

## Wigan and Leigh Hospice

# Wigan and Leigh Hospice

### Inspection report

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### Ratings

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

# Summary of findings

## Overall summary

This inspection took place on 5 and 6 October 2016 and was announced. We provided 48 hours' notice of our visit to ensure the registered manager would be available to facilitate our inspection. The service was last inspected on 8 October 2013 and was found to be meeting all the regulations we reviewed at that time.

Wigan and Leigh Hospice is a registered charity, situated in the Hindley area of Wigan. The hospice was founded in 1982. It is an adult hospice for people aged 18 or over and delivers specialist palliative care to people who have a life threatening illness from any disease and who are thought to be in the last year of their lives. The hospice is a purpose built unit and provides ground level accommodation for up to 14 inpatients. Facilities included: 14-bed inpatient unit in 14 separate rooms; a patient and visitor lounge; an overnight room for families; a multi-faith room; three complementary therapy rooms; two counselling rooms; outpatient clinics; free of charge car parking; meeting rooms for hire.

Exceptional management and leadership was demonstrated at Wigan and Leigh hospice. Our discussions throughout the inspection demonstrated that there was an open culture which empowered people to plan and be involved in the high quality care provided at this service. This meant that people continuously had a say in how they wanted their care to be delivered. The strong and positive management approach resulted in people receiving a tailored inclusive service which focused on them receiving individualised care.

There was a hospice in your home service provided by a team of nurses, healthcare assistants and volunteers. The team offered one-to-one time with patients and gives practical as well as emotional support alongside hands-on nursing care, including daytime visits and occasional overnight stays. By providing additional support in this way the team enabled more people to stay in their own homes as they come towards the end of their lives.

There was also a team of clinical nurse specialists employed by and based at the hospice who provided support in person or via the telephone advice line.

Medical and Nurse Specialist outpatient clinics were held in the Hospice's Woodview Centre. They offered specialist assessment or review for patients with complex or rapidly changing symptoms who needed specialist assessment.

There were five hospice doctors of whom four were very experienced in hospice care. In addition there were two registrars on the on-call rota with one doing a half day a week of daytime clinical work at the hospice as well as some teaching. The medical director was part of the leadership team and a member of three hospice governance committees. There were three consultants working at the hospice.

Wigan and Leigh hospice is registered with the Care Quality Commission (CQC) to provide care for up to 14 people on the inpatient unit. At the time of our inspection there were 12 people being cared for and approximately 250 people receiving care and support in the community. Of these 250 people, the manager

told us that provision of personal care was limited and they provided more emotional and practical support.

All the people we spoke with during the inspection told us they felt safe when they received care and treatment from hospice staff. There were appropriate policies and procedures in place with regards to safeguarding and whistleblowing. This told staff how they would be supported if they reported poor practice or other issues of concern.

We looked at the way medicines were prescribed and managed at the hospice and found that medicines were managed safely. There were clear, detailed policies and procedures covering the different aspects of medicines management.

There was an accountable officer who submitted reports to the controlled drugs local intelligence network (LIN) and attended LIN meetings. Controlled drugs were handled safely and nurses checked stocks weekly. The accountable officer audited the medicines every six months. Staff were encouraged to report medicine errors so lessons could be learnt and practices made safer.

People and relatives we spoke with in the inpatient unit told us they did not have to wait to receive assistance from staff and that call bells were always responded to in a prompt manner; this was confirmed by our observations during the inspection.

Our review of staff rotas and our observations confirmed there were sufficient numbers of staff on duty to provide the care people required.

We observed that the standards of cleanliness throughout the entire building were very high and everywhere was very clean, tidy and fresh. The hospice premises were subject to monthly checks and results were recorded and acted upon. An infection control committee met regularly to review standards, discuss policy and ensure implementation of appropriate guidelines.

An external contractor had carried out a risk assessment of the premises and provided a report to the chief executive officer. This helped to identify and manage health and safety risks within the premises.

There was an emergency contingency plan in place which included information about what action to take as a result of an unforeseen event.

Regular fire alarm checks were undertaken and water chlorination and Legionella testing was carried out and recorded. All equipment was subject to annual checks or as required as part of their maintenance schedule and comprehensive records were maintained and up to date.

People who used the service and relatives consistently told us they felt staff were well trained and had the skills to provide effective care. They had access to a range of training as part of their on-going development.

Staff completed a period of induction when they started their employment. Volunteers were also required to complete a period of induction and topics covered included specialist palliative care within a hospice setting, confidentiality, responsibilities/boundaries, moving and handling, fire safety, health and safety and safeguarding. Staff were knowledgeable about people and told us that they received appropriate training and support.

Each person had a care plan with regards to eating and drinking. The kitchen staff worked with the dietitians to make sure that food was nutritionally sound and food was homemade.

We saw that teams within the hospice engaged proactively with other professionals to achieve good outcomes for people.

People's legal rights were respected because staff understood their responsibilities in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). At the time of the inspection there was nobody subject to a DoLS order. There was a policy and procedure in place for consent to care and treatment. Best interest decision making care plans were in place as required when someone lacked capacity and capacity assessments were completed by doctors.

The building was light and airy and pleasantly decorated with high ceilings and lots of light. People had a spacious individual room and all bedrooms overlooked the garden area.

Everyone we spoke with was positive about the hospice and said that staff were caring and kind. Staff also told us they cared for each other. The same care was applied to making sure staff were aware of patients' communication needs. A section within the care plan noted people's information access needs.

People were encouraged to discuss their care and were involved in advanced care planning. The hospice carried out an initial assessment which looked at their pain, level of comfort, family and their mood. We saw that staff spoke in a quiet tone and ensured they were at the same eye level of the person when talking with them.

When staff were completing advance care plans with people who used the service they discussed with them whether or not they wished to be resuscitated. There was a counselling service at the hospice and the service held placement agreements with local educational establishments and offered placement contracts to student counsellors. The counselling service was involved with bereavement support for people. They supported people to create keepsakes if they wished. The counselling service had identified a need to develop carers groups and was forging links with another local organisation to do that.

There was a focus on people's spirituality if that was important for them. The hospice had consulted with patients and carers to look at how to make the original chapel more accessible.

There was a team of bereavement support volunteers, counsellors and complementary therapists that could be accessed by anyone linked to a person using the hospice who required it.

We saw that sensitive conversations took place in private with confidentiality fully maintained and information was only shared, with the patient's consent, with those who were authorised to see it.

All the people we spoke with during the inspection told us the hospice had been responsive to their needs, providing them with an excellent service. Care plans were person centred and contained risk assessments where needed with guidance for staff.

Care plans contained contact details for people's relatives, friends and others and their GP's. Any allergies were also recorded and noted on people's MAR charts. Any tasks for the day were visible in people's care plans.

People's views about their strengths and levels of independence and health and what their quality of life should be, were taken into account and explanations were given to people about their care plans. There was a range of palliative care information for each person. This identified their clinical diagnosis, resuscitation status, and the 'patient insight' section identified whether or not the person was aware of their diagnosis.

Daily records, which recorded what had happened each day for each person, were completed in a timely manner.

People were supported to maintain relationships with people that mattered to them. People were supported to follow their interests and take part in social activities. People were able to use the chapel as a 'reflection room' which offered a peaceful space where people and their visitors were welcome to sit if they wished. There was an arts and crafts room with lots of useful materials available and people could undertake this activity in their own room if they wished. There was a hairdressing salon available to people and their relatives and a bright and airy new coffee shop was due to be opened that would be available seven days a week, all day and night.

