

Bolton 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

The inspection took place on 28 and 29 September 2016 and was announced. The previous inspection took place on 20 August 2013 when the service was found to be meeting all requirements reviewed.

Bolton Hospice is a registered charity operating from purpose built premises close to Bolton town centre. The hospice is set in rural grounds with a large car park.

The hospice had 14 inpatient beds, and all patients are accommodated in single rooms. At the time of the inspection renovations were being carried out to complete the work to en-suite all 18 rooms following the addition of four bedrooms add extra rooms to allow the hospice to accommodate up to 18 patients and they had updated their registration to ensure they were registered for this number.

Close family members are able to stay overnight if they wish to do so. Other services include a planned day therapy unit, outpatient clinics, bereavement support and a hospice at home service. On the day of the inspection there were nine patients in the inpatient unit which was operating at a reduced capacity of 12 beds due to the building works.

There was a registered manager employed. 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.

Relatives told us they felt their loved ones were safe and secure. Appropriate safeguarding policies and procedures were in place and staff were aware of how to report a concern.

The recruitment process was robust and the induction programme thorough and comprehensive. Training was on-going for all staff, including volunteers, clinical and non-clinical. Staffing levels were sufficient to ensure people's needs were met.

All staff received regular supervisions and there were frequent reflection sessions to help ensure continual improvement in staff skills and knowledge. Staff and volunteers were well supported by colleagues and management.

Incidents and accidents were logged appropriately. These were audited, analysed and issues identified and addressed as required. General and individual risk assessments were in place and were reviewed and updated as required. All health and safety procedures were in place.

Systems for ordering, storage, administration and disposal of medicines were robust and the medicines room was extremely tidy and well ordered. This helped ensure medicines, including controlled drugs, were managed safely.

The service were working within the legal requirements of the Mental Capacity Act (2005) (MCA) and there was evidence of best interest decision making where it was appropriate.

People's nutritional needs were assessed and staff ensured these requirements were addressed by the catering staff. Staff were aware of any risks with regard to nutritional and hydration issues and these were documented appropriately so that risks could be minimised.

The building was warm, clean and tidy. The premises were being extended to incorporate more beds and this work was being carried out sensitively, with the least possible disruption for patients and families. The service was in the process of trying to create a more dementia friendly environment.

Patients, relatives, staff and volunteers all described the service as caring, inclusive and supportive. We saw staff delivering the service with kindness and compassion. There was a range of literature for people to pick up explaining the services offered and how to access them.

Spiritual support and counselling was offered in a range of different ways, including multi-faith services, one to one bereavement counselling, bereavement groups and social activities and access to particular religious support. There was a multi-faith prayer and reflection room, which provided a quiet space for people to use as they wished.

Care plans included all relevant health and personal information and these were reviewed and updated as required. People's individual support needs were documented and followed by staff.

There were a number of complementary therapies offered by the service and these could be accessed by patients and families. We also saw that patients' pets were allowed to visit, with prior agreement, and pets for therapy visited those who wanted this.

Complaints and concerns were addressed in a timely and appropriate manner. We saw that these were analysed and cross referenced with accidents and incidents to help the service address any patterns and trends.

There was a clear leadership and management structure at the service and regular meetings between various staff groups were held. This helped ensure everyone was up to date with current guidance, good practice and changes.

All staff were supported with their personal development and staff described the culture at the service as supportive and inclusive.

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.

Relatives told us they felt their loved ones were safe and secure. Appropriate safeguarding policies and procedures were and staff were aware of how to report a concern.

Staff recruitment was robust. Incidents and accidents were logged and audited appropriately. There were appropriate risk assessments and health and safety procedures were in place.

Medicines were managed safely at the service.

Is the service effective?

Good ●

The service was effective.

The induction programme thorough and comprehensive and training was on-going. All staff received regular supervisions.

The service were working within the legal requirements of the Mental Capacity Act (2005) (MCA) and there was evidence of best interest decision making.

People's nutritional needs were assessed. The service had aspects of a dementia friendly environment in place but were working towards improvements in that area.

Is the service caring?

Good ●

The service was caring.

Patients, relatives, staff and volunteers described the service as caring, inclusive and supportive. There was a range of literature explaining the services offered and how to access them.

Staff delivered the service with kindness and compassion towards patients and relatives throughout the service.

Spiritual support and counselling was offered in a range of different ways.

Is the service responsive?

The service was responsive.

Care plans were person-centred and included all relevant health and personal information.

There were a number of complementary therapies that could be accessed by patients and their relatives.

Complaints and concerns were addressed in a timely and appropriate manner.

Good 

Is the service well-led?

The service was well-led.

There was a clear management structure and regular meetings were held between a variety of staff groups to help ensure everyone was up to date with current guidance, good practice and changes.

All staff were supported with their personal development and staff described the culture at the service as supportive and inclusive.

Good 

Bolton 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.

The inspection took place on 28 and 29 September 2016 and was announced. We gave the provider 48 hours' notice so that we could ensure our attendance at relevant meetings and to arrange to visit some patients and their relatives, with their consent, via the hospice at home service, which enables patients with advanced illness to be cared for at home, and to die at home if that is their preference.

