were involved with the assessment and referral process. Their needs and choices were fully considered. They were listened to and involved in making shared decisions.

People had individual care and treatment plans which described their specific needs and preferences, with clear directions for staff to follow. Changes in people’s needs and conditions were monitored and responded to.

People appreciated the various therapies and counselling sessions which were available to them. These services were also available to family members and friends. Bereavement support was available to people both as one to one counselling and group sessions

Occupational therapies and activities were available including: aromatherapy massage, reflexology, physiotherapy, calligraphy, art courses and presentations from outside speakers. The catering team provided cooking skills classes, for people who had been bereaved and carers who may need support.

Processes were in place to effectively manage and respond to any complaints, concerns and general dissatisfactions.

Good



Is the service well-led?

The service was well-led.

People consistently described their experience of the service in positive terms. One person told us, “I just wish I could come every day.”

The service’s vision, values and philosophy of care were effectively shared and supported by the management and leadership team. Throughout the inspection we observed managers and staff conveying these values into action, in the way they interacted with people and delivered care and support.

Good



Summary of findings

Structured arrangements were in place to continually monitor, review and develop the service. Processes included consulting with people on their experiences. Consideration was given to the sensitivity of ensuring this was done in a timely way. The information received was appropriately shared and used to influence any future developments.

There were appropriate arrangements for governance, including supervisory and reporting procedures. We found there regular audits and checks of the various systems and practices. Accidents, incidents and near misses were reported, investigated and analysed. Any necessary action was taken to respond to and manage risks, which may compromise people's well-being and safety.

Hospice Care for Burnley and Pendle

Detailed findings

Background to this inspection

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

The inspection was carried out on 11, 12 and 13 March 2015. The first day of the inspection was unannounced. The inspection was carried out by a team of four inspectors. The team included an adult social care inspector, two specialist advisors, one focusing upon palliative and nursing care, the other on medicines management. There was also an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider completed a PIR (Provider Information Return). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to

make. We reviewed the information we held about the service, including notifications and the details within the PIR. We contacted the local 'Health Watch' for their views on the service.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with six people using the service and five relatives/friends. We talked with five volunteers. We spoke with and/or interviewed, nurses, auxiliary nurses, the chef, domestic staff, the maintenance team, the registered manager/chief executive, doctors, the pharmacist, the spiritual coordinator, the quality and development coordinator, the family support coordinator, the end of life care facilitator and the chair of the service.

We spent time with people observing the care and support being delivered. We looked round the premises. We reviewed a sample of records. These included three people's care plans and other related documentation, staff recruitment records, medication records, policies and procedures, records of complaints, audits and development plans.

Is the service safe?

Our findings

The people we spoke with did not express any concerns about their safety and wellbeing when using the service. During the inspection we did not observe anything to give us cause for concern about people's general welfare or the security of the premises. We saw staff interacting and supporting people sensitively, giving consideration to people's individual needs, preference and abilities. We observed people being carefully assisted around day services in a calm and respectful way. Staff were seen carefully ensuring people's safety on the corridors and in communal areas, they waited patiently to allow people to move through at their own pace.

The service had policies and procedures to support an appropriate approach to safeguarding and protecting people. There was some information available for people on abuse and keeping safe, including leaflets from the local authority, health authority and local advocacy services. Information included within the PIR (Provider Information Return) outlined the processes in place to promote and maintain safety at the service. Including that the service had policies and procedures in place based on best practice guidance and legislation with specialist advice being sought where required.

Staff spoken with told us they were not aware of any abusive or inappropriate practice at the service. One commented, "I have worked here over ten years and have never seen anything untoward, no shouting or bossing patients and no bullying amongst staff." Staff explained how they kept people safe. They were aware of the signs and indicators of abuse and neglect. Their comments included, "We consider people who are at risk and vulnerable, constantly aware of picking up on any concerns" and "We are vigilant around changes in behaviour and what people say, we check things out." They were clear about what action they would take if they witnessed or suspected any abusive practice. Staff were aware of the service's 'whistle blowing' (reporting poor practice) policy and expressed confidence in reporting any concerns. Staff confirmed they had received training on safeguarding and protection. They also had access to training on equality and diversity; this was to increase their understanding of protecting people from the harmful effects of discrimination.