At the end of their life people received compassionate care. They had advanced care plans in place which noted their preferred place of care and death. We saw staff show compassion and care to a person at the end of their life and their family during the inspection. The individualised plan of care in the last days of life recorded the tailored care provided to a dying person and their family. There was clear recognition by the multi-disciplinary team when a person was dying and once that was established all actions taken were in accordance with the person's wishes. People could sleep and stay overnight with their relative. There was a relative's room where they could make drinks and snacks.

There was a system in use which allowed families to be able to spend time with their loved one after death. This allowed time for them to say their goodbyes in private. When a person had passed away the hospice offered a bereavement service to families and carers. Quarterly remembrance evenings also provided a forum for those who had recently lost a loved one in the hospice's care to come together and remember them.

The hospice had a positive approach to using complaints and concerns to improve the quality of the service. The service had a policy and procedure for managing complaints which outlined the arrangements for investigating and responding to complaints. We noted that any concerns had been taken seriously, investigated, action taken and lessons learned. We saw that outcomes from complaints were linked to change of practice when necessary.

The hospice used a variety of different methods to seek, listen and take action based on feedback received including questionnaires, a comments box, and feedback and evaluation questionnaires. We noted that the relatives of many people who had previously used the hospice had made a financial donation in recognition of the quality of care their relative had received and due to the organisation being a charity.

Our discussions throughout the inspection demonstrated that there was an open culture with staff empowering people to plan and be involved in the high quality care provided at this service. Staff were passionate about their roles when they spoke to us and during the inspection, people were unanimous in their positive comments about working at the service and were very keen to tell us about their area of work.

The hospice had a stated vision and a clear set of values which were referenced in a document called 'Hospice Mission Statement, Vision and Values'. There was also a statement of purpose in place. The hospice is a charity overseen by a group of trustees. These trustees were selected from the members and represented a spectrum of skills which were of benefit to the hospice. Members represented the local community.

We saw evidence of regular clinical audits, for example of medicines management, safeguarding concerns raised as well as the health and safety of the care environment. These resulted in action plans to improve

where appropriate.

Due to the Day Hospice being under-utilised, this area was now changing and being developed into a 'wellbeing centre' which would be therapy-led rather than nurse-led. It had not been possible to keep the service running during the transition period due to staff leaving for unconnected reasons. Other areas being developed were the café and refurbishment of the inpatient unit had started to make it more homely and welcoming.

Partnership working was an integral aspect of how the leadership and management of the service sought to improve care provision through the sharing of best practice, service development and joined-up care, particularly when packages included multiple agencies and care providers. The service worked in partnership with Allied Healthcare Professionals Team employed by Bridgewater Community Healthcare NHS Foundation Trust, and at the time of the inspection was looking at adapting the 'feed at risk' policy from the local acute trust. Different managers within the hospice also worked extensively in partnership with other organisations and had a lead role in that particular area and information from partnership meetings was used to inform the delivery and improvement of services at the hospice.

## 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.

People said they felt safe at the hospice, with staff having a good understanding about how to report safeguarding concerns.

We found medication was handled safely.

The premises were clean with appropriate systems in place to reduce the spread of infections.

### Is the service effective?

Good ●

The service was effective.

People said staff were well trained and had good skills.

Staff had access to a wide range of training and received appropriate supervision.

People at the hospice told us about the high standard of food and drink available.

### Is the service caring?

Good ●

The service was very caring.

People and relatives told us staff were extremely kind, caring and compassionate.

The ethos of care was person-centred and valued each person as an individual. People felt that they mattered. Staff were skilled at helping people to express their views and communicated with them in a sensitive and caring manner.

People received care and treatment which enabled them to have a dignified and pain free death. Families and those that mattered to people were supported to spend quality time with them and were also able to access bereavement support following their family member's death.

### Is the service responsive?

Outstanding ☆

The service was very responsive.

People received care that was highly personalised to their individual needs, wishes and requests.

Staff worked in partnership with people to develop care plans which enabled them, as far as possible, to fulfil their wishes and goals.

People were encouraged to provide feedback about the care they received from the hospice. Robust systems were in place to share lessons learned from complaints with staff and ensure any required changes in practice took place.

The service was evaluating how the hospice served the lesbian gay bisexual and transgender (LGBT) community and whether or not the hospice services were LGBT friendly. Staff understanding of this area and the literature required was being developed.

### **Is the service well-led?**

The service was exceptionally well-led. Partnership working was an integral aspect of how the leadership and management of the service sought to improve care provision.

There was a registered manager in post. People commented positively about the quality of leadership in the service. The leadership team promoted an open and positive culture that placed people and staff at the centre of the service.

The leadership team promoted strong values of person-centred care and worked in partnership with other organisations to provide high quality, evidence based end of life care for the local population.

The hospice had a range of robust monitoring systems in place in order to review the quality of people's care and the environment. There was a clear commitment to on-going service improvement throughout the hospice.

**Outstanding** 

# Wigan and Leigh 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 5 and 6 October 2016 and was announced. The inspection team consisted of three adult social care inspectors. At the last inspection on 8 October 2013 the hospice was meeting the required standards inspected at that time.

We gave 48 hours' notice that we would be visiting the service. This was because the service provided a hospice at home service to people in the local community and we needed to arrange to visit people in their own homes. We also wanted to ensure the registered manager would be available to facilitate our inspection.

We looked at information we held about the hospice. We looked at notifications we had received. Statutory notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. Before the inspection, the provider completed a Provider Information Return (PIR). 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 used the information they had given us to help with our planning.

At the time of our inspection, there were 12 people on the inpatient unit. During the inspection we spoke with the medical director, the chief executive officer, the registered manager, the palliative care education lead, the cook, the receptionist, two volunteers, a ward sister on the inpatient unit (IPU), the senior staff nurse administering medicines, a staff nurse on the IPU, three people receiving services on the IPU, two relatives on the IPU, two occupational therapists, a dietician, three health care assistants, and a social worker. We also spent time with three health care assistants and a nurse working in the community and spoke with one person and their relative, when we visited them at home.

During the inspection we looked at the care records for four people using the inpatient unit and six

medicine administration records (MAR's). In addition we reviewed a range of records relating to how the service was managed; these included five staff recruitment files, training records, quality assurance systems and policies and procedures.

## Is the service safe?

### Our findings

All the people we spoke with during the inspection told us they felt safe when they received care and treatment from hospice staff. One person on the inpatient unit (IPU) said, "I am very safe. It is a beautiful place which is spotlessly clean." A second person told us, "They check people regularly." A third person commented, "Staff are absolutely brilliant, they can't do enough for you." A relative told us, "[My relative] is safe here." A person receiving support at home said, "They are lovely, always lovely." A relative of a person receiving support at home said, "The hospice at home service are very understanding about the type of help needed and what is required by the family; not every family is the same and wanting the same assistance."

We saw that the staff practice was safe and that staff took great care to ensure that every area of the service was run safely. An example of this was the hourly checks of people who used the IPU service. Members of staff checked people's safety in relation to health, equipment and environment throughout the day. Access to the hospice was through the reception which was staffed from 8.00 am until 8.00 pm. At other times access was gained via the video entry system connected to the Inpatient Unit nursing station. This provided a secure environment for people.

We looked at the systems in place to safeguard people from the risk of abuse, within the service. There were appropriate policies and procedures in place with regards to safeguarding and whistleblowing. This provided staff with guidance on how to report poor practice or other issues of concern.