The inspection team consisted of two inspectors from the Care Quality Commission and a Specialist 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.

In order to plan our inspection we looked at information we held about the service. 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. Prior to the inspection we contacted four professionals who have regular contact with the service to obtain their views.

The clinical nurse director showed us around the hospice in patient unit, day hospice and education unit and we looked around other areas of the building.

We spoke with two patients, four relatives, the registered manager, the clinical nurse director, the inpatient unit lead nurse and nursing sister, two hospice at home nurses, a ward clerk, three volunteers, a social worker, a therapist, the spiritual lead who was about to retire and the new spiritual lead, the catering manager, support services manager, two hospice educators and a pets for therapy dog owner. We also spoke with a representative of the Bolton People Affected by Cancer (PAC) group. We accompanied a

registered nurse from the hospice at home team on a visit to two people's homes.

We looked at four people's care records and observed practice throughout the two days of our inspection. We reviewed other records relating to the running of the hospice, such as policies and procedures, safety checks and maintenance records and were shown feedback gathered from people in a recent survey by the service and via the external 'iWantGreat Care' system.

We looked at ten staff recruitment files and training records relating to those staff. We also looked at staff disciplinary records, quality assurance systems including audits, quality accounts prepared by the hospice for 2016-2017 and the hospice business plan.

Is the service safe?

Our findings

People told us they felt safe at the service. One patient told us they felt there should be more people supporting the hospice setting. "I would like them (the hospice) to have more help. I feel safe". A relative we spoke with said, "When my [relative] was here they felt safe, secure and well looked after. Completely relaxed". Another relative said they felt their loved one was safe.

Appropriate safeguarding policies were in place relating to both vulnerable adults and children. These policies helped ensure the correct management of any allegations of abuse. There was guidance around how to raise a concern and who to report to. The policy had references to other related policies such as equal opportunities, employment and whistle blowing. There were flow charts for easy reference so that staff could follow the procedures in a straightforward way.

Issues, such as the development of pressure areas of Grade 3 or above, were recorded and reported appropriately to the local authority safeguarding department and the local Clinical Commissioning Group. Notifications of these were also forwarded to the CQC.

There was an appropriate whistle blowing policy in place, so that staff could report any poor practice they may witness. This policy made reference to other related policies, such as confidentiality, prevention of harassment and bullying, employment, complaints, clinical incidents and near misses. Staff we spoke with were aware of the policy and were confident to report any issues.

The service used CCTV in particular areas of the building for security. There was clear guidance in place about the use of CCTV, how long footage was kept and who was authorised to view the footage. Notices throughout the premises publicised the use of CCTV around the building to ensure people were fully aware of its use.

We saw that staffing levels were sufficient staff to address the needs of the patients at the time of the inspection. On the in-patient unit there was a lead nurse, at least three other nurses and two health care assistants. In addition there was an administrator and two volunteers, who changed drinks for patients and helped to give out lunches. The chefs also came onto the unit to serve lunch. The service had increased its staffing levels recently on nights to four nurses, due to patients' dependency levels and the design of the new build. This demonstrated their responsiveness to patient need.

The Hospice at Home, which enables patients with advanced illness to be cared for at home, and to die at home if that is their preference, always had a team of two nurses attending calls because of the risks associated with giving out controlled drugs (CDs), which are some prescription medicines are controlled under the Misuse of Drugs legislation. This meant there were good levels of trained staff for each call. Their manager was available back at the hospice, so they had someone to call on if required. This helped ensure patients and families were fully supported in the community.

There was a consultant, a specialist palliative care doctor and two trainee doctors employed at the service.

There were also occupational therapists, physiotherapists and a social worker who had practicing privileges at the hospice but were employed by the local Foundation Trust and local authority respectively.

We looked at ten staff files and saw that the recruitment process was robust. Each file included personal details, a new starter checklist, an application form, interview notes, an offer letter, a health questionnaire, terms and conditions of employment, proof of identification, two references and Disclosure and Barring Service (DBS) checks. DBS checks help ensure employees are suitable to work with vulnerable adults. We also saw within the files details of sickness and absence, proof of professional identification number (PIN) for clinical staff and other relevant documents.

We looked at records of disciplinary procedures. These were clear and we saw evidence that the service's procedures were followed appropriately. This demonstrated the service's commitment to ensuring a good standard of conduct and professionalism was exhibited by all staff and volunteers.

Accidents and incidents were recorded appropriately and cross referenced with complaints. Incidents were logged; issues and timelines for actions were identified. We saw that actions were completed in a timely manner. The senior managers audited and analysed the logs to look for patterns or trends to help prevent reoccurrence. This, in turn, helped facilitate a safer service for people.

Individual risks relating to people's health were identified. Risk assessments for issues such as pressure ulcer prevention, nutrition, pain, manual handling and the use of bed rails were kept within people's care records. For example, where one person had a pressure ulcer, this had been identified in a timely manner because the risk assessment had identified they were high risk. There was continuous on-going assessment of the wound, the notes described the wound in detail and there were clear management plans in place.

