Bury Hospice

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Bury Hospice is a charity which provides a range of hospice services for adults with a life-limiting illness. The hospice is purpose built and provides accommodation on the Inpatient Unit for up to 12 patients. The hospice also has a Day Hospice and Hospice at Home service.

The hospice is purpose built and is situated in a residential area of Bury, not far from the town centre. The hospice is set in well-maintained gardens with adequate parking and clearly defined parking areas for disabled visitors.

Services are free to people, with Bury Hospice receiving some NHS funding and the remaining funds are achieved through fundraising and charitable donations.

There were six patients being cared for in the Inpatient Unit during our inspection, 20 patients being cared for in the community by the Hospice at Home service and 10 patients attending the Day Hospice.

We inspected Bury Hospice on the 21 and 28 March 2017. The first day of the inspection was unannounced. We last inspected Bury Hospice in April 2016 where we found there were several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to the lack of audits on the quality and safety of the service, no formal staff supervision, incomplete training records and no business continuity plan in place to deal with emergencies that could arise and possibly affect the provision of care.

During this inspection we found that the service had met all the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The hospice had a manager registered with the Care Quality Commission (CQC) who was present during the second day of the inspection. A registered manager is a person who has registered with CQC 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 and associated regulations about how the service is run.

We were assisted on the first inspection day by the hospice care team manager; a registered nurse with a wealth of nursing and palliative care experience.

The expressions of gratitude relayed to us demonstrated that patients and their families were cared for with the utmost compassion, kindness, dignity and respect. Patients spoke highly of the kindness and caring attitude of the staff. Patients told us they received the care they needed when they needed it and that staff were knowledgeable and committed. Visitors told us they were always made welcome.

Discussions with staff and visitors demonstrated to us that the staff recognised and considered the

importance of caring for the needs of family members and friends. Patients were supported at the end of their life to have a comfortable, dignified and pain-free death. The nursing and medical staff showed they were highly skilled in pain and symptom control. The staff we spoke with had an in-depth knowledge of the care and support that patients required.

We saw that patients were assisted in a way that respected their dignity and privacy. We observed respectful, kindly and caring interactions between the staff, patients and visitors. The patients looked extremely well cared for and there was enough equipment available to ensure their safety, comfort and independence were protected.

The care records showed that patients were involved in the assessment of their needs. Their preferred place of care at all stages of their illness and the arrangements in the event of their death were documented. The care records we looked at showed that risks to the patient's health and well-being had been identified, such as poor nutrition, the risk of developing pressure ulcers and the risk of falls. We saw care plans had been put into place to help reduce or eliminate the identified risks.

Suitable arrangements were in place to help safeguard patients from abuse. Policies and procedures for safeguarding patients from harm were in place and staff had received safeguarding training.

The hospice had safe and effective systems in place to manage medication. There was medicine support in place from a pharmacist employed by the local hospital who told us they had a good working relationship with the staff and the doctors.

We found patients and their families were cared for and supported by sufficient numbers of suitably skilled, competent and experienced staff that were safely recruited. Staff received the essential training and support necessary to enable them to do their job effectively and care for patients safely.

All areas of the hospice were secure, well maintained and accessible for people with limited mobility. In addition good infection control procedures were in place; making it a safe environment. Systems were in place for carrying out regular health and safety checks and we saw that equipment was serviced and maintained regularly.

Staff were able to demonstrate their understanding of the principles of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions.

We saw that patients were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. Patients who were at risk of malnutrition and poor hydration had their food and fluid intake monitored to help ensure their well- being.

We were told that a change in the management board structure of the hospice had enabled staff to understand the clear levels of responsibility and accountability within the whole hospice team

To help ensure that patients received safe, effective care and support, systems were in place to monitor the quality of the service provided. Systems were also in place for receiving, handling and responding appropriately to complaints.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Sufficient suitably qualified and competent staff who had been safely recruited were available at all times to meet patient's needs.

The system for the management of medicines was safe and the care records showed that risks to the patient's health and well-being had
been identified.

All areas of the hospice were secure, well maintained and accessible for people with limited mobility. In addition, good infection control procedures were in place; making it a safe environment.

Is the service effective?

Good

The service was effective.

Staff were suitably supported and had undertaken the essential training necessary to enable them to do their work effectively and safely.

Staff were able to demonstrate their understanding of the principles of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

Patients were provided with a choice of suitable nutritious food and drink to ensure their health care needs were met.

Is the service caring?

Good

The service was caring.