Staff displayed a good understanding of safeguarding people who used the service and those we spoke with were familiar with these policies and knew how to escalate concerns within the service. They also knew they could contact people outside the service if they felt their concerns had not been listened to. A social worker who was permanently based at the hospice said, "I help to train staff and volunteers in safeguarding. The registered manager is very pro-active in meeting families if there are any issues. The staff always display an understanding of people's needs and safeguarding's don't happen very often." People could be confident that staff knew what to do in the event of any concerns regarding their wellbeing. The registered manager spent time with all new staff during their induction with the aim of ensuring that all staff knew her and felt able to report or discuss concerns they may have about the organisation.

We looked at the way medicines were prescribed and managed and found that they were managed safely. There were clear, detailed policies and procedures covering the different aspects of medicines management. People brought the medicines prescribed by their own doctor with them to the hospice and these were used if they were suitable for use. There was a checklist for staff to complete to determine suitability. Medicines for use within the hospice were supplied by two pharmacies in order that they obtained their medicines legally. Controlled drugs were supplied by a pharmacy which held the correct licence. Controlled drugs (CD's) are medicines which require stricter legal controls to be applied to prevent them: being misused, being obtained illegally or causing harm.

A pharmacy technician from the supplying pharmacy visited the hospice twice a week to check all people's own medicines. In addition a rotational pharmacist from Royal Albert Edward Infirmary visited the hospice

once a week to carry out medication audits and if required they destroyed people's own CD's with a nurse. Stock CD's were destroyed by the rotational pharmacist from the local acute trust whenever it was necessary. Controlled drugs were checked by a second nurse. This ensured people's safety.

During the inspection we spoke with the accountable officer. The accountable officer is the person who has a legal responsibility to ensure that controlled drugs (drugs liable to misuse) are properly managed at the hospice. If necessary the accountable officer submitted reports to the controlled drugs local intelligence network (LIN) and attended LIN meetings. The accountable officer audited the medicines every six months. We checked a sample of controlled drugs stock and found no discrepancies. The term 'unlicensed medicine' is used to describe medicines that are used outside the terms of their UK licence or which have no licence for use in the UK. Unlicensed medicines are commonly used in some areas of medicine such as in palliative care.

Medicines were stored securely. Medicine room temperatures and fridge temperatures were checked regularly by staff and were within normal range. If medicines are not stored at the right temperature they may be less effective or unsafe to use.

Appropriate arrangements were in place for managing the pipeline supplying oxygen to people's bedsides. Oxygen cylinders were also available and there was signage to identify the places in the building they were kept. Emergency equipment was checked each day to make sure it was ready for use if needed, which meant the service could respond safely to an unexpected event that required the use of this equipment.

Staff were encouraged to report medicine errors so lessons could be learnt and practices made safer. Incidents involving medicines were recorded and appropriate action was taken in a robust fashion. The visiting pharmacist identified any omissions weekly and these were reported as errors. When errors were identified the deputy accountable officer would speak to the staff member and either observe their practice, ask them to complete a reflection on the incident or reassess their competency to administer medicines. The errors were linked to the staff member's HR file and were discussed at a quarterly medicines management meeting.

People and relatives we spoke with in the inpatient unit told us they did not have to wait to receive assistance from staff and that call bells were always responded to in a prompt manner; this was confirmed by our observations during the inspection.

Our review of staff rotas and our observations confirmed there were sufficient numbers of staff on duty to meet people's needs in an unhurried way. The registered manager told us that any staff absences were covered by hospice staff and that RGN agency staff were never used; this helped to ensure people received safe and consistent care. We noted there was also a team of trained volunteers who undertook a range of non-clinical roles throughout the hospice. By having enough staff working at the hospice, this meant people's needs could be met safely.

The hospice in your home service (HiyH) had 2.2 full time equivalent registered nurses, 6.8 full time equivalent health care assistants (HCA's) and 0.2 full time equivalent complementary therapists. Volunteers were also available to offer companionship. The service ran over seven days between the hours of 8:30am and 9pm with HCA support between 9pm and 8 am.

The HiyH service primarily provided day support. These were 90 minute visits to people in their own homes and staff sat with the person whilst family/carers had a break. They provided personal care if required or any other support if needed. They could also provide a care package in the short term if a care package from an

agency could not commence immediately. They also provided night support to supplement Marie Curie night sitting service. The team liaised with Marie Curie to arrange this. Volunteers were also available to provide companionship. The volunteer service ran between 9.30am and 4.30pm Monday to Friday; the HiyH service operated seven days a week between 8.30am and 9.00pm with HCA night support between 9.30pm and 8.00am.

Safe recruitment procedures were in place. We looked at staff recruitment files and saw that they had completed an application form, which included information about their qualifications, experience and employment history. They had two written references in place, one of which was from the last employer, personal identification and evidence of a Disclosure and Barring Service check.

This also applied to the team of volunteers who worked at the hospice. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions and minimised the risk of unsuitable people being employed. Checks of nursing qualifications had been carried out prior to nurses starting work and regularly thereafter, ensuring they were suitably qualified for their role. Nursing qualifications and registration details were checked with the Nursing and Midwifery Council (NMC). The NMC is the regulator for nursing and midwifery professions in the UK. The organisation maintains a register of all nurses, midwives and specialist community public health nurses eligible to practice within the UK.

The standards of cleanliness throughout the entire building were very high and everywhere was very clean, tidy and fresh. There were a team of domestic assistants who worked in different areas of the service. Cleaning schedules were in place to identify different jobs required but these had not always been consistently completed. However, the cleanliness of the service indicated that staff were completing all cleaning tasks. There were separate cleaning schedules for the kitchen which were signed. Staff had access to personal protective equipment (PPE) on the IPU. Alcohol gel was available throughout the service. The risk of infection was minimised because the domestic staff were thorough in keeping the hospice clean.

An infection control committee met regularly to review standards, discuss policy and ensure implementation of appropriate guidelines. For example, at an infection control meeting held in July 2016 we saw that new cleaning equipment had been sourced to more effectively clean sinks, a ceiling hanging maiden had been purchased to increase floor space in the laundry areas and reduce the potential for the spread of infections and a new mattress audit tool had been introduced. After each meeting, which were bi-monthly, an action log was created identifying the issue, the action required, who was responsible and the timescale for completion. The hospice was a member of the Hospice and Independent Providers – Preventing Infection Together programme. Staff attended regular meetings chaired by the infection control lead from Wigan Borough Clinical Commissioning Group (CCG).

An external contractor had carried out a risk assessment of the premises and provided a report to the chief executive. This was to help to identify and manage health and safety risks within the premises and included an overview of the premises, a risk profile, risk levels and action priorities, control measures required and an associated action plan. For example we saw that the risk assessment had identified the need to provide adequate fencing or protection to water features, where there was a risk of drowning, and this had been completed.

Regular fire alarm checks were undertaken and water chlorination and Legionella testing was carried out and recorded. All equipment was subject to annual checks or as required as part of their maintenance schedule and comprehensive records were maintained and up to date. Staff received initial and updated training on the safe use of equipment including the use of PPE where required.

There was an emergency contingency plan in place which included information of what action to take as a result of an unforeseen event such as loss of utilities supply, loss of staffing, fire and flood. The plan included contact numbers for relevant persons and suppliers/contractors.

We looked at the arrangements in place for managing accidents and incidents and preventing the risk of reoccurrence. Accidents and incidents involving people who used the service were recorded in order to maintain current records. These were audited and reported upon in some cases. For instance the incidence of falls and pressure ulcers was audited, recorded and benchmarked against other hospices. Where it was necessary incidents and accidents were reported to the local authority and CQC. Near miss incidents were identified and themes collated and acted upon. Safety incidents were shared with the hospice trustees and clinical commissioning group (CCG) partners on a regular basis.