We saw that risks were discussed with patients and staff told us that patients were given advice on risk but their right not to follow the advice given was respected if that was their wish. This meant patients and families felt they were fully involved with discussions about risks and responses.

Audits we looked at demonstrated the service's culture of learning from mistakes and continually improving the service. We saw that, when shortfalls had been identified, prompt action had been taken to remedy the situation and learn from it. Learning was cascaded to staff, where appropriate, to facilitate improvement in service delivery and continual learning for staff.

There were clear plans in place for any situation where a person may need resuscitation. There was a defibrillator in the reception area which all staff had been trained to use in the event of such an emergency. A defibrillator is a device that gives the heart an electric shock when someone's heart has stopped (cardiac arrest) and is a vital step in giving people a better chance of survival

General risk assessments had been completed in relation to each department by the staff in that department. These were reviewed annually and each area of risk was assessed and scored, the level of risk being identified. A score of nine or above led to that item being added to a risk register. The risk register went to the Quality and Standards group every two months for discussion and review.

An audit had been undertaken in February 2016 of all risk assessments. This audit looked at the scoring system and continuity with regard to risk assessments. We saw that the audit had identified that review dates for policies were not always appropriate, meaning that some policies had been out of date. It also identified inconsistencies with regard to scoring. Actions had been identified and carried out and these included addressing training needs, ensuring scoring was consistent across all risk assessments and putting

in appropriate review dates.

There was a service level agreement with Royal Bolton hospital to carry out certain health and safety checks of equipment such as testing water for legionella bacteria to help prevent the risk of infection. Water temperature checks were carried out monthly and the shower heads cleaned. The service had links with the hospital infection control teams. Gas and electric was also checked by Royal Bolton Hospital estates team. Gas safety inspections were carried out regularly. We saw certificates relating to the regular annual servicing and maintenance of equipment, such as the lifts and patient hoists.

Emergency fire procedures were displayed throughout the building. Fire alarm tests and fire drills were undertaken regularly and this helped ensure all personnel were aware of the correct procedures and were confident to follow them. We saw that one of the boards had been replaced following a small kitchen fire, as this was found not to be working correctly. This demonstrated a commitment to ensuring equipment was in working order at all times so that people's safety could be promoted consistently. Fire strategy meetings were held regularly where discussions took place about any incidents relating to fire safety. These discussions helped ensure learning was taken from any incident in order to continually improve safety at the service.

The service had a policy and a business contingency plan in place to ensure that any emergency, such as flood, loss of heat, gas, electricity or water, loss of accommodation or catering could be dealt with efficiently.

We spoke with the catering and housekeeping manager who was one of health and safety leads. They told us that the hospice had a service level agreement with the Royal Bolton hospital to provide estate services. Health and safety meetings were held regularly and someone from each department attended. These meetings were minuted and the minutes were then discussed as a permanent agenda item at team and management meetings.

We saw that the service used the Prime system, a computer system for the collection and analysis of statistics, which enabled statistics and reports to be compiled. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) reporting was also done online through this system.

The in-patient unit lead nurse and sister assisted when we were looking at medicines and observing a medicine round. They were able to answer all our questions without hesitation. They were very knowledgeable about the use of the controlled drugs and their effects. They explained all the procedures clearly and we observed the sister administering medicines efficiently.

The hospice had service level agreements in place with Royal Bolton Hospital for patient named medicines and with Salford Hospital for stock controlled drugs. The supplying pharmacy for stock CDs had the appropriate licence in place to supply controlled drugs. The Royal Bolton Hospital pharmacy managed stock levels and the hospice staff carried out daily checks of Controlled Drugs (CD).

Staff followed standard operating procedures when administering and managing medicines. These were kept in the medicine room for all staff to access and staff had signed to say they had read them. All staff completed medicine training annually and competencies were checked.

We observed a medicine round and saw that medicines were given safely. The nurse completing the round checked the person's identification bracelet and asked them their date of birth checking against the MAR chart they had taken into the room with them, before administering medicines. They checked the person's

position before they took the medicine and gave a drink with any tablets. When they saw that a tablet may be a risk to someone they administered the medicine in a different form. For example, a paracetamol tablet was changed to paracetamol liquid to assist a person who had difficulty swallowing. The nurse locked the trolley prior to entering the patients' rooms so that medicines were secure.

Fridge and room temperatures were checked daily and we saw they were within the recommended limits. Clear guidance was available for staff to follow. There was a pharmacy cleaning rota for staff to follow and this had been completed for September.

We looked at the system for ordering medicines. A doctor signed the order in line with current guidance before it was sent to hospital. When the order was dispensed the hospital pharmacist signed to say it has been sent and then the staff on the inpatient unit (IPU) checked and signed the medicine in. If there were any occasions where staff had to collect CDs from the hospital pharmacy this had been risk assessed and operating procedures were followed. Both hospitals kept copies of prescriber signatures to check against.