Patients and families spoke highly of the kindness and caring attitude of the staff. Patients were cared for with the utmost compassion, kindness, dignity and respect.

Patients were supported at the end of their life to have a comfortable, dignified and pain-free death. The nursing and

medical staff showed they were highly skilled in pain and symptom control.

Visitors were made welcome and the staff recognised and considered the importance of caring for the needs of all family members and friends. The spiritual and pastoral support of patients and their families was considered and respected.

Is the service responsive?

Good

The service was responsive.

The care records showed that patients were involved in the assessment of their needs. A patient's preferred place of care at all stages of their illness and the arrangements in the event of their death were documented.

Staff were skilled in recognising when a patient was in the last days of life and were able to provide the appropriate care.

Suitable arrangements were in place for reporting and responding to any complaints or concerns.

Is the service well-led?

Good

The service was well-led

The service had a registered manager in post.

Clear lines of accountability and effective methods of communication were in place to ensure patients and their families received the best possible service.

Systems were in place to monitor the quality of the service provided to help ensure that patients and their families received safe, effective care and support.

Bury Hospice

Detailed findings

Background to this inspection

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

This inspection took place on 21 and 28 March 2017. The first day of the inspection was unannounced. The inspection team consisted of one adult social care inspector, a pharmacist and a specialist professional advisor (SPA). A SPA is a person who accompanies the inspection team and has specialist knowledge in certain areas. The SPA at this inspection was a specialist in end of life care.

Before our inspection we looked at the previous inspection report and records that were sent to us by the registered manager to inform us of significant changes and events. Prior to our inspection of the service we were provided with a copy of a completed provider information return (PIR). This is a document that asked the provider to give us some key information about the service, what the service does well and any improvements they are planning to make.

We spoke with four in-patients, one patient who was receiving care at home, three family members, one palliative care doctor, a visiting pharmacist, the registered manager, the care team manager, three registered nurses, one health care assistant, one student nurse, four volunteers, the cook and one of the domestic staff.

We looked around all areas of the hospice, looked at how staff cared for and supported patients and their families and looked at meal provision. We reviewed six patient's care records, the medicine management system, three medicine records, and three staff recruitment and training records. We also reviewed records about the management of the hospice.

Good

Is the service safe?

Our findings

Patients and relatives we spoke with told us they felt safe and well cared for. Comments made included; " We couldn't feel safer. The staff are so good and so kind" and "[Relative] felt safe and happy in your hands."

Policies and procedures for safeguarding people from harm were in place. These provided staff with guidance on identifying and responding to signs and allegations of abuse. The training records we looked at showed that all staff had received training in the protection of vulnerable adults and children. Staff we spoke with told us they had received training in safeguarding adults and children and they were able to articulate the procedures they would follow to raise concerns.

The PIR informed us that the registered manager took an active part in the Safeguarding and Quality Forum that was chaired by the NHS Bury Lead Nurse for Adult Safeguarding.

We saw the service had a whistleblowing policy. This told staff how they would be supported if they reported poor practice or other issues of concern. A member of staff stated they were aware of the whistleblowing policy but had not needed to use it. The staff member added that they would be more inclined to do so now, than with the management structure that was previously in place.

The care records we looked at showed that risks to patient's health and well-being had been identified, such as poor nutrition, the risk of developing pressure ulcers and the risk of falls. We saw care plans had been put into place to help reduce or eliminate the identified risks.

Inspection of the staff rosters and discussions with patients, staff and relatives showed there were sufficient, suitably qualified and competent staff available to meet patient's needs. All the patients we spoke with told us they received immediate attention both during the day and night and whenever they used their call bell.

We saw that patients under the care of the hospice were looked after by a specialist palliative care team. The team comprised of medical, nursing, allied health care professionals such as a physiotherapist and dietician, plus ancillary and administrative staff. The team were supported by volunteers.

The medical team of two palliative care doctors was led by a Consultant Physician who visited the hospice at least twice a week. We were told the medical team cared for patients on the Inpatient Unit and the Day Hospice as well as patients visiting for outpatient appointments. Although there was no doctor on site at all times we were made aware that 24 hour medical cover was provided. We were told that, in addition to one of the hospice palliative care medical staff being 'on call' for advice, the hospice used the 'out of hours' doctor service if necessary. Staff told us they were aware and knew how to contact the on call doctor and the out of hours service. The registered manager told us of the hospice recruitment plans to strengthen the medical cover for the weekend and for 'out of hours.'