## Is the service effective?

### Our findings

People who used the service and relatives consistently told us they felt staff were well trained and had the correct skills to provide exceptional care. One relative told us, "They support [my relative] in understanding what they are doing." A person on the inpatient unit (IPU) said, "The staff always know the history. I know this because every time they come to see me they have up to date knowledge of my treatment."

We saw staff had access to a wide range of training as part of their on-going development. The training matrix identified staff had completed core training. Staff received a range of other training courses, specific to caring for people with palliative care needs.

Staff were well supported to develop their knowledge and skills. We looked at the induction programme that newly appointed staff had to undertake on commencement of their employment. Induction programmes help staff to understand what is expected of them and what needs to be done to ensure the safety of the staff and the people using the service. Volunteers were also required to complete a period of induction and topics covered included specialist palliative care within a hospice setting, confidentiality, responsibilities/boundaries, moving and handling, fire safety, health and safety and safeguarding.

Staff clearly showed their knowledge of people and their needs and told us that they received appropriate training and support. One member of staff said, "We get great support from managers. The registered manager and chief officer are always checking we are okay; we have the time to spend with people. It's nice to see them [People who used the service] as a person; get to know them. It's the first time since I became a nurse in any job that I've been able to do that." Another staff member told us, "I'm just as enthusiastic now as when I started."

During the inspection staff told us and we saw that they had access to one to one supervision, at least four times each year and staff also took part in group discussions. Supervision is a meeting between staff and senior workers; it gives staff an opportunity to discuss their work, training and development needs. A supervision record was completed outlining the focus of discussions and records were also held electronically with the human resources (HR) system. We saw records to confirm staff received an annual appraisal which included a review of performance and progress within a 12 month period. This process also identified any strengths or weaknesses and areas for growth. The service used an electronic recording system called SystemOne. SystemOne is a clinical record system used to record people's care electronically in real time and share information with other healthcare professionals.

The hospice was involved in working closely with other services to improve care for people affected by terminal illness. They extended expertise and knowledge and ensured that hospice care was reaching more people. An example of this was the hospice taking part in an initiative involving eight care homes in the Wigan and Leigh area called Hospice in Your Care Home.

The hospice in your care home team worked in partnership with the care homes to enhance the quality of care received by people in the last few weeks and days of life, with the aim of promoting comfort and

dignity. The team was made up of five experienced registered nurses and a health care assistant from the hospice and worked closely with nursing home staff to promote training based upon the most up-to-date research available and equip them with the practical skills and knowledge needed to provide sensitive, timely and compassionate end of life care. This also served to reduce unnecessary hospital admissions made in the last few days of life by providing dedicated support and basic training in palliative and end of life care.

In addition, the palliative care education lead had conducted several training events held for GP's around the Mental Capacity Act (MCA), DOLS and the role of the Independent Mental Capacity Advocate (IMCA). As a result of training carried out for the GP's these areas had been identified by them as an area in which they would like further training particularly when completing Advance Care Plans with their patients.

The medical team was made up of doctors with a wide range of skills and experience. There were three consultants working at the hospice. One worked full time at the hospice; one worked at the local hospital and carried out one or two sessions plus on-call at the hospice and a third consultant worked between both locations. They were all part of an on-call rota. There was a senior hospice physician who gave a lot of support to the community team and carried out joint visits with the palliative care nurse specialists.

There were five hospice doctors of whom four were very experienced in hospice care. They worked predominantly on the IPU and provided some cover for the community service. There was a multi-disciplinary team (MDT) educational forum held weekly. The medical team took part in case reflection, journal clubs and discussed audits as part of their development. Registrar trainees who had a six month placement at the hospice were expected to carry out an audit as part of their training.

In addition there were two registrars on the on-call rota, with one doing half a day per week of daytime clinical work at the hospice as well as some teaching. They were supernumerary to the existing staff rota. GP's trainees trained at the hospice received regular teaching.

The medical director was part of the leadership team and a member of three committees at the hospice. She carried out appraisals for doctors and was part of a reciprocal arrangement to do appraisals for doctors at another service. This promoted a fair and equitable system.

People's nutritional needs were assessed and recorded. Each person had a care plan outlining their needs in relation to eating and drinking. These were developed when the person had been identified as being at risk because of some difficulty with eating or drinking.

The assistant cook we spoke with told us that they visited people every day to gather their menus and ask about preferences. They were supplied with dietary sheets by the nurses on the IPU which gave details of special diets, food consistency required and likes and dislikes. This information gave them the information they required to ensure that people received their food in a form that was safe.

All the people we spoke with gave positive feedback about the meals provided in the hospice and told us staff always went out of their way to meet their preferences. There was a head chef and five assistant cooks working across seven days in the kitchen. Volunteers worked in the kitchen helping with washing up. Daily menus were in place and staff said these were "Not set in stone; people can have anything they want." They gave us an example of one person asking for tripe and told us, "We got it for them."

One person told us when asked about the food provided, "Anything I want even if no-one else is having it. She [cook] does chips soft so I can eat them." A second person said, "The cook comes around and asks what

I want to eat. Everything I have asked for they have done; the meals are lovely."

The cooks worked with the dietitians to make sure that food was highly nutritious. We saw that the food was freshly prepared and cooked on the premises. One cook said, "Food is such a big thing for people because they have sometimes lost control of other things. If we can give people what they want we do."

Fridge temperatures had been checked daily to ensure food was kept at the optimum temperature, maintaining freshness. Kitchen staff told us that plate guards and specialist cutlery was available in the IPU kitchens if people needed them.

We saw that the hospice teams engaged proactively with other professionals to achieve good outcomes for people. Multi-disciplinary team (MDT) meetings took place every week for inpatient and community services. The social worker and allied healthcare professional, a counsellor and consultant attended the meetings.

"Every patient with palliative and end of life care needs within Ashton, Leigh and Wigan will have timely and equitable access to a high quality service across all settings, delivered by appropriately trained professionals" was the vision statement for the hospice. We saw that along with the inpatient unit, clinics and day services the hospice provided a service to people who wished to be at home.

The hospice in your home team primarily provided community support for a duration of approximately 90 minutes per visit. They provided a night service to supplement existing care, for instance to supplement the Marie Curie support already in place. This service was prioritised according to need in partnership with the Marie Curie service. The support hospice staff provided was based on a holistic assessment. This is an assessment of the whole person, taking into account mental and social factors, rather than just the symptoms of a disease. Staff provided emotional support and linked in with other services such as district nurses, OTs and dietitians. The social worker who was employed by Wigan council and based at the hospice and worked between the community teams and the IPU giving practical support to people. A person receiving support in the community told us, "From day one they made it totally clear I could ring to ask any questions, however trivial they might seem, and they will not be treated as trivial; the service has not felt at all intrusive and I can't fault them."

There was a day service at the hospice but this was currently being refurbished and changed into a wellbeing centre. A manager for the service had been appointed and they spoke with great enthusiasm and understanding of people's needs when describing their plans. They told us people would be able come to the centre to access various groups and therapies. There would be no nursing input directly into the centre as this would be by the district nurses and specialist palliative care nursing assessment and support would be available through the hospice nurse specialist clinics when required. Clinics were held separately. This was to give hospice patients particularly those in the community a place to socialise whilst receiving support through various means.