Risks to people's safety were appropriately assessed, managed and reviewed. We found individual risks had been assessed and recorded in people's care and treatment records. The assessments were different for each person and reflected risks associated with their specific needs and preferences. Management strategies had been drawn up to guide staff on how to manage identified risks. We found people who used the service had been involved in the risk assessment process and reviews and evaluations had been carried out on a regular basis. Staff expressed an awareness of these management plans and how to keep people safe. Risk assessments were also carried out in relation to other matters, including group outings and activities such as visiting animals and pets. Information in the PIR described a future development as, "To develop better information sharing to reduce clinical risk, improve patient safety and enhance patient autonomy and choice by recording patient preferences."

Processes were in place to maintain a safe environment for people who used the service, visitors, volunteers and staff. One visitor told us, "It is a great relief to see (our relative) in such wonderful surroundings. This has really put our minds at ease because this is the best place possible for them in the circumstances." We looked around the premises and found all the areas seen were safe and well maintained. We spoke with the maintenance team and domestic staff who explained their roles in maintaining a safe, secure and clean environment. They confirmed that regular checks were carried out on equipment and facilities and that any repairs or improvements were rectified in a timely way. Records showed arrangements were in place to check, maintain and service fittings and equipment, including gas and electrical safety, water quality/temperatures and nurse call systems. We found health and safety risk assessments and fire safety risk assessments were in place. Regular fire drills and fire equipment tests were being carried out. Premises security checks were carried out daily. Systems were in place to record and proactively respond to accidents, incidents and near misses. A risk log was maintained which recorded identified risks and the planned time-scales to minimize or eliminate the risks. There was a health and safety group who met regularly to discuss and share actions for improvements across the services.

The service had defined contingency procedures to be followed in the event of emergencies and failures of utility services and equipment. The procedures included the

Is the service safe?

contact details of the relevant agencies and contractors. This meant managers and staff had information at hand to appropriately respond to risks associated with unforeseen circumstances.

We looked at the arrangements in place transporting people to and from the hospice. Processes were in place to consider and minimize, any risks to people using the transport on an individual basis. The vehicles in use were well maintained and suitably equipped, for people's wellbeing, safety and comfort.

We looked at how the recruitment processes protected people who used the service. Staff spoken with confirmed their involvement in the procedures. We reviewed the recruitment records of four members of staff. The process included applicants completing a written application form, including various declarations and their employment history. The required character checks had been completed before staff worked at the service and the checks had been recorded. The checks included taking up written references, an identification check, and a DBS (Disclosure and Barring Service) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. Face to face interviews had been held and records had been kept of interview questions and the applicant's responses.

New employees were recruited on a probationary period, this meant their suitability and competence in the role was monitored and considered, prior to a permanent contract being offered or declined. The service also had clear staff disciplinary procedures to follow should staff be identified as responsible for unsafe practice or inappropriate conduct.

The people we spoke with did not express any concerns about the availability of staff. We observed staffing levels on day services and the in-patient unit and found there were sufficient on duty to respond to people's needs and choices. All the staff spoken with considered there were sufficient staff available at the service; one told us, "I feel there are enough staff on the team." We looked at a selection of staff rotas, which indicated systems were in place to maintain consistent staffing arrangements. The registered manager indicated staffing arrangements were reviewed on an ongoing basis and we found that a comparison analysis of the staffing arrangements and various risk assessments had been carried out. However,

there was no structured, conclusive process in place to monitor and assess staffing levels to ensure there were sufficient suitable staff to meet people's individual needs and to keep them safe. The registered manager agreed to take action in respect of this matter.

We looked at the way the service managed and supported people with medicines. We found there were robust processes in place to safely handle medicines. None of the people spoken with raised any issues around support with their medicines.