We saw a safe system of recruitment was in place. We looked at three staff files. The staff files we looked at contained an application form including full employment history, professional references, proof of address

and identity including a photograph of the person. We saw that checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant.

During the last inspection there was no evidence to show us that the registered nurses had their registration checked with the Nursing and Midwifery Council (NMC). During this inspection we saw there was a system for regularly checking the nurses remained validated with the NMC. These checks should help to ensure patients are protected from the risk of being cared for by unsuitable staff.

We looked at the systems in place for the management of medicines. We spent time speaking with a pharmacist from the local hospital who told us how they supported the hospice. We were told they visited the hospice on a weekly basis and undertook ward rounds with the doctors. Their role was to ensure that the medicines prescribed were clinically appropriate. They also checked the prescription records to ensure they were accurately completed. They told us they had no concerns about the quality of prescribing and felt that medicines were being managed in a safe and effective way.

Medicines in use were stored securely in patient's rooms with access restricted to authorised staff only. Stock medicines were kept in a locked clinical room that was clean and well organised. There was no evidence of medicines being over-stocked.

Appropriate arrangements were in place for the management of controlled drugs (CDs). CDs are medicines that require extra checks and special storage arrangements because of their potential for misuse. There was a clear audit trail of CD s all the way through from receipt to destruction, including accurate transfer from the CD register to the destruction register. The drugs for destruction were stored correctly in tamper-proof bags.

We saw that the emergency drug stock was checked regularly to ensure there were sufficient quantities and that the stock was not out of date.

We checked the medicine fridge and saw that daily monitoring of the fridge temperature was being undertaken. Whilst the fridge was in the required range when we checked it, the high temperature for the previous two weeks was logged as 9.6C– outside of the 2-8C required range. We suggested to the staff that this was possibly due to the fact that the fridge door had been left open at some stage and the thermometer had not been re-set. We discussed with the staff the need to escalate any concerns in relation to the fridge temperature being outside of the required range; necessary to ensure the fridge is not faulty. Medicines may spoil and not work properly if they are kept at the wrong temperature.

We looked at the prescription records of three patients. They were accurately and legibly written including their allergy status. All medicines had authorisation signatures and were signed for by the staff administering them.

One patient had an additional chart for their pain relief patch, which although only requiring changing weekly, was checked on a daily basis to ensure it was still in place. The chart documented the location of patches and it was signed to confirm it had been checked. This was good practice.

One patient had a syringe driver in place to deliver their medicines in a controlled way. We were able to see the documentation in the prescription chart for this. There was a separate card for the syringe driver that was clear and logical and included information of the batch numbers and expiry dates of the drugs added to

it. There was evidence of four hourly checks including battery, flow rate, volume infused, keypad locked, and infusion site checks. The chart was thorough and robust and accurately completed.

We were shown the medicines policy and also evidence of medicine audits. The medicines policy was detailed and had recently been reviewed to include an updated section that dealt with medication errors.

We found all areas of the hospice were clean, bright, well maintained and suitably furnished and decorated. Rooms were spacious and uncluttered. Bathrooms were clean and tidy. Adequate supplies of clean linen were available. The patients and relatives we spoke with told us they felt that the environment was clean and comfortable.

The car parking areas were well laid out with very clear signage and clearly defined parking areas for disabled visitors. During the daytime hours up to 5pm, people were able to enter the hospice via the automatic doors and be greeted at the reception desk by two of the hospice volunteers. Out of hours the external doors were locked and people had to ring the doorbell for access. CCTV monitors were in place at the reception desk and on the Inpatient Unit. The provision of CCTV enabled the staff on the Inpatient Unit to see who required admission to the building. This helped to keep people safe by ensuring the risk of entry into the building by unauthorised persons was reduced.

We looked to see what systems were in place in the event of an emergency. We saw personal emergency evacuation plans (PEEPs) had been developed for each patient. These were kept in a central file at the reception desk. This information assists the emergency services in the event of an emergency arising, helping to keep everybody safe.

We saw the emergency resuscitation equipment that included a heart defibrillator, airways, oxygen and face masks was located in a designated prominent position on the corridor close to the Inpatient Unit.

We looked to see what systems were in place in the event of an emergency or an incident that could disrupt the service and/or endanger people who used the hospice. The hospice had a business contingency plan in place. This informed staff what to do in the event of such an emergency or incident and included circumstances such as; failure of the gas, electricity, heating and water supplies and the breakdown of essential equipment. This meant that robust systems were in place to help protect the health and safety of people in the event of an emergency situation arising.