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). At the time of the inspection there was nobody subject to a DoLS authorisation.

There was a policy and procedure in place for consent to care and treatment. Best interest decision making care plans were in place as required when someone lacked capacity and capacity assessments were completed by doctors. Where there were any restrictions on a person there was a specific care plan in place with an explanation of why and what staff should do.

Do not attempt cardio pulmonary resuscitation (DNACPR) had been considered and discussed with people who used the service. We saw that one family had been unhappy about this form being completed by a previous healthcare provider. Their concerns had been discussed and an explanation given of what signing the form meant for a person. There was clear guidance for medical staff on SystemOne telling them how the forms should be completed.

As part of the inspection we looked around the premises. The building was light and airy and pleasantly decorated with high ceilings and lots of light. People had a spacious individual room and most bedrooms overlooked the garden area. Outside the main building there were extensive tree-lined landscaped gardens with a variety of planting and seating areas and a pond that was safe and secure to walk around. These areas provided a safe and welcome outside space for people and families and meant people cared for in bed could access the outdoors. We saw that there was a room available on the inpatient unit where relatives could stay overnight.

At the time of the inspection, alterations were being made to the environment to make it more accessible for people living with a dementia in line with good practice guidelines and the main reception area had already been completed with appropriate colour schemes. A new café had been built that would, when fully opened, be accessible to all visitors, staff and people who used the service. Alterations were also being made to create a new exit door for relatives visiting at night time so that people's privacy and dignity were maintained and disturbances minimised. Additionally a new bedroom was being designed for use by people with bariatric needs, which included a wet room. Bariatrics is the branch of medicine that deals with the causes, prevention, and treatment of obesity. This demonstrated the hospice had considered creative ways of improving people's quality of life and promoted their well-being through the design of the physical environment.

Referrals to other services were evident in the care plans we viewed. We heard at a multi-disciplinary team (MDT) meeting about one person who had a percutaneous endoscopic gastrostomy (PEG) tube removed. A PEG is a tube which is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. This meant that they would not receive adequate nutrition so had been referred to the dietitian for advice and support. We saw evidence in care plans of links with palliative care nurses and consultants at the local hospital and found that GP's were updated when a person went home. In addition people were referred to internal services such as counselling or complementary therapies.

## Is the service caring?

### Our findings

Everyone we spoke with was extremely positive about the care provided at the hospice. One person said, "I cannot praise them enough." A staff member commented, "They [patients] become like family when they are here. We get an insight into their lives and they become a part of your life." A social worker who was also a trained best interests assessor told us, "Staff always display an understanding of people's needs and the service very much works in the best interests of the person concerned."

Comments recently received from relatives of people who had used services included, 'Thank you for the kind care and attention you gave to [my relative] over the past few weeks, it was clear that the care you gave was the best she had received', and 'Thank you very much for the excellent care and support you gave to [my relative] during her time at the hospice and also for the kind and compassionate support you gave to the family during her visits and following her death,' and 'Our family are extremely grateful for the kind and sympathetic care extended not only to [my relative] but also to us in those last few days. Her death in the hospice care gave her dignity and peace.'

Staff told us they cared for each other. They told us, "We are like one big family." We saw that staff were vigilant with each other and we were told by staff that the registered manager and chief officer were constantly speaking to them and checking they were okay.

There was a communications officer at the service who had developed a communication plan. The aim was to keep staff, volunteers and other organisations involved through effective communication. We saw that a communicating and transmitting device supplied to one member of staff after their hearing deteriorated meant that they could continue to do their job.

The same excellent care was applied when making sure staff were aware of patient's communication needs. A section within the care plan noted people's information access needs. This determined whether or not a translator was needed, what insight the person had and their level of involvement in decision making. It identified how they coped with the impact of illness and what their coping mechanisms were. Where necessary there were management plans in place for staff to assist them in making sure everyone had access to information. One person who used the service told us, "The staff answered all my questions in detail."

Staff were highly motivated to provide people with the care they wanted. People were encouraged to discuss their care and were involved in advance care planning. One person had expressed a wish to go home but felt they were struggling with mobility. The doctor met with them and explained the options for their treatment and explored with them what they wanted. They had said, they wanted, "A quality of life." The doctors discussed ways in which their spouse and children could be supported if they went home and set going home as a goal with all the staff working towards doing so.

When we visited a person in their own home we observed the thoughtful and caring interactions between staff and the person receiving support. Before carrying out assistance staff asked the person what it was they

wanted them to do, and gained their consent before doing anything. We saw that staff spoke in a quiet tone and ensured they were at the same eye level of the person when speaking with them. Staff ensured the person's dignity was respected and gave reassurance throughout. Clear explanations were given about why and how staff were administering care and staff were very careful with assisting the person to move due to their pain levels. The staff demonstrated a high degree of patience when carrying out their tasks, showing care and compassion and chatting to the person throughout. The person told us, "They are lovely, always lovely. I look forward to their visits, it cheers me up to have a chat with different people." The relative of this person described how a previous experience with the hospice had helped her [relative] to feel less anxious about receiving the service.

The hospice carried out an initial assessment which looked at people's pain, level of comfort, family and their mood. This was a patient outcome scale which gave good feedback about people's current situation. In addition there was a carer's support needs assessment tool to identify any needs for carers. This helped when looking at goals and planning people's care providing care and support to the whole family.

When staff were completing advance care plans with people who used the service they discussed with them whether or not they wished to be resuscitated. The records of discussions reflected what people wanted. If required, a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form had been completed which recorded those decisions. During these discussions people had also been asked where their preferred place of care would be. Where people had chosen to be cared for at home this was identified as a goal, along with any plans that were needed if they were already on the IPU. If they lived at home then plans to support their decision were made with input from the hospice at home team. One person told us, "You've got support behind you. They explain everything really well and ask what I want."

There was a counselling service at the hospice and the service held placement agreements with educational establishments and offered placement contracts to student counsellors. The counsellor acted as their mentor and offered clinical supervision. A student counsellor was in the planning stage of a research project on how men deal with bereavement. The results would be used to identify better ways of supporting men. Counselling was used to support people and their families.

We saw in one person's care plan that they were becoming, 'less engaged.' Within eight days a further record showed that the person and their spouse had received joint counselling and there was a marked improvement in the person's mood demonstrating the benefits of the counselling service for people.

The counselling service was involved with bereavement support for people. They supported people to make memories if they wished. One person had been helped to create a journal for their son to have when he was older. People could create hand prints and photographs which the creative support staff framed for the person. The counsellor told us that they sometimes saw children whose parents were receiving care from the hospice. They worked with them and supported them pre and post bereavement. They used therapeutic board games, puppets and dolls in a "Show me" activity which helped children talk about their feelings. In addition they created memory jars with children. This enabled children to look at happy and sad memories, choose a colour to represent the memory and put coloured sand in layers in a jar. These represented those memories which would provide them with comfort when they were bereaved.

The counselling service had identified a need for more robust support for carers. They had started forging links with another local organisation in order to have joint carers groups. This would add a peer support element to bereavement and prevent isolation of carers where possible.

There was a focus on people and what was important to them. The hospice had consulted with patients and

carers to look at how to make the original chapel more accessible. We looked at feedback recently received, which had all been dated to identify when it was received. One relative had commented, "Our [relative's] wish was to remain at the hospice at the end, having assured us that this was the right thing to do. From the moment we walked into the hospice the care and attention both [my relative] and we received was flawless. We want to therefore thank you from the bottom of our hearts for allowing [my relative] to die with the dignity and pride that she deserved. We will never forget all that you did."