The service had an accountable officer for controlled drugs in accordance with The Misuse of Drugs Regulations. The accountable officer had responsibility for the standard operating procedures for the safe handling of controlled drugs, which were regularly audited. The service also benefited from the support of a pharmacist, for medicines advice, reviews and overseeing safe processes.

The medical team were responsible for reconciling a patient's medicines upon admission. The nurses spoken with told us they checked any medicines people brought in with them to ensure they were suitable for continued use. The service had developed a checklist to support this process. Doctors told us that if a person wanted to take an over the counter remedies or alternative remedy, they would advise them if it was safe for them to take it and take their wishes into account.

The service had a process in place to assess, record and plan for people choosing to self-administer their own medicines. On the day care unit, people were encouraged to manage their own medicines when they visited for the day. The service had introduced processes to ensure that each person's preference and ability to manage their medicines was routinely assessed, planned for and reviewed.

We looked at two care plans on the inpatient unit and saw detailed information regarding the pharmaceutical care of the people, along with visual pain assessment charts to describe the individual's pain relief plan and assist the nurses in deciding when the pain relief was needed. On the inpatient unit, we observed arrangements were made to provide sensitive, safe and timely support with pain relief.

All medicines including controlled drugs were stored securely in the inpatients unit. We noted that the controlled drugs key was not secure on the day services unit, however there were no medicines in the cupboard at the time. We

Is the service safe?

discussed this with the registered manager who acknowledged our concerns and agreed to ensure the keys were kept by the designated nurse and to maintain an audit trail for the safe handling of the keys.

People who used the service had access to individual secure cupboards for the storage of their own medicines on the day service unit. On day services we saw safe and protective practices carried out when people had brought their own medicines with them. People's medicines were also stored in individual secure cupboards on the inpatient unit.

We found there were comprehensive audits of the medicine management practices carried out at regular intervals. We looked at copies of the audits completed within the previous six months and found no major concerns had been raised. Processes were in place to appropriately highlight and rectify any discrepancies directly with the medical team. The members of the medical team gave us examples of improvements in safer and accountable practice as a result of the audits.

All new staff with designated responsibilities for medicines, completed medicines management induction training which included the services' policies and procedures. They were then assessed for competency before they could administer medication. The service also had additional e-learning modules on relevant topics and staff had begun working through these. Arrangements were place for staff to receive annual syringe driver training. This ensured staff skills and competency were kept up to date.

We found the services' pharmacist had observed some staff administering medicines as part of the regular auditing process. At the time of the inspection, there was a risk that some staff were not up to date with their medicines training and their skills and competence may not have been formally assessed in the past 12 months. However, the registered manager had already identified this as an area requiring improvement. Plans were in place to ensure all relevant staff had annual medicines training and the competency assessments were to be more structured to ensure each staff member had their knowledge and skills checked annually.

Is the service effective?

Our findings

People we spoke with indicated they were satisfied with the services they received. All said they wished they had accessed the service earlier. Their comments included: “The therapies here are fantastic” and “The support I have received has been very quick and has given me a new lease on life.”

We asked people for their views and opinions on the skills and abilities of the staff team. They told us, “They are extremely professional in all that they do”, “I am with people who understand exactly what I am experiencing, I don’t have to pretend” and “We are surrounded by very professional and dedicated staff here.”

We looked at how the service trained and supported their staff. There were systems in place to ensure all staff received regular training as part of the service provider’s comprehensive ‘mandatory training framework’. The programme included e- learning modules and classroom based teaching. The key areas covered included, fire safety, infection prevention and control, manual handling and information governance. All relevant staff were supported to access palliative and end of life care, tailored to their individual experience and qualifications.

Processes were in place to offer and facilitate additional specialised training and study sessions in response to identified learning and development needs. Staff told us of the training they had received and confirmed there was an ongoing training and development programme at the service. One told us, “They are really good with supporting our continuous professional development.” We looked at training records which confirmed this approach. The service supported staff as appropriate, to attain recognised qualifications in health and social care. All staff had an annual appraisal of their work performance and a formal opportunity to review their training and development needs.