We looked at the documents which showed equipment and services within the hospice had been serviced and maintained in accordance with the manufacturers' instructions. This included checks in areas such as gas safety, legionella, portable appliance testing, lift, hoisting equipment, and the fire and call bell system. These checks help to ensure the safety and wellbeing of everybody staying, working and visiting the hospice.

Inspection of records showed that a fire risk assessment was in place and regular in-house fire safety checks had been carried out to check that the fire alarm, emergency lighting and fire extinguishers were in good working order and that the fire exits were kept clear.

We saw that accidents and incidents were recorded and monitored to identify how the risks of re-occurrence could be reduced.

Since the last inspection the hospice had engaged an external Health and Safety company. On their recommendations the hospice has supported eight members of staff across all the key areas within the service to successfully complete the Level 3 Award in Health and Safety in the Work Place. These staff

members now formed the Health and Safety Forum of the hospice. This helps to ensure the health, safety and well being of everybody staying, visiting or working at the hospice.

We were told that Health and Safety meetings were held monthly and were shown the notes of the meeting that had been held in January 2017.

We looked at the on-site laundry facilities. The laundry looked clean, well-organised and secure; access to the laundry was by the use of a 'key fob' held by staff. Hand-washing facilities and protective clothing of gloves and aprons were in place. The laundry was adequately equipped with an industrial washing machine that regulated the temperature according to what was being washed. We saw that clean and soiled linen was kept segregated by means of separate laundry rooms.

We saw infection prevention and control policies and procedures were in place. We were told there was a designated lead person who was responsible for the infection prevention and control management. Colour coded mops, cloths and buckets were in use for cleaning; ensuring the risk from cross-contamination was kept to a minimum. Hand-wash sinks with liquid soap and paper towels were available in all clinical areas, bedrooms, bathrooms, sluices, toilets, the kitchen and the laundry. Alcohol hand-gels were in place at reception and throughout the corridors. Good hand hygiene helps prevent the spread of infection. We saw that appropriate arrangements were in place for the safe handling, storage and disposal of clinical waste.

Prior to the inspection Bury Council sent us a copy of the Infection Control Audit that had been undertaken on 14 February 2017 that showed a commendable overall rating of 93%. The registered manager told us that the issues that needed attention were being addressed.

We saw that, following a food hygiene inspection in March 2015, the hospice had been rated a '5'; the highest award.

Good

Is the service effective?

Our findings

Patients and relatives told us that staff were knowledgeable and were able to provide care in an effective manner. Patients we spoke with told us they received the care they needed when they needed it. Comments made included; " My wishes are always taken into account. They [staff] are so kind, so lovely" and "The staff check everything properly. They are excellent."

We looked at some of the responses from the 'feedback post cards' that had been made available to patients and families during the years of 2016 and 2017. Responses included; "During [relative's] time with you [relative] received every type of care needed. As a family we are very grateful", "The flexibility of visiting enabled us to have lasting memories", "You helped me through the last few days. Thank you" and "During [relative's] time with you they received every type of care needed. As a family we are very grateful" and "Thank you for doing the things that we as a family found hard to do."

The PIR informed us that the hospice had an excellent relationship with the Pennine Acute Specialist Palliative Care Team. This resulted in the hospice medical officer attending the hospital to assess and initiate the admission of a patient. This enabled an effective, supported transfer for the patient helping to allay their fears and anxieties.

Patients stated that they had been involved in discussions about their treatment and they had been kept fully informed. Relatives said that their relatives' wishes were taken into account and further evidence of this was seen in the 'thank you' notes sent to the hospice staff.

One patient had undergone a minor surgical procedure on the morning of the inspection and they told us they felt that this had been carried out in an effective manner and that there was adequate monitoring of their condition following the procedure.

Conversations around the subject of advance care planning were seen in the care plans. We saw that in some instances it had been deemed inappropriate to have the conversation at that time.

We were told that patients were supported at the end of their life to have a comfortable, dignified and pain free death. A discussion with the nursing and medical staff showed they were highly skilled in pain and symptom control. Comments made from the feedback cards included, "You created a calming and peaceful atmosphere" and "You gave [relative] comfort and peace of mind in their final days."

We were told that verbal and written 'handover' meetings between the staff were undertaken on every shift. This was to help ensure that any change in a patient's condition and subsequent alterations to their care and treatment were properly communicated and understood. We were shown the written handover sheets that were in use.