Spiritual care was person-centred and aimed to help people discover hope, resilience and inner strength in times of illness or loss. Staff worked with each person to explore their needs, whether they would benefit from a faith-based approach or a non-faith approach. The clinical staff at the hospice had all undertaken training to help them explore these issues with people and to support them on their spiritual journey.

Spiritual care included compassionate listening, careful exploration of the issues, and gentle touch. For those who wished, the hospice arranged for their own faith leader or one of the hospice volunteer chaplains to visit them. The aim was to help people cope with their situation; to give them strength to put their lives into context and find a sense of peace and acceptance.

Quarterly remembrance evenings provided a forum for those who had recently lost a loved one in the hospice's care to come together and remember them. The services were mainly non-religious, with a short religious section at the end for those who wished to take part in this. During the service the names of those who had recently died were read out, candles are lit, readings and music played - sharing the experience with others. This helped people come to terms with their loss and helped them to feel less alone in their grief.

There was a team of bereavement support volunteers, counsellors and complementary therapists. The counsellors provided counselling support for hospice patients requiring it and alongside the bereavement support volunteers provided bereavement support for anyone linked to a person receiving support from the hospice. The team visited people to provide both pre and post bereavement support. The first contact was made within one week of referral, with a telephone service also available. This meant people had access to advice and guidance to be able to deal with any sensitive situations, linked to their loved ones.

We saw that sensitive conversations took place in private with confidentiality fully maintained and information was only shared, with the patient's consent, with those who were authorised to see it. The hospice ensured that discrimination in any form was not tolerated with particular reference to the protected characteristics within the Human Rights legislation. All clinical staff had received advanced or enhanced communication skills training enabling them to enter into challenging conversations with people and their relatives with compassion and clarity.

## Is the service responsive?

### Our findings

All the people we spoke with during the inspection told us the hospice had been responsive to their needs, providing them with an excellent service. One person said, "The staff explain everything. I'm mind-blown, they think of everybody." The relative of a person receiving support at home said, "Every member of staff has been lovely. You don't feel it's a stranger coming into your home. It's like [my relative] has made a friend and she tells us about them." A social worker said, "The manager is very pro-active in meeting families if there are any issues, for example to change medicine administration times." An occupational therapist commented, "We are all very much involved and want to develop the service more. I suggested the need for bariatric facilities and this is now being put in place." A dietitian said, "The service very much follows what people want and need and other professionals such as speech and language therapists (SLT) are always involved to ensure we meet individual needs."

Care plans were person centred and contained risk assessments where needed with guidance for staff. The hospice used SystmOne for care planning and record keeping. It had elements within it to protect people's privacy. For instance there was an alert when we logged on to SystmOne that there were two people with the same name on the consultant's caseload. This ensured that the consultant identified the correct person and did not share confidential information inadvertently.

There was an Advice Line which was available 24 hours a day, seven days a week to patients, carers and healthcare professionals who were seeking advice about palliative and end of life care issues, such as pain and symptom control or about access to Hospice services. During the evenings and overnight, calls were handled by the IPU nursing team.

Any tasks for the day were visible on SystmOne. For example there was a message for staff about changes to one person's medicines from the pharmacy. This enabled staff to provide care with the most current and up to date information available.

People's current status and presentation was noted using a risk rating, called a RAG rating. This referred to a status of red, amber and green depending on the level of risk identified. This could be seen clearly on the system. People's views about their strengths and levels of independence and health and what their quality of life should be, were noted and explanations were given to people about their care plans. For example where a person had pain we saw that staff discussed this with them and agreed aims and objectives with the person for dealing with this. We saw that staff were skilled at observing nonverbal signs of pain and consulted medical staff in order to make sure that the person was receiving pain relief medicines in addition to considering other means of relieving the symptoms of pain. For one person this included heat pads, relaxation techniques and complementary therapies. A pain diary had been started and staff used a pain scale assessment to determine the person's levels of pain on a daily basis. This allowed staff to choose the best treatment from a list of options decided by people who used service and staff to make sure people's pain was controlled.

There was a range of palliative care information for each person. This identified their clinical diagnosis and

resuscitation status. The patient insight section of the care plan identified whether or not the person was aware of their diagnosis. The family circumstances were noted and people's psychological and spiritual care needs were also identified in their care files. We saw that one person's notes recorded that their relative had been involved in an accident and this had resulted in the person not sleeping well because they were worried. This information demonstrated that staff were knowledgeable about people's wider circumstances in order to provide them with the correct support, based on changing circumstances.

Daily records, which recorded what had happened each day for each person, were completed in a timely manner. The handover information sheets recorded entries that had occurred overnight. For example it was noted at the morning handover meeting that controlled drugs had been given at 00.01am for one person. We found that people's care plans and risk assessments were being reviewed and updated constantly keeping a current record of events.

People were supported to maintain relationships with people that mattered to them. For example when one person wanted to spend time with their husband at their own home it was arranged quickly to ensure that their wishes were met. An occupational therapist commented, "The hospice are constantly involved in supporting families and I feel they get a lot a lot of support from the hospice, who treat people as they would like to be treated themselves."

Another example was when one person's relative wanted their family member to receive alternative therapy. This was not dismissed and doctors took time to discuss with relatives and explore the possible effects of this with them. They decided together that this was not a viable option for this person and they supported the person throughout the decision making process.

People were supported to follow their interests and take part in social activities. A number of different complementary therapies were on offer, including aromatherapy, reflexology, reiki and hopi ear candling. The sessions typically lasted an hour and were provided at the hospice itself. Due to the high demand for this service the hospice provided up to 12 sessions for patients and up to six sessions for family members.

There was a 'Reflection Room' which offered a peaceful space where people and their visitors were welcome to sit if they wished. Faith books and religious artefacts were available for the major religions. There were books of pictures of inspiring places, prayers and words of comfort which some people may find helpful but the main aim was to provide a quiet space for people.

There was an arts and crafts room with lots of useful materials available and people could undertake activities in their own room if they wished. There was a hairdressing salon available to people and their relatives and a bright and airy new coffee shop was due to be opened that would be available seven days a week, all day and night. There was a large conservatory style lounge that overlooked the garden areas providing a pleasant outlook. This provided an area where people could relax and reflect.

Due to the Day Hospice being under-utilised, this area was now changing and being developed into a 'wellbeing centre' which would be therapy-led rather than nurse-led. It had not been possible to keep the service running during the transition period due to staff leaving for unconnected reasons. The new manager for this centre had already been recruited and whilst the hospice was awaiting further funding confirmation they had spent time planning and developing the service and associated paperwork.

Body Image was considered when people became involved with the hospice. People sometimes had appearance changing surgery or had things such as a PEG in place. This affected how they felt about themselves. Any changes were noted in the care plan and within the hospice there was a counsellor who

was available to speak with people and who worked with them to find solutions to their worries or offer support.

A team of physiotherapists and occupational therapists, employed by Bridgewater Community Healthcare NHS Trust, was based at the hospice. They worked in an integrated way with members of the hospice staff and visited people on the ward, at home or as outpatients, according to their needs.