All new staff completed an initial induction training programme to a nationally recognised standard. The registered manager explained competency frameworks were being developed to underpin the training programme. We were introduced to a group of new employees who had

attended the service as part of their initial training. Processes were in place to ensure all volunteer staff received appropriate training as part of their initial induction, with subsequent mandatory training updates.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people’s best interests. DoLS are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken. There was information to demonstrate appropriate action had been taken as necessary, to apply for DoLS and authorisation by local authorities in accordance with the MCA code of practice. Staff spoken with had an understanding of the MCA 2005. Records and discussion showed arrangements had been made for staff to access training on the MCA 2005 and DoLS. The service had accessible policies and procedures to underpin an appropriate response to the MCA 2005 and DoLS.

During the inspection we observed staff involving people in routine decisions and consulting with them on their individual needs and preferences. We found the care pathway assessment process included screening and recording people’s capacity to make their own decisions and choices. Records and discussion showed people had been involved with their initial assessment, the care planning processes and reviews. This included their consent to care and treatment and any specific requirements. One person told us they felt that both the medical and nursing team in the in-patient ward were very informative. They believed that the staff provided sufficient information about their care needs to satisfy their level of understanding. We saw examples of completed Do Not Attempt Resuscitation (DNAR) orders, which people had been appropriately involved with.

We looked at the way people were supported with food and drink. People made positive comments about the meals provided at the service. One person told us, “The food is brilliant!” The care pathway assessment involved screening people’s nutritional and dietary needs, including any conditions which may influence their food and fluid intake. This resulted in a care plan to direct an appropriate response. Records and discussion showed nutritional and hydration needs were monitored and reviewed. Doctors

Is the service effective?

and dieticians were liaised with as necessary. Processes were in place to ensure people's individual dietary needs, preferences likes and dislikes, were recorded and shared appropriately with the catering team.

We spoke with the catering manager who explained the systems in place to provide people with an interesting, nutritionally balanced and varied diet. There was a four week seasonal menu which included various daily options for people to choose from. However, people could also request any specific meals and food choices. We were told, "If we have the ingredients we will make it." The catering staff had regular daily contact with people who used the service. This enabled them to discuss with them the meals on offer, their choices and also gain insight into their satisfaction with the meals provided. On the in-patient unit there was a kitchenette, where snacks and drinks could be prepared for people at any time.

We noted various drinks were readily available and regularly offered to people and their relatives/visitors. People were supported to eat their meals wherever they wished, including dining areas, or their own rooms. On the first day of our visit we observed the lunch time meals service on the day services unit. The tables were neatly laid out with napkins, appropriate cutlery, side plates and glasses. We noted people enjoying the social occasion of the mealtime experience. We saw people being sensitively supported and encouraged by staff to eat their meals. Food and drinks were brought to people very carefully and placed on secure surfaces, so that they could comfortably and safely reach the drinks and food as appropriate. A three course meal was provided, the food looked hot, well cooked and attractively presented.

We looked at the way the service responded to people's day-to-day health needs. People spoken with gave us examples of how their health care needs had been recognised and sensitively managed. We noted comprehensive assessments had been completed on people's physical health, medical histories and psychological wellbeing.

Arrangements were in place for people's healthcare needs to be monitored. On the inpatient unit daily morning meetings were held to discuss people's individual's needs. This ensured the doctors made the nurses aware of medicines they had prescribed and also involved them in the discussions around the aim and rationale of treatment and symptom relief. We observed a handover session between nurses on the inpatient unit and heard in depth discussions around people's individual needs. The nurses coming onto a shift were fully updated around any medication changes as well as any clinical changes. A written summary sheet was also kept updated. This demonstrated how well the nurses knew the individual needs of the people they were caring for.