We were informed that the hospice medical team carried out a daily ward round from Monday to Friday, adopting an anticipatory approach to both care planning and prescribing. This helps to ensure that

wherever possible patient's needs are anticipated and planned for.

We looked to see how staff were supported to develop their knowledge and skills. A detailed induction programme was in place for all new staff, with the necessary training, both mandatory and clinical being undertaken within a few weeks of new staff taking up post. New staff were allocated a mentor to offer support, guidance and advice. Staff told us that they had a period of being supernumerary in the first few weeks of post. A competency checklist was in place which was completed by both the new member of staff and their mentor. This helps to ensure that the staff member is confident and competent enough to undertake their duties.

The staff we spoke with told us they had undertaken the essential training necessary to enable them to do their work effectively and safely. A discussion with the qualified nursing staff showed they had received clinical update training in topics such as; pain and symptom control, counselling, verification of death, advanced communication skills, medication management and syringe drivers.

During the last inspection it was identified that staff did not receive formal supervision. We were told this was due to the previous lack of management support. During this inspection we found that formal supervision of staff was in place. Supervision provides a safe and confidential environment for staff to reflect and discuss their work and discuss any learning and development needs they may have. We saw records to show that in addition to formal supervision, staff received an annual appraisal which included a review of their performance and progress within a 12 month period.

The volunteers we spoke with told us they felt supported and valued by their manager and by the hospice staff. They told us about the induction and the training they had received when they began working at the hospice.

The care team manager told us that the hospice had links with organisations such as Hospice UK, Greater Manchester Strategic Clinical Network, The National Council for Palliative Care and Members of North West Chair and Chief Executive group. The senior nursing staff also attended meetings with their peers within other hospices. Having these links enabled them to share good practice, develop ideas and offer support to each other.

We asked the registered manager to tell us what they understood about the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes, hospices and hospitals are called the Deprivation of Liberty Safeguards (DoLS). What the registered manager told us demonstrated they had a good understanding of the MCA and DoLS and knew the procedures to follow if an authorisation was required. We were told that no person in the hospice was subject to a DoLS.

Patients told us that any procedures undertaken were explained fully and their consent was gained before any treatments or procedures were started. We saw how staff requested the patient's consent before attending to their needs. The nursing staff told us, and visiting relatives confirmed that patient's wishes were recorded and respected. The care records showed where discussions had taken place with patients about

their wishes, especially in relation to whether they wished to be resuscitated or sent to hospital.

We checked to see if patients were provided with a choice of suitable and nutritious food to ensure their health care needs were met. A discussion with one of the cooks showed they worked closely with the nursing staff to ensure the texture, variety and content of the meals provided was appropriate for the patients. The cook was very knowledgeable about any special diets that patients needed and was also aware of how to fortify foods to improve a patient's nutrition. We were told none of the patients had any religious or cultural dietary requirements. The cook told us there would be no problem accessing halal or kosher foods if required. We were told that if patients didn't like the choice of meal on the menu they could always have something else from the food stocks. We were told that food was always available out of hours. In addition to some food stock areas of the main kitchen always being available, the cook told us that each evening the Inpatient Unit kitchen was stocked up with drinks and snacks.

We observed the lunchtime meal being served. The meals were well presented. Patients we spoke with had no concerns over the quality of the food and said they were given adequate choices. It was documented in the patient's notes if they had any food allergies and the kitchen staff were made aware of this information. Records of any allergies, likes, dislikes and special diets were also kept in the kitchen.

The care records we looked at showed that patients had an eating and drinking care plan and they were assessed in relation to the risk of inadequate nutrition and hydration. The registered manager told us that the hospice continued to have access to a 'palliative dietician' who would advise them on any specific concerns they may have.

Kitchen facilities were available for relatives on the Inpatient Unit and they were able to get snacks and drinks for their relatives and themselves at any time. Relatives told us they felt this was helpful. One comment from a 'feedback post card' was, "A great big thanks to the cooks who kept us going with the beautiful food which meant it was one less worry."

We were told by the care team manager about the services and facilities in place to support a patient's health care needs. The Day Hospice continued to offer a service one day a week, on a Wednesday from 10am to 3pm. The Day Hospice is managed by one registered nurse who is supported by a healthcare assistant and volunteers. Whilst attending the Day Hospice patients are able to access the services available to the inpatients, such as medical, nursing, spiritual and psychological support. We were told that due to financial constraints the hospice was not able to employ a person to provide complementary therapies, such as aromatherapy; however they did have a volunteer aromatherapist who worked two days at the hospice.