For those people with degenerative neurological disorders such as progressive supranuclear palsy or motor neurone disease, the hospice provided a specialist clinic once a month. This was usually undertaken jointly with the palliative medicine consultant and neurosciences community matron, who had highly specialised skills in the care of these patients. Where possible, the hospice endeavoured to see people early in the illness, so that discussions could be held and plans made for their future care needs

At the end of their life people received outstanding and compassionate care. They had advance care plans in place which noted their preferred place of care and death. We saw staff show compassion and care to a person at the end of their life and their family during the inspection. The individualised plan of care for the last days life reflected the care given to the dying person and their family. One person was recorded on the hospice website as saying, "The atmosphere in the hospice is so calming and peaceful. My mum was very well looked after in her last few days. Me and my family really can't thank them enough." A second person had said, "Many of you will take the view that the hospice helped my dad to accept his condition and die as painlessly and peacefully as he could. But you would be wrong...they allowed my dad to live!"

There was clear recognition by the multi-disciplinary team when a person was dying and once that was established all actions taken were in accordance with the person's wishes. We saw an example of a priest having been involved at the person's request with the family present. In addition the family's fears and any concerns were explored by staff. One person's care plan said, 'Touch and talk to the patient. Encourage the family to do so.'

People could stay overnight with their relative. There was a relative's room where they could sleep and make drinks and snacks. One example of this support was when one person was admitted to the hospice whose adult daughter had a learning disability. They suffered separation anxiety and so staff arranged for the daughter to stay with their mum in the same room.

There was a system in use which allowed families to be able to spend time with their loved one after death. This allowed time for them to say their goodbyes in private. When a person had died the hospice offered a bereavement service to families and carers. The service contacted the next of kin and offered bereavement services should they be needed. From this point, people 'self-referred', by asking the hospice for help if required. Following this the hospice undertook a bereavement assessment, to understand the level of help required and to provide suitable support, through trained counsellors and volunteers. This demonstrated that the hospice helped people come to terms with their grief and to recover emotionally.

Quarterly remembrance evenings also provided a forum for those who had recently lost a loved one in the hospice's care to come together and remember them. The evenings were mainly non-religious, with a short religious section at the end for those who wished to take part in this. During the service the names of those who had recently died were read out, candles were lit, and relatives listened to readings and music, sharing their experience with others. This helped people come to terms with their loss and to feel less alone in their grief.

One of the registrars was carrying out a service evaluation looking at how the hospice served the lesbian gay

bisexual and transgender (LGBT) community and whether or not the hospice services were LGBT friendly. Staff understanding of this area and the literature required was being developed. This was being undertaken after recent training attended by a doctor who had identified there was a need for improvement. Following the project recommendations will be made to the board

We looked at the latest survey carried out with bereaved relatives and saw that the responses were consistently positive. The service had evaluated the responses received and data identified 87% of relatives felt very satisfied/satisfied with the availability of the palliative care team to the family; 84% were very satisfied/satisfied with the emotional support provided to the family; 84% were very satisfied/satisfied with the way the family was included in treatment discussions; 87% were very satisfied/satisfied with how effectively the palliative care team managed the person's symptoms; 83% were very satisfied/satisfied with the emotional support provided to the person.

Written feedback comments received by the service from relatives included, "Thank you very much for the care and support you gave to [my relative]; thank you also for the kind and compassionate support you gave to the family following [my relative's] death, it is all very much appreciated," and "We would like to express our heartfelt thanks to all the doctors, nurses and extended staff; you all gave love care and compassion not only to [my relative] but also to the family that spent the final days with him. You allowed us to fulfil [my relative's] final wishes by letting us take him outside to feel the sun on his face and hear the birds in your gorgeous gardens, his first time out in 18 months and one of his favourite pastimes," and "Both myself and family members wish to express our sincere thanks to everyone involved in [my relative's] care for their loving kindness and patience; not only did everyone care for [my relative] but also for myself and our very small family, we shall remember you with great fondness," and "You do a fantastic job and it was a great comfort to all the family knowing [my relative] was being looked after by such caring people."

The hospice had a positive approach to using complaints and concerns to improve the quality of the service. There was a policy and procedure in place and information about the complaints procedure was on display throughout the hospice. The registered manager told us any complaints received were dealt with quickly and people received a written response.

We noted that any concerns had been taken seriously, investigated, action taken and lessons learned. We saw that outcomes from complaints were linked to changes in practice when necessary. A regular report was produced for management and the Board of Trustees detailing any complaints received; this enabled trustees and the management team to ensure lessons were learned from complaints in order to improve people's experience at the hospice. We also saw a summary of the lessons learned and actions taken from risks and complaints which helped the service learn. For example as a result of previous concerns raised the hospice had reviewed nursing documentation, reviewed the needs of bariatric people, provided training in conflict resolution for all staff and reviewed the design of the IPU.

The hospice used a variety of different methods to seek, listen and take action based on feedback received. They included questionnaires, a comments box, and feedback and evaluation questionnaires. Details of how to make a complaint were also available within the information leaflets that were given to each person at the start of their service. Feedback could be given using the hospice website.

People and relatives we spoke with in the inpatient unit told us they did not have to wait to receive assistance from staff and that call bells were always responded to in a prompt manner; this was confirmed by our observations during the inspection.

We looked at feedback recently received, which had all been dated to identify when it was received and

comments included, "The care, dedication and compassion of the staff was truly amazing, without who we could not have managed," and "Heartfelt thanks to the nurses who made it possible for [my relative] to be at home in his last few days, without their care and comfort it would not have been possible."

We noted that the relatives of many people who had previously used the hospice had made a financial donation in recognition of the quality of care their relative had received and due to the organisation being a charity.

## Is the service well-led?

### Our findings

There was a registered manager in post. 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. The registered manager was also the director of clinical services.

Exceptional management and leadership was demonstrated at Wigan and Leigh hospice. Our discussions throughout the inspection demonstrated that there was an open culture which empowered people to plan and be involved in the high quality care provided at this service. This meant that people continuously had a say in how they wanted their care to be delivered. The strong and positive management approach resulted in people receiving a tailored inclusive service which focused on them receiving individualised care.

Staff were passionate about their roles when they spoke to us and during the inspection, people were unanimous in their positive comments about working at the service and were very keen to tell us about their area of work. A social worker told us, "The culture is excellent here, I've been treated as part of the team since day one and there is definitely no health and social care divide here." An occupational therapist said, "The managers have supported me very well in the past with difficult circumstances."

The hospice had a stated vision and a clear set of values which were referenced in a document called 'Hospice Mission Statement, Vision and Values'. These values were the guiding principles which determined how all staff, clinical and non-clinical, approached their work at the hospice and were based on compassion, respect, dignity, hospitality, justice and trust. We saw that the hospice staff forum had been consulted to generate ideas and suggestions had been made to try to reduce the number of stated values in order to encapsulate the essence of hospice care. The staff forum was on-going and had been established to facilitate communication between staff and senior members of the leadership team. This showed that the values were understood by the staff group, who had contributed to their development.

There was also a statement of purpose in place. A statement of purpose is a legally required document that includes a standard set of information about a provider's service. The service appropriately submitted statutory notifications to CQC as required and had notified CQC of all significant events, which had occurred in line with their legal responsibilities.

An up to date registered manager's certificate was on display in the office premises in addition to an appropriate certificate of employers' liability insurance and certificate of registration with CQC as required.

The hospice is a charity overseen by a group of trustees. These trustees were selected from the members and represented a spectrum of skills which were of benefit to the hospice. Members represented the local community. On some occasions the hospice did advertise trustee positions. The trustees underwent the same background checks as staff at the hospice and undertook an induction. They had to complete a conflict of interest form. This meant that the hospice was doing all it could to ensure that members of the

board of trustees were fit and proper persons to hold that office.