Information in the PIR included plans for future developments which were ongoing; in the way the service accessed and shared information with partner agencies, including GP practices and district nursing services. This was to help avoid repetition, promote continuity of care and improved partnership working. We were also made aware that specific additional equipment was being obtained to more effectively respond to people's needs and medical conditions.

Is the service caring?

Our findings

All the people spoken with told us they were happy with the care, treatment and support provided at the service. Their comments included: “This place has lifted my spirits”, “I can be exactly me and people understand and care” and “Amazingly the hospice staff felt that my partner would benefit from their support too and now they join me here, we are so lucky.” Visitors spoken with told us: “(my relative) is getting the best care possible” and “The staff here are devoted to the work that they do and the patients that they care for.”

We observed people being supported and cared for by staff with kindness and compassion. It was apparent from the discussions, that staff knew the circumstances and personalities of each person they interacted with. Conversations about the person’s general well-being and home life were explored. Staff listened to people’s responses and discussed any concerns that the person might be experiencing. We observed practical action being taken to sensitively promote people’s comfort and well-being. We saw people were treated with dignity and respect and consideration was given to their privacy. Visitors spoken with told us they had been very closely supported throughout their relatives/friends stay and that all the staff at the service had been very helpful.

Records and discussion provided examples of people being sensitively involved with their care and treatment. People felt that both the medical and nursing team in the in-patient unit were very informative when explaining ways of responding to their needs. A visitor described the compassionate way in which sensitive information had been shared with them by the doctor. We found individual care records included agreements and information around people’s preferences for their end of life care and any advanced decisions. We found appropriate consideration was given to confidentiality of information. One visitor told us, “They have no problems sharing information with us but only if (my relative) has agreed to this.”

Doctors and nursing staff spoken with understood their role in providing people with compassionate care and support. They were aware of people’s individual needs, backgrounds and conditions. They described how they delivered care and promoted people’s independence, dignity and choices. One visitor told us, their relative was “Fiercely independent

but the staff managed this in a very tender and respectful way.” The domestic, maintenance and catering staff spoken with also demonstrated compassion and kindness within their supportive ancillary roles.

We talked with the spiritual coordinator who told us of the processes in place to respond to people’s individual faith and cultural needs. There was a team of volunteers reflective of the multi-faith community, including people with no religious beliefs. People who used the service and their families/friends could request contact from a team member at any time and home visits could be arranged. The team would respond to informal request and also provided the offer of support to the staff team.

There were numerous suitably equipped rooms for therapies and confidential discussions. The in-patient unit included single rooms with en-suite facilities. The service had quite recently adapted the premises to include accommodation for relatives who wished to stay close to people on the in-patient unit.

We noted there was a notice board in the office on the in-patient’s unit which displayed people’s names and other details. It was acknowledged that people may rarely enter the office and have access to this personal information; however the board could also be seen from outside through the window. We discussed this matter with the registered manager who acknowledged our concerns and indicated this matter had previously been raised as needing attention. We were assured action would be taken to make improvements.

The service had a range of leaflets and booklets, to inform people of the services available and what they could expect from them. This information was designed to increase people’s awareness of the various services and help them make decisions and choices around accessing them. There was a weekly peer support group session for people and their relatives. This offered people to access guidance/information, share their ideas and provided social support. The service had also introduced a user group, to assist the management team in proactively consulting with people to help identify areas for future development. The registered manager explained this had involved the group carrying out an audit of the premises. This approach meant people with experience of the service, had been given the opportunity to undertake a

Is the service caring?

useful and valued role. Information in the PIR included plans to influence the way care was delivered by involving the user group with auditing care delivery and specifically care delivery around privacy, dignity and choice.

Is the service responsive?

Our findings

Hospice Care for Burnley and Pendle had strategies to integrate and share its services with the community it serves and other providers. We were told of the various initiatives in place to actively link with the local community, such as: hospitals, schools, care homes, local community groups and religious organisations. We found people who used the service were made aware of and encouraged to engage with other support networks which could have a positive impact on their quality of life.