Medicines were stored securely. A CD checklist was completed daily and the liquids were checked weekly. CDs are medicines which require stricter legal controls to be applied to prevent them being misused, being obtained illegally or causing harm. Any discrepancies were noted and staff were able to evidence where these discrepancies had been investigated and any actions taken. We did random checks of each CD cupboard and saw that they were correct and the CD book was completed correctly.

Patients' own medicines were kept in a locked cupboard in their room. The hospice generally used stock medicines and the patient took their medicines home although on occasions their medicines were used to prevent wastage. Patients' own CD's were kept in a separate cupboard in the medicine room. If their CDs needed to be used there was a policy for checking the suitability of the patient's own medicines against certain criteria. If necessary, patients' own CDs were disposed of in line with hospice policy.

Is the service effective?

Our findings

People consistently told us that the service provided them with effective care. All of the patients and their relatives that we spoke with were highly complimentary about the care and treatment provided by competent and skilled staff in a clean and pleasant environment. Patients told us their desired health outcomes were discussed and staff encouraged and supported achievable goals for patients and families to achieve, such as being as pain free as possible or being stable enough to be supported at home. Referrals were made appropriately to other services, such as Macmillan Nurses and District Nurses, with whom the hospice had excellent links.

The hospice was a training environment, providing placements for student nurses and doctors, which helped add to their knowledge and skills in the area of palliative and end of life care. The educators explained that the scheme also helped ensure the service had a regular supply of enthusiastic and interested staff members to complement the existing staff team.

The education department was proactive in the way they used their skills for the benefit of their own staff and other professionals in the local area, such as social workers and teachers, via the education centre. Childhood bereavement training was delivered and this had been attended by the hospice's own staff as well as staff from other agencies. Hospice educators also went into schools to deliver talks on bereavement. This demonstrated the service's commitment to helping educate more professionals in the community so that support for bereaved children within the local community was robust and extensive. The service had links with the local university where they delivered a course on palliative and end of life care, which was a stand-alone course or could be counted as part of a degree level course.

We spoke with the two educators based at the education centre within the hospice. They explained the staff and volunteer induction and training programme, which included a corporate induction for all staff. There was a range of mandatory training which all staff were expected to undertake. This included fire safety, major incidents, health and safety, confidentiality, data protection and information governance, security, equality, diversity and inclusion, infection control, communication essentials, safeguarding children and adults. Clinical and non-clinical staff undertook other training which was specific to their role. We saw that there was a mandatory training workbook for all staff, which had to be completed and checked by their supervisor to help ensure understanding and competence. All mandatory training was refreshed on an annual basis to ensure staff skills were current. We looked at the staff training matrix, which confirmed that all training was up to date.

Staff we spoke with told us the induction programme was thorough and they felt well prepared for their employment. They said that training was on-going. One staff member said, "I have worked here for eighteen months and I had communication skills training that was appropriate to my job just after I started work here". All nursing staff also had a 12 month preceptorship, so that on-going professional development could be monitored by the staff member and the service to ensure they were on track with this. Preceptorship is a structured period of transition for the newly qualified nurse, midwife or allied health professional when they start employment. This meant that people who used the hospice had access to staff who were consistently

developing their skills and knowledge in order to give patients effective care.

All staff were given a staff handbook on commencement of their employment. This included relevant policies, standards of conduct, accident and fire procedures and information about staffing issues. This was currently being updated to include the new logo and changes in policies.

Staff received clinical supervision, debriefing sessions, wellbeing sessions and peer support. They also received resilience and mindfulness training, which helped them deal with the emotional demands of the job. There were also links with occupational health at the Royal Bolton Hospital, which employees could access. In addition the spiritual lead was involved in inductions, which helped ensure staff were aware of the need to respect people's cultural and spiritual requirements leading up to and after death.

We spoke with members of staff, such as therapists and social workers, who were employed by other agencies but worked within the hospice environment. They told us they were well supported by the hospice management team, and by all staff working there, and could seek support any time. One staff member told us, "They [hospice management] are supportive and inclusive around training, emotional needs and management".

We spoke with three volunteers, one who had also been a patient. They commented, "I couldn't manage without the hospice, it has been a lifeline. I did a speech at the ladies lunch". We had a general discussion with the other two volunteers. They said they had received training and that they enjoyed coming to the hospice. They said they worked in three hour blocks which was manageable.

Staff meeting minutes evidenced that guidance, new research and developments, were promoted. The service followed local and national guidance for specialist palliative care and had strong links with the local hospital, the community and the local Clinical Commissioning Group (CCG). The hospice was responsive to national strategies and utilised the cancer network, National Institute for Health and Care Excellence (NICE) guidance and were a pilot site for the care record for the dying patient, the north west Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policy and procedure, the cord compression pathway and protocol. This demonstrated the service's commitment to ensuring they worked in line with current good practice guidance.