Patients are also supported by the Hospice at Home service. This consists of an experienced small team of registered nurses who care for patients in their own home who are seriously ill and nearing the end of their life. We were told the service operates from 8am to 4pm, Wednesday to Saturday. We spoke on the telephone to one patient. They told us, "They are the first call on my list when I need help. I trust them. Their help is fantastic and they are so kind and so respectful."

Good

Is the service caring?

Our findings

The expressions of gratitude relayed to us demonstrated that patients and family members were cared for with the utmost compassion, kindness, dignity and respect. Comments made included; "I can't thank them enough. They are absolutely wonderful", "They care about us too. I don't know what I would have done without them" and "Fantastic. Words can't express how I feel."

Responses from the 'feedback post cards' included; "You listened with true compassion and dedication", "You made us feel like [relative] was the only patient", "You gave us strength, love, care and time", "You treated us with compassion and dignity which made [relatives] final days easier" and "From the nurses to the cleaners everyone was brilliant."

Patients on the Inpatient Unit told us they felt that the staff were very kind. We were told that staff had time to listen to them and that their care was delivered in an unhurried way. We saw that dignity and privacy was respected, with procedures being carried out with the bedroom doors closed.

We found the environment had been organised in a way that promoted people's privacy, dignity and confidentiality. All the bedrooms were for single occupancy and there were many places within the hospice where conversations could take place in a quiet environment without interruption.

We found the hospice had placed great importance on ensuring that people's bathing experience was not just a task but was something that was pleasurable and relaxing. One of the bathrooms had a Jacuzzi bath and there were plenty of individual bottles of relaxing bath gels for patient's use.

From our observations we saw that staff approached patients in a kind and sensitive manner; often with a gentle touch to a patient's hand or shoulder. Staff knocked on doors, waited and asked permission before they entered bedrooms. All the staff we spoke with, including volunteers, spoke passionately about ensuring that patients and their families were cared for with dignity and compassion. We found that staff had a very good understanding of the needs and wishes of the people within their care.

We were told that some staff had undertaken training in 'enhanced communication skills'. This training is designed to enhance skills for communicating effectively with people in a way that embodies compassion, dignity and respect.

We saw that the hospice had links with a Dementia Project Worker for a local dementia service. We were told the professional was available, if needed, to offer advice and support for the staff when caring for any patient living with dementia.

We saw that visitors, including children, were made welcome by the staff. Routine visiting times were between 11am and 9pm. We saw there was a children's play area in one part of the dining room that had plenty of toys and various seating for the use of children of different ages. A comment from a 'feedback post card' was, "The playroom and biscuit tin were a firm favourite of the grandchildren." Another comment was,

"The flexibility of visiting enabled us to have lasting memories."

In the event of a patient nearing the end of their life, visitors who wished to stay close to them could stay in one of the two family rooms available or stay with their relative at their bedside. This showed to us that the hospice recognised and considered the importance of caring for the needs of all family members and friends during such a difficult time. One patient told us they were very grateful that there was such a facility within the hospice as it meant their partner could stay and spend quality time with them as they lived a considerable distance from the hospice and travelling time was long.

Thank you cards from many patients and relatives were seen on the Inpatient Unit and in the offices. All indicated that the care had been, 'second to none', and many bereaved relatives noted that they were cared for as well as the patients.

The team manager told us that the spiritual and pastoral support of patients and their families was always considered and respected. We were told visits to the hospice were regularly undertaken by a Roman Catholic priest and a Church of England minister. We were told that people could choose to have their own clergy visit them and also take Holy Communion if they wished. We saw that information about the beliefs and practices of various religions was kept in the staff office on the Inpatient Unit. This helps staff to meet the cultural and religious needs of the community they care for.

We saw there were lots of leaflets available for patients and their families. The information leaflets provided information on the facilities and services provided by the hospice and covered a range of topics such as; complementary therapies, bereavement services, counselling and psychotherapy services, information about advocacy services and information about other organisations that provided support and could possibly be of some benefit to them. This meant that patients were supported to have access to information to help them make decisions about their care.

We asked the registered manager to tell us what happened when a patient was extremely ill but wished to spend their final days at home. We were told that everything possible would be done to ensure the patients' wishes were respected. We were told about the partnership working in place within the community services, such as the district nurses, occupational therapists and physiotherapists to ensure that suitable staffing and equipment would be made available within the patient's home to ensure their needs and wishes would be met.