People spoken with indicated they had been involved with the assessment and referral processes. One relative told us, “The transfer to the service was managed in a very efficient and caring way.”

Information included in the PIR described the service’s referral and assessment process. This included a referral pathway process for the types of service available. Referral meetings were held daily. The process was designed to respond to priorities including people’s clinical needs and also to their individual preferences.

On admission to any of the services a holistic assessment was carried out with the person. This ensured people had their needs listened to and that they were involved in any decision making. The day service manager described the aim as, “To provide a bespoke service of care that specifically addresses the needs of each individual, not just clinical needs, but the needs of the whole person from an emotional, psychological and well-being perspective.” The hospice at home service aims to respond to requests for end of life care/crisis support, within one hour of receiving a referral. The service can provide 24 hour care in the person’s own home to enable them to die in their preferred location.

A referral processes had also been developed to effectively share information when people moved between the services, for example from hospice at home to day services.

We looked at three people’s assessments on the in-patient unit and found they and/or their relatives had been actively involved with the process. We found information had been obtained as appropriate from other services, including GP’s, hospitals and district nurses. The assessments were very comprehensively completed and included details of people’s specific needs and choices. Areas assessed included, dependency, clinical, spiritual, social needs and

agreed decisions around advanced care planning. There were additional assessments in response to individual risks, such as risk of falls, difficulties with swallowing and the development of pressure ulcers. There were detailed care and treatment plans in response to identified needs and preferences, with clear directions for staff to follow on meeting the needs.

People’s healthcare needs and well-being were monitored. Records were kept of changes in people’s conditions and the delivery of care, including any nursing interventions. Regular meetings were held to discuss and review people’s individual’s needs and preferences. Care and treatment plans were accordingly revised and updated in response to changes in people’s needs and circumstances.

People spoken with told us how much they appreciated the various therapies and counselling sessions which were available to them. They said: “The therapies are fantastic”, “The relaxation therapy I receive here helps me to clear my mind”, “The visualisation tasks and therapies help me feel more restful and allow my mind to float free from the pain that lives inside me” and “The counselling really helps me to rest.” We found the counselling and massage therapies were also offered to family members and friends of people using the service. Bereavement support was available to people for patients, their families, friends and others. We spoke with the family support coordinator, who described the arrangements in place to offer confidential bereavement counselling and also informal peer group support events and activities.

We observed people using the service being supported and cared for in response to their needs and preferences. On day services, there were various activities taking place including a craft session and an exercise class. We noted there was much friendly chatter, many smiles and a lot of laughter!

We were made aware of the various therapies and activities available which included: occupational therapy, aromatherapy massage, reflexology, physiotherapy, calligraphy, art courses and presentations from outside speakers. There were examples of people’s art work and crafts on display along with photographs of people participating in events at the service and within the community. We were shown a room with gym equipment which was due to be made available, to help promote physical health and wellbeing. One member of staff explained how they supported people to access the

Is the service responsive?

internet and showed them how useful computers can be in helping to manage their lives. The catering team were also involved in providing cooking skills classes, for people who had been bereaved and carers who may need support, guidance and practical advice.

We looked at the way the service managed and responded to concerns and complaints. None of the people we spoke with expressed concerns or raised any complaints about the service. People were actively encouraged to voice their opinions within the assessment and review process, consultation surveys and in the various group meetings.

Each of the information booklets, providing a guide to: in-patients, day services and hospice at home, included a summary of the complaints procedure. Along with a compliment, concerns and suggestions section with a tear off response slip, which people could complete to offer

feedback. Additionally there was a separate guide to the service's complaints procedure. This explained the process to follow to make a complaint, how this would be managed and the expected timescales for a response following investigation. The procedure included the contact details of other agencies where complaints can be referred to.

We found the service had systems in place for the recording, investigating and taking action in response to complaints and concerns. There had been two complaints/concerns raised at the service within the last 12 months. Records and discussion with the registered manager showed the matters had been effectively investigated and resolved to the satisfaction of the complainants. Information within the PIR showed in the last 12 months the service had received 120 written compliments.