All appropriate staff members attended multi-disciplinary meetings within the hospice. This helped ensure all staff involved with a patient were aware of their progress, health and social care needs and wishes. There was evidence of discharge planning and the hospice had recently funded a discharge planning co-ordinator's post. We asked the nurse manager if the hospice had a rapid emergency discharge plan, she told us this was currently a work in progress

The Mental Capacity Act 2005 (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 so that they can 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions

on authorisations to deprive a person of their liberty were being met. Staff had received training in MCA and DoLS and were aware of the principles of the MCA. We saw that information regarding a person's mental capacity was documented within their care plans and that the hospice used the Bolton wide MCA assessment. Best interests decisions were made, with the involvement of the patient, appropriate family and other relevant people, where required. DoLS applications were made appropriately and staff were aware of the implications of these.

At the multi-disciplinary meeting (MDT) that we attended, one person had wanted to go home. The consultant said they had assessed their capacity and had to apply for a DoLS authorisation as they were not able to make that decision. Family were consulted and involved in the best interest decision making process. The patient had since died and the service had followed guidance by informing the coroner because they had a DoLS in place and had also had recent surgery. The family were fully aware and involved with this process.

There was evidence within the patients' care notes that individuals had consented to and agreed their care plans. If the patient was unable to consent, due to a lack of capacity, this was clearly documented and where a person had nominated a person to have lasting power of attorney (LPA) for health and wellbeing they had been consulted

We saw that care records included Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms and these were kept at the front of the patients' case notes where they could be seen immediately. The DNACPR forms were completed by either the GP in the community and sent to the hospice, or the hospice specialist doctor and countersigned by the consultant within the required time frame. Forms either indicated that the patient had been involved in the discussion or stated that the patient was unable to make this decision because of their diagnosis and condition.

The nutrition care policy was followed throughout the service. Intake of food and drink was recorded and patients and their relatives were invited to add any additional snacks they had to the sheet which was kept in people's rooms. We saw that they had done this. Everyone we spoke with told us the food was excellent and people could have a choice of food. One person we spoke with said, "Meals are so good, so appealing, well cooked and well presented".

Where appropriate a risk assessment was in place, for example one person had their risk of malnutrition assessed and scored, which then indicated that a care plan should be in place. This had been completed. The nutritional assessment identified specific areas of need and risks. Their food diary identified that staff gave them whatever they wished. We saw that cereals had been given to one person at lunchtime, which was what they could eat and what they wanted. This information was shared with kitchen staff.

We spoke with the chef who explained that the service had a four weekly menu but people could have any other items if they wished. There was no set time for breakfast and there were cereals fruit, yoghurt and cooked breakfasts on offer. At lunch time the chef went to speak to patients to take orders for their lunch. The meals were provided on nicely presented trays or there was an option to use the two dining rooms. The chef told us these were used a lot at Christmas or when families visited. The service offered visitors up to three hot meals per room as well as sandwiches and these were on a menu with prices. The service had also recently started to offer a hot breakfast to visitors.

We saw that patients' nutritional status was recorded in the case notes. Some patients had been identified as requiring support to improve their nutritional status for example if they needed food to be given via percutaneous endoscopic gastrostomy (PEG) feeding. This is when a person is unable to eat their food orally

and receive it through a tube into their stomach. One patient required thickened fluids which means a thickening substance is added to juice or water in order to minimise the risk of choking. This was clearly documented in the care records.

Mealtimes were protected and there were notices alerting visitors and professionals to this throughout the in-patient unit. Prior to the meal being served the meal time co-ordinator, who was a nurse, went around all the rooms to make sure people were in a safe position to eat, that they had the cutlery they needed and checked any other needs they might have. They also stayed with the chef throughout the lunchtime service to assist with any issues that may arise relating to eating and drinking. Volunteers delivered trays and also assisted people to eat and drink. Blue trays were used for special diets or when someone required assistance, as a visual aid for staff. Plate guards and specialist cutlery were used when needed.

Although there was no need for it during our inspection the service had dementia friendly crockery. This was yellow in order to contrast with the tray and make sure it was visible to the person. Lunch on day two of the inspection was homemade soup, two hot lunches and one hot desert. In addition, there was a sweet trolley which contained cold deserts if people preferred that option.

There were kitchenettes on each area of the in-patient unit where snacks such as biscuits, cakes, chocolate, cereals and drinks were on offer. There were also lollipops and ice cream tubs available.

There were flasks of water in rooms, which were changed regularly throughout the day. Other cold drinks were available such as fruit juices and there was alcohol available if people wanted it. Hot drinks could be made in the kitchenettes either by the patient, relatives or volunteers.

Every morning the chef was given a handover sheet which incorporated each person's nutritional assessment. If a patient's condition had deteriorated the handover sheet would tell the chef to go and speak with the nurse. Mealtime co-ordinators had suggested this happen when discussing what improvements could be made to the system. This had improved communication between the kitchen and nursing staff.

A computer programme was used by the kitchen staff to input menus and gave details of nutritional values. It gave per portion nutritional breakdown, ingredients and methods of preparation. In addition photographs of the meals could be put on to the system to ensure consistency.

The chef was the health and safety representative for the kitchen and there was also a nutrition group attended by an Occupational Therapist (OT), chef, lead nurse and nurses from In patient unit (IPU) and the day hospice. The nutrition group had identified that the amount of fluid taken in by patients was not being evidenced and this had led to the introduction of the current food and fluid charts. This demonstrated that areas for improvement were identified and acted upon.