We also asked about the care provided to a patient after they had died. We were told that patients remained in their own temperature controlled room after death. This enabled family and friends to spend quiet private time with the patient before being taken to the funeral director.

The hospice had a Sanctuary room where patients and their families and visitors could sit peacefully or talk with staff in private. We were told the Sanctuary was open 24 hours a day and was for the use of everybody, including staff. We looked in the room and found it to be quiet and calming. There was a 'memory tree' in the Sanctuary where bereaved people could hang a message on a branch in memory of their loved one.

The hospice also offered a Bereavement Support Service. The service offered caring support to any family members or friends of someone who had died in the care of any of the hospice services. We were told that approximately six weeks after a patient had died a letter was sent to their main carer and/or close relatives or friends to offer bereavement support. We were also told that the hospice had recently started to send out a token containing wild flower seeds for families, if they so wished, to plant in memory of their loved one.

We were told that people could also contact the hospice directly. Bereavement support was offered on a one to one basis either at the hospice or in some circumstances, in people's own homes. The length of time people received support depended on how they felt.

We were told that the hospice held regular remembrance services three times a year at Bury Town Hall. They are non-religious services and are dedicated to patients who have recently died. The visiting clergy from the hospice, the nursing staff and volunteers from the hospice give up their time to attend the service and help support people who have been bereaved. During the service the names of those who have died are read out and a candle may be lit in their memory.

We saw that support was extended to relatives and friends of the patients by means of the Family Support Service. The service offers a one to one listening service to people, either at the hospice, their home address or by telephone. The service gives people the opportunity to talk to someone outside of their family and friends about their feelings and emotions at a time when they are involved with someone who has a life-limiting illness.

We were informed that care was extended to the hospice staff by offering access to 1-1 counselling. The hospice has a Special Leave Procedure that supports staff to be with their families during particularly difficult family circumstances.

Staff we spoke with were aware of their responsibility to ensure information about patients was treated confidentially. We saw that care records were kept in the staff office in both the Inpatient Unit and the Day Hospice; this helps to ensure that information about patients is kept secure. We saw that information leaflets were displayed throughout the hospice explaining to patients how the hospice kept their information safe and confidential. The leaflet explained what information was kept, why it was needed, how the information was used, how it was kept safe and when, how and by whom, it could be accessed.

Good

Is the service responsive?

Our findings

Patients told us of how quickly the nursing and medical staff responded to their needs. They also told us that staff took the time to listen to them and always answered their questions in a kind and sensitive way. A comment from one of the 'feedback post cards' was, "During [relative's] time with you they received every type of care needed. As a family we are very grateful."

Some of the staff, although understanding of the financial constraints placed on the hospice, continued to express their disappointment that the Day Hospice was only operational for one day a week. Concerns were also expressed about the under- utilisation of the hospice beds.

The PIR informed us that all referrals to the hospice were held on a waiting list which was reviewed daily by the multidisciplinary team of medical and nursing staff. If an assessment of the person showed their need was urgent they would be admitted to the Inpatient Unit that same day. We were told the Hospice at Home team liaised with other healthcare professionals at the start of their shift to determine priority of need for the care required in their own home. The hospice held weekly palliative multi-disciplinary team meetings where each patient's current needs were discussed.

We saw that the admission documentation contained information that 'followed' the patient throughout the service. The care records showed patients were involved in the assessment of their needs. The six care records that we looked at contained sufficient information to show how the patient was to be supported and cared for. A patient's preferred place of care at all stages of their illness and the arrangements in the event of their death were documented.

We were told that the hospice had strong links with both the specialist palliative care teams within the hospital and the community. It was explained that discussions in relation to patient's care choices took place at key stages, both prior to and whilst within the hospice services. This level of communication and sharing of information promotes a seamless and supportive transfer, admission and discharge process for both patient and family. Shared core documentation across the services is a central element to communicating a patient's care plan and level of input and care required at each stage of their illness. This process also negates the patient/family from having to repeat their 'story' several times in what can be a short time frame.

We saw that staff used appropriate measures to monitor a patient's pain or other escalating symptoms such as nausea. Pain check lists were seen in the care plans and these were completed appropriately. Any escalating symptoms were referred to the medical team quickly for review.

A discussion with the staff showed they were passionate about providing good quality end of life care. Training records and discussions showed that the hospice staff were skilled in recognising when a person was in the last days of life.