Is the service well-led?

Our findings

People spoken with consistently described the service in positive terms. All indicated satisfaction in their experiences of the care and support they received. One person told us, “I would choose to die here.” Everyone shared their appreciation of the caring and inclusive ethos at the service. Two comments were, “It is a very happy place” and “I just wish I could come every day.”

The service’s vision and philosophy of care were well represented within policies and procedures and the defined statement of purpose. New employees and volunteers were made aware of the aims and objectives of the service during their induction training. We found the culture of compassion, caring and kindness was replicated within all staff and volunteers working at the service. Throughout the inspection we observed managers and staff conveying these values into action, in the way they interacted with people and delivered care and support. One staff member told us, “Our aim is to get our patients to the ‘right place’ in managing their symptoms and lifting their sense of well-being.”

There was a manager in post who had been registered with the Care Quality Commission since 2011. The registered manager was also the chief executive and was responsible for ensuring the service met its legal requirements. There was a clearly defined management structure with senior staff having designated responsibilities for key areas of management, including: care delivery, quality and safety, finance, human resources and fundraising. Staff spoken with indicated they were aware of the service’s management structure and lines of accountability. Staff spoken with told us the managers were approachable and they felt they could take their concerns to them and they would be listened to. They described managers as ‘supportive.’ One member of staff told us, “I think the management and leadership here is very good.” Another commented, “I love coming to work, this is the best job I have ever had.”

The managers were supported by the hospice executive team which monitored the organisational effectiveness and directed the strategic development of the service. We spoke with the chair of the executive team who explained

the processes in place to monitor and evaluate people’s experience of the service. This included six monthly ‘inspections’ across the service, this involved asking people who used the service and staff for their views and opinions.

People who used the service were invited to complete satisfaction questionnaires on their experiences. There were various methods for this type of consultation across the departments. Consideration was given to the sensitivity of ensuring this was done in a timely way. The information received was appropriately shared and used to influence any future developments at the service. The ‘user group’ was also utilised to consult with people about their views and experiences. The manager explained that the user group were to be consulted upon regarding the content of future satisfaction surveys. Information in the PIR indicated that an annual staff consultation survey was to be introduced within the year. We discussed with the registered manager, the potential value of consulting with other stakeholders for their views and opinions of the service.

There were appropriate arrangements for governance, including supervisory and reporting procedures. Various sub committees and groups had been established to maintain and monitor a safe and effective delivery of care. These included, clinical and policy audit group, health and safety and human resources. We found there regular audits and checks of the various systems and practices. Such as infection prevention and control, medicines management, nutrition, and clinical care. The service had a staff representatives committee. Staff from all service areas were encouraged to bring evidence of good practice or areas of concern to the committee for discussion and for appropriate action to be taken. This meant that there was a proactive approach to quality assurance and all staff were aware of potential risks that may compromise people’s well-being and safety.

Staff reported all accidents, incidents and near misses. These were investigated, analysed and reported on. This took account of how circumstances had impacted on people’s care, safety and well-being or clinical effectiveness. Reports included actions to be taken to respond to issues identified and how they were to be managed.

We looked at structured proposals for future developments. This included a rationale and analysis of the current circumstances and proposed intentions, with

Is the service well-led?

consideration given to any training and cost implications. Where a specific project was identified representatives from across the service were enrolled to set up a working group to plan and implement the project. There were various meetings convened to promote good communication across all the departments at the service. A regular newsletter was produced and quarterly communication meetings were held to ensure staff were kept aware of service developments.

The service had developed strong links with partner agencies including, GP practices, district nursing services

and Macmillan Nurses. The service was a member of Hospice UK, which is the national membership charity for organisations providing or supporting hospice care across the United Kingdom. Additionally, managers and staff were members of various associated professional organisations such as, the Association of Bereavement Service Coordinators Hospice and Palliative Care, the National Association for Hospice at Home and the National Hospice Catering Group.