The day to day management of the hospice was conducted by the registered manager, chief executive officer and medical director who, in partnership with the trustees, formed the leadership team. In addition there were people carrying out different functions within the hospice in areas such as finance and communications. Three senior sisters ran the inpatient unit supported by staff nurses, health care assistants, administration and ancillary staff as well as a very large workforce of volunteers who worked in all areas of the service. Every person played their part to ensure that people were well cared for and the service ran smoothly.

When we spoke to the chief executive officer they were able to outline the current challenges to the service included needing more support within the nursing team; the amount of change; and making sure that what the service delivered was evidence based, safe and effective.

One staff member told us, "The chief executive officer is a true gentleman. He consults us about changes. Some people do this as a paper exercise but he genuinely wants our opinion. His door is always open. Even if he is very busy he will stop what he is doing to listen to what you have to say." A second member of staff said, "The managers within the hospice take on board what patients need without bureaucracy. They are really keen on making things better and are good at changing if they aren't." Feedback from the relative of a person who had recently used the service stated, 'Words seem somewhat inadequate to express my enormous thanks for your care and concern in looking after [my relative] during the last five weeks of his life. I was greatly impressed by your total availability and your willingness to give some word or explanation when needed – nothing ever seemed to be too much trouble. To have the opportunity to see the hospice and all it stands for in such an intimate way is greatly inspiring. May you continue to use your wonderful skills for many days to come.'

The staff we spoke with told us that team meetings were held regularly and they were encouraged to share their views and opinions about their work. Staff told us that that everyone was part of the same team and "Being able to work so closely with senior management is great." Another staff member said, "We get great support from managers."

During the inspection we attended a staff evaluation feedback meeting following the completion of a staff survey that had been facilitated by an independent body. The chief officer told us the purpose of the meeting was to feed back to staff the results of the survey and identify any trends in an open, honest and collaborative way.

The survey had been undertaken with a total of 46 hospices across the country taking part. We looked at results from the survey and saw that between 91% and 100% of staff agreed: they understood what the hospice wanted to achieve; they believed in the aims of the charity; they enjoyed their work; they liked the working environment; they were proud to work for the organisation; they enjoyed working with other people at the hospice; they were clear about what was expected of them in their job roles; they felt like they were making a difference; they had not been bullied at work. This showed the service measured and reviewed the delivery of care, treatment and support and provided comparator benchmark data to the staff group against other hospices nationally.

At the time of the inspection the hospice was awaiting the results of another satisfaction survey carried out for bereaved relatives. Although the results were not available at the time of the inspection for 2016 we looked at results generated for 2015 and saw that most bereaved carers were satisfied with the end of life care provided to their family member. We saw that 100% of carers were very satisfied/satisfied with their

relative's comfort on the inpatient unit; 86% were very satisfied/satisfied with explanations about people's medical conditions; 100% felt dignity was respected; 86% were given information about the side effects of treatment; 100% felt attention was given to the person's description of symptoms; 86% were very satisfied/satisfied with the availability of the palliative care team. Analysis of this information identified the inpatient unit had achieved significantly higher scores for seven out of 17 questions asked when compared nationally to other hospices, and the home service had achieved significantly higher scores for all of the 17 questions asked when benchmarked nationally. This demonstrated that the service measured and reviewed the performance of clinical treatment and care against other similar organisations.

Throughout the course of the inspection we saw the registered manager and chief executive officer frequently walking about the premises and enquiring about the welfare of people and the staff group. Conversations between staff and the chief executive officer and registered manager were warm, friendly and positive which demonstrated that the managers were visible and had a genuine supportive approach to the staff team. We observed this was welcomed by staff. This also allowed an opportunity for managers to keep under review, the day-to-day culture in the service including the attitudes, values and behaviour of staff.

We saw evidence of regular clinical audits, for example of medicines management, safeguarding concerns raised as well as the health and safety of the care environment. These resulted in action plans to improve where appropriate. Reports from these audits were submitted to the relevant governance committee for review. Governance at the hospice was overseen by both trustees and the local clinical commissioning group (CCG).

The hospice delivered an initiative to eight care homes in the Wigan and Leigh area called Hospice in Your Care Home. The hospice in your care home team worked in partnership with these care homes to enhance the quality of care received by people in the last few weeks and days of life, with the aim of promoting comfort and dignity.

In connection with the 'hospice in your care home' initiative we attended a celebration event that was conducted shortly after the date of the inspection to recognise the progress made by those involved. All the staff we spoke with who had received this training and support from the hospice told us that it had been invaluable in up skilling staff to more effectively support people with end of life care. They told us that hospice staff were welcoming, supportive, understanding, patient and informative and that they felt much more competent and confident as a result. We noted that it was the hope of the hospice to extend this service to all nursing homes across the borough in the future.

Several areas of the building were being developed including the café and additional bedrooms had also just been completed to make them more homely and welcoming. The registered manager told us how a local school worked alongside people to undertake art work and also carried out themed activities for example regarding the history of coal mining. We saw that art work previously created was on display throughout the building, providing a point of interest.

We spoke with the medical director about research projects that the hospice was currently involved in. One project was called 'Famcare' which is a national initiative gathering feedback from bereaved carers run by the Association of Palliative Medicine. The bereaved carers of patients who had used the in-patient unit or home care (community nurse specialist) service were sent questionnaires and feedback was used to improve the quality of service. There was a response rate of 35% for the inpatient unit and 42% for home care and the results were very well evaluated. A lot of areas at the hospice had exceeded the required benchmark, however the response from the inpatient unit was only seven bereaved carers and so results needed careful interpretation.

Other projects included a 'bowel working group' on the inpatient unit which developed following a constipation audit. We saw that the MDT group had developed a bowel template for SystmOne so that records were standardised. At the time of the inspection the group was working on operational guidelines.

The service also worked in partnership with Allied Healthcare Professions Service employed by Bridgewater Community Healthcare NHS Foundation Trust and at the time of the inspection were looking at adapting the 'feed at risk' policy from the local trust.

The hospice were also adopting in full the revised 'symptom management guidelines' developed by the regional palliative care group. At the time of the inspection these had been approved but were not yet in use.

The service had taken part in research to evaluate the efficacy of McKinley syringe pumps. They had also taken part in the North West audit group's steroid audit which demonstrated that they were willing to question their own practice and learn from others striving for excellence.

Partnership working was an integral aspect of how the leadership and management of the service sought to improve care provision through the sharing of best practice, service development and joined-up care, particularly when packages included multiple agencies and care providers. Different managers within the hospice also worked extensively in partnership with other organisations and had a lead role within the area. Information from partnership meetings was used to inform the delivery and improvement of services at the hospice. For example, the chief executive officer was an advisory council member (vice chair) for Hospice UK, the North West representative for Hospice UK and attended the Wigan Borough Palliative and End of Life Care Committee.

The clinical director, who was also the registered manager was a member of the Wigan Borough Palliative and End of Life Care Committee, a member of the North West Executive Clinical Leads in Hospice and Palliative Care (ECLiHP) and part of the age well project led by the CCG.

The medical director was the deputy chair of Wigan Borough Palliative and End of Life Care Committee, a member of Wigan Borough Cancer & Palliative Care Partnership (Local Implementation Team), attended Wigan borough palliative medicine consultants meetings, was a member of the health education north west joint training committee in palliative medicine and co-ordinator of the association for palliative medicine neurological palliative care special interest forum.

The hospice nurse specialist manager attended the greater Manchester and east Cheshire strategic clinical network palliative care advisory group, the Wigan borough palliative and end of life committee, held joint meetings with the hospital specialist palliative care team and attended the north west hospices non-medical prescribing group.