The chef attended a catering group where they met with other chefs from hospices in the area. They shared ideas and good practice. In addition there was a hospice quality partnership which carried out bulk buying making the food purchases more cost effective.

The chef told us, "Even if you took out the nutritional value of food, mealtimes provide some normality in people's lives. They provide routine and remind people of the time. They also make sure that people see someone."

We walked around the building and found it to be warm, clean and tidy. The premises were being extended when we inspected, to incorporate more beds and make them all en-suite. This was being carried out

sensitively, with the builders making noise only for short periods of time and ensuring patients' safety at all times.

A recent dementia audit had highlighted that the environment could be improved in this area. The registered manager told us that they were trying to create a more dementia friendly environment within their renovations and would consider this for any future improvements or changes to the building. They had already started to ensure their service was dementia friendly including dementia friendly clocks and signage within the premises. In addition there was dementia friendly crockery. This meant that people living with dementia would be less confused and able to be a little more independent within the environment.

Is the service caring?

Our findings

People we spoke with told us they received excellent care and treatment and were very well looked after within the hospice environment. Relatives said they were made very welcome and they told us they were supported to bring pets in, with prior agreement, if this would help the patients' well-being. A patient in the in-patient unit said, "I can honestly say I've had nothing to complain about. The treatment I've received is 110%. Staff are brilliant, I think they are very caring. They go out of their way to get what I need. It's like being in a ten star hotel. Whatever help I've needed I've got it. I have only had the best treatment I could wish for. I really appreciate everything they do; they get help to people who need it as quickly as they can".

An individual we spoke with told us, "When my [relative] was here [relative] was completely relaxed. I've always been impressed by the way they look after relatives as well as the patient. They make you feel part of everything".

Another relative was full of praise for staff and the way in which they managed their [relative's] care. They told us that the consultant and nurses were always asking what they wanted for the patient and what they could do to achieve that. They had asked that the family sit together and for the patient to have no pain. They told us the consultant was trying to make sure that happened. The relative also told us that staff had let them sleep in same room as their loved one as they had not wanted to leave. However, the staff had noticed the previous night that they were looking very tired and had arranged for them to sleep in a bedroom close by to get a better rest. The relative was a little reluctant to leave their loved one but staff made a promise to check on the patient every few minutes and leave their door open. The relative was confident they had done that and felt the staff were very supportive of the whole family.

There were 'Have your say' leaflets throughout the reception and ward areas for people to complete. We saw the results of the care at end of life survey of relatives. This demonstrated that people were positive about the care received by their relatives from the hospice service. Comments included, "I sincerely say there was nothing else that Bolton Hospice could have done for my [relative], they had the best possible care and help they could have wished for"; "High standard of care and attention"; "Nothing you could have done better"; "The care my [relative] and my family received was truly outstanding, I couldn't fault it"; "[Relative] was treated with the utmost care and dignity"; "Nothing is too much trouble and it is clear how much the staff care about each individual". With regard to the hospice at home service, comments included, "Everything was done with love and care"; "The team looking after my [relative] were excellent. They looked after [relative] with dignity and care".

The service had begun to use an independent agency to collate patient reviews of their experience at the hospice, called 'iWantGreatCare'. The clinical lead told us this was a more user friendly method than those used before and reviews could be placed straight on the hospice website or completed on a form and returned. All comments, positive and negative, were then uploaded to the website and analysed to drive improvements to the service.

We spoke with a representative of a group of people who had been affected by cancer. They were positive

about their experience of the hospice services. They told us the service had been helpful in providing somewhere for their group to meet, refreshments and administrative support. They described the service as, "Arguably the most user friendly place". They said the spiritual support offered to patients, relatives and staff was "exemplary".

One staff member said they had been working for the organisation for eighteen months. They told us, "The nursing staff are amazing; there is a real difference in the care here compared to the care in hospitals. Their professionalism and friendliness makes the difference; the nurses are as you would expect them to be in a hospice".

We saw that people's privacy and dignity was respected. All the rooms were built so that they had a private garden area which was not overlooked by any other patient's room. The new rooms were also being built in the same way, with people's privacy in mind. We observed, throughout the inspection, staff treating people with respect, listening to their views and wishes and taking time to ensure the patient and their family were happy with the care delivered. Staff told us people's dignity was important and we saw that they knocked on people's doors and waited to be admitted to their rooms.

We attended a multi-disciplinary meeting (MDT) whilst conducting the inspection. The MDT meeting showed how staff supported people and their families in a caring and thoughtful way. Staff discussed a family who had just been referred. The daughter was struggling with caring responsibilities and complementary therapy appointments had been made for both service user and daughter so that staff "Could get alongside them to get to know them better." Another person had been involved with Occupational Therapy (OT), who had used complementary therapies to get to know the family and the patient. They had discussed how they might use memory box work and how they might help them prepare to tell their grandchildren about their condition. One person had recently died in hospital in distressing circumstances. The specialist doctor had discussed this with the palliative care nurse at the hospital and alerted the spiritual leads in case of any bereavement issues.