We were shown the 'Individual Plan of Care and Support for the Dying Person in the Last days and Hours of

Life' document. This document included information and guidance for staff in relation to the priorities of care in the last days of life. This included issues such as an individual plan of care covering aspects of food and drink, symptom control, psychological, social and spiritual support. Also the recognition of dying, preferences of care, advanced care plans and communication with the patient and their family.

We saw that patient notes were kept in the Inpatient Unit office. Separate notes were kept by the medical staff and these were in a trolley in the doctor's office. Nursing staff told us they could access the medical notes at any time if they needed to.

We were told that patients were discharged from the hospice services if and when it was appropriate and a written summary of their needs accompanied them. The discharge of patients involved an individual assessment of their needs, including needs of their family, and liaison with other specialist palliative care staff.

The Hospice at Home team told us how they worked in partnership with the community district nurses and specialist palliative care nurses to ensure the best possible outcomes for patients. This was in respect of being able to access specialist palliative medical and nursing services and also the appropriate equipment. We were told that plans were in place to relocate some of the community specialist palliative care professionals into the hospice in the very near future.

The hospice had a complaints procedure that was made available to patients and their families. We were told that any complaints made would be taken seriously, and appropriate action taken to address any issues raised. We were shown the computerised complaints log that was in place.

Relatives indicated that they would be comfortable approaching any member of staff if they had something they wished to discuss, or if they had any particular concerns or complaints. In addition staff were able to describe the process they would use should a complaint arise from a patient or a relative.

We found that sufficient and suitable equipment and adaptations were available to meet patients' needs. Each bedroom had a special type of bed that helped staff position patients more easily. The beds and chairs had a pressure relieving mattress in place to promote comfort and help prevent pressure ulcers developing. Each bedroom also had a 'rise and fall' chair to assist patients with their mobility and provide comfort. The bathrooms and toilets had assisted bathing or showering facilities and fixed aids and adaptations were in place. This helps to promote a patient's independence and comfort and assist in their safe moving and handling.

Good

Is the service well-led?

Our findings

The service had a registered manager who was present during the second day of the inspection. A discussion with the registered manager showed they were clear about the aims and objectives of the hospice. This was to ensure that the hospice was run in a way that supported the need for patients to have the best quality specialist palliative and end of life care. We saw that a poster was displayed throughout the hospice showing what the 'core values' of the hospice were.

Following the last inspection a full review of the governance structure had been undertaken and a new chairman, interim general manager, and a new board of trustees have been appointed. The registered manager told us they had brought to the hospice considerable experience of leadership in hospice and health care environments and a diversity of other organisational and professional experience.

During the last inspection we found there was no business plan in place. During this inspection we were shown the business plan that had been implemented for the period of 2016 to 2018. The registered manager told us it had been developed through comprehensive consultation with the staff. We were told that progress against planned aims and objectives was reviewed through board meetings and that investment and business development strategies were related to the business plan aims and objectives.

We were shown some of the reports from the meetings of the Board of Trustees and the Clinical Governance Committee that were held monthly. The reports demonstrated the clear levels of responsibility and accountability within the management structure.

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help registered providers assess the safety and quality of their services. This helps to ensure they provide patients with a good service and meet appropriate quality standards and legal obligations. The service had a good system of regular auditing in place for aspects of care and safety such as; health and safety of the environment,, pressure ulcers, pain management, infection control and medication.

We saw that there was a clear system in place to monitor, review and investigate all accidents and incidents.

We saw that management sought feedback from patients, their families and visitors through the use of the 'feedback postcards' that were left in patients' rooms. We were told it had been recognised that there was a variable uptake with the postcards and that the hospice planned to review the current method and to consider the phone 'applet' system of 'I Want Great Care'.

We were told that a staff survey was undertaken recently to provide the Board and Executive Team with an insight into important issues such as; welfare, morale & internal communication. We were told that the findings would inform management decision making and promote an open culture to share concerns and information.

Staff and volunteers spoke positively about working at the hospice. They told us they felt the culture of the hospice had changed over the last few months and they were kept more informed of issues that were taking place. We were told that the current management were approachable and were 'visible'. They also told us they would be comfortable about approaching senior staff about any issues of concern.

Staff told us that they had staff meetings with senior staff every three months, however some staff felt they would like to have them more often. One member of staff stated they thought there could possibly be more feedback from management as they still found out information from the local press that had not been shared within the hospice environment.

We checked our records before the inspection and saw that accidents or incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant we were able to see if appropriate action had been taken by management to ensure patients were kept safe.