We spoke at length with the Spiritual Care and Bereavement Support Leads. One was about to retire from the service, the other just commencing their employment and they were currently working together to have a meaningful handover period. They were available for everyone within the service, patients, relatives, friends and staff and provided support and counselling, led various bereavement groups and facilitated three memorial services per year for families to remember their loved ones. These were well attended and the bereavement groups, which included social activities, had remained popular and they told us people continued to attend for years after they had lost their loved one. The spiritual leads had implemented a bag used mainly for bereaved children, where they could put in various items, such as a booklet, tissues, teddy bear, stones for remembrance and cards with phrases on them. The cards included phrases such as "I need a hug" to be used when children found it difficult to articulate their feelings. These bags had proved helpful for children in coming to terms with a loss spiritual leads told us the bags had also proved popular with teenage children. They were now looking at producing adult packs to give out at the point of access to patients and families.

The bereavement service, within one month of a death, sent out a card with dates of the groups and information about grief. If the person felt this was too soon they were invited to the next group. These groups could offer activities, such as walking, one to one counselling or family counselling. The spiritual assistance was inclusive and there were volunteers from different faiths who attended the hospice as well as telephone numbers for all major faiths. There was a multi-faith prayer and reflection room which had displays of many religions, beliefs and practices. This provided a quiet space away from the in-patient unit and could be accessed by anyone who wished to use it.

We saw that the service produced a patient and family guide and a hospice at home leaflet. These could be produced in languages other than English if required and included a range of information and guidance around the services offered. The service was strongly committed to promoting equality, diversity and inclusion and had a Charter, setting out how they would meet challenges within the service. The Charter was visible around the building via posters on the walls. It was written in straightforward, clear language, which was unambiguous and was meaningful to people. For example, the charter stated, "Never judge people by their accents, culture, customs or your personal prejudices; get to know everyone before making judgements". The Charter had been devised during staff training sessions, demonstrating how staff were involved, and therefore invested in the work. People we spoke with felt the service was inclusive and lived up to the values outlined within the charter.

Communication between staff, patients and families was excellent. All staff had received training in communication skills and had also received training in cultural and spiritual issues at the end of life. There had been recent training on Islam and End of Life care which had increased staff's understanding and knowledge in this area. The service had a Care Quality Steering Group that championed certain areas such as dementia, carers, communication and well-being. This helped staff develop knowledge, understanding and empathy in these subjects.

People using the service at the time of the inspection were able to communicate with staff or had a representative who could do this on their behalf. However, the service had access to independent advocates, who they would contact if the need arose to help ensure people remained fully involved in their care delivery and their best interests were respected.

Nursing staff we spoke with told us there were many extra services offered within the hospice, such as a range of therapies. When patients and families accessed therapies at the hospice this gave them a feeling of inclusion and normality. They were not simply a patient, but an individual accessing therapeutic and beauty treatments, similar to those they may have used in other settings previously. This was also a positive and pleasant experience they could share with a family member, which was non-medical related.

Nurses also told us that, when patients wished to renew their wedding vows at the hospice the service could make contact with a local charity. The charity supplied a hairdresser and beautician, to do the patient's hair, nails, and make up at no cost. They also provided flowers and the catering was arranged by the hospice for the patient. On people's birthdays the catering department arranged a birthday cake for them and it was also possible for patients to use one of the lounges for any celebrations they may have. This could have an extremely positive effect on the patient and their loved ones and give them a boost when enjoying a happy family occasion.

The service was committed to helping ensure people had a dignified death which was as pain free and comfortable as possible. They understood the need to help family and friends through this time and the service had recently purchased a special system which meant that people could spend more time with their loved ones following their death. A comfortable, quiet 'viewing room' was also available so families could return and spend more time with their loved one if they wished to. This gave people the time they needed to say their goodbyes and start the process of acceptance.

Is the service responsive?

Our findings

All the people we spoke with told us the responsiveness of the service was excellent. One patient said, "Staff tell me, 'The minute you feel any little pain you must tell us' and they are straight on it." The hospice had implemented a pager system that allowed an improved response time to nurse call. The Equality, Diversity and Inclusion Charter, seen all around the building, encouraged staff to, "Treat everyone with the same level of importance"; "Celebrate differences and similarities", and, "Lead by example".

Health and social care professionals we spoke with were highly complimentary about the hospice and its staff. They told us the service was person-centred and responsive to the individual needs of the patients and their families and that staff went out of their way to deliver the highest quality service possible.

We saw examples throughout the two days that staff lived up to the values outlined within the Charter, taking time to listen to patients and families, responding to needs quickly and treating each person as an individual. There was a holistic assessment, that is for the whole of the person, for each patient and the service ensured that the patient was fully involved in this, if possible. If they were unable to participate in the assessment, their representative would contribute to the process. People's wishes for the end of their lives were recorded and shared, with their consent, with other relevant professionals.

We accompanied the hospice at home nurses and saw they were very compassionate in their care of a patient's partner. They asked about their wellbeing and if there was anything they could do for them. They checked whether or not the patient required any personal care and the partner asked for assistance with personal care, which the nurses attended to immediately. The nurses did not rush and took time to have a chat with the patient's partner. They were very empathetic and gave support verbally and practically. We spoke with the patient's partner. They told us, "They are very good, they never rush. They will do anything I want, they ask if I need anything too."

We had discussions throughout the morning with hospice at home nurses. They give out a patient and family guide when they started a service and all their telephone numbers were recorded in the person's home so that they could ring the hospice at home team. They said that they completed the district nurses' notes on visits as they led in the person's care but kept their own records at the hospice. They told us that the district nurses gave out information about death and what to do afterwards but if a person died six weeks later the hospice would write to the person and offer bereavement support.

When we arrived at the second person's house they were in crisis and the relative was distressed, so we did not go into the home. One nurse told us when they came out of this person's home, "It is at times like this, when you can make a difference to someone by leaving them comfortable, that you realise what a great job this is."

We attended the nursing handover between morning and afternoon staff. Detailed information relating to the patient was shared. For example, any significant conversations which had taken place and any treatments that had taken place that morning such as physiotherapy, occupational therapy or

complementary therapies. The service had started a new system where printed electronic nursing and medical handover sheets were produced. This had improved the exchange of information.

We went on to look at four people's care records and saw they held personalised information. The baseline assessment completed considered people's home circumstances, access and support needs, their sensory and cognitive needs and their memory. There was a joint care plan compiled by both the nurse and the patient and activities of daily living were assessed.

We saw within the care records that when patients were admitted their name, and the name they preferred to use, was documented in the case notes. This was used thereafter when writing about the person and demonstrated individualised care starting at admission.

All care plans and risk assessments were person centred and included people's views. We saw that care plans were regularly reviewed to ensure changes and updates were fully documented and plans were up to date at all times. There was evidence of patient involvement within the care plans or, where relevant, the involvement of their chosen representative. Throughout the inspection we witnessed staff giving full explanations of all interventions and care delivery; ensuring patients were fully on board with care and treatment.

Therapies were available in the day centre for people and their families. Aromatherapy massage, hair and image therapy were available in the two clinic rooms and people were also able to access creative therapy in the day centre if they wished to. This extended to in-patients too. There were two complementary therapists employed at the service. Therapies provided activities that could be enjoyed by both patients and their families. This helped to strengthen and maintain bonds between the patients and their loved ones and to avoid the patients becoming socially isolated. The rooms at the hospice had been enlarged and this also helped support relationships between patients and their loved ones as the larger rooms allowed more people to visit, if the patient wanted this.

We met a 'pets as therapy' dog and his owner who told us the dog visited the hospice twice a week and visited the day hospice and the IPU. They gave us an example of when one day they were called into a room by a relative. The relative wanted to thank them for visiting the patient and as they were talking the dog stood by the bed and licked the patient's hand. This was seen as a gesture of comfort for the person.

There was a regular multi-disciplinary team meeting held at the service. At these meetings each patient's status and current needs were discussed. One person had stated their preferred place of care as home but they had needed additional support as they were semi-conscious and required medicine through a syringe driver. After further discussion the patient and family had agreed that the hospice was the best setting for the patient. A second person was identified as low in mood. The OT said they had been an outdoor person but were now unable to go out. They had been seen in clinics and day centre visits had been arranged for them to try and alleviate their feelings of social isolation.

The calls through the helpline were discussed. A district nurse had used this service to ask for advice from hospice staff about their patient. This case was discussed and the family circumstances considered. The district nurse had been advised to refer to the hospice at home service as an initial measure. There were beds allocated for people later that day. One person was being admitted who had support from the Trust palliative care nurse who worked alongside hospice staff to arrange the admission.

The patient leaflets and guides could be produced in a range of languages for patients and their families. This included literature available for children and for those with disabilities about the loss of a loved one

and what to expect when someone is dying.

The hospice had an appropriate complaints policy in place and this was outlined around the premises and within the literature given to patients and families. A patient guide was available in every room, outlining the service and how to make a complaint should they want to.

We looked at how the service responded to concerns and complaints. We saw the complaints/concerns log which documented the issues raised and response made. Most concerns were informal and we saw that appropriate responses, such as an apology to the patient and family, had been actioned. If necessary a member of staff may be spoken with or referred for further training or supervision. It was clear from the responses that the service listened to, and took seriously, any concern raised. We saw that an action plan was put in place when a complaint was raised formally. One of these action plans included staff team reflections on what had happened via team meetings, speaking with individual staff and offering a meeting with family and bereavement counselling. We saw that incidents and accidents were cross referenced with complaints to ensure these were dealt with in the correct way.

Is the service well-led?

Our findings

Patients, relatives and friends, staff and other professionals all felt the hospice service was well managed. One patient said, "It must be hard for them to maintain the quality of care. What they do now is brilliant." A staff member told us, "I have never worked anywhere that is so organised", and a volunteer commented, "The biggest part is raising awareness so that people are not scared to come into the hospice. I look forward to coming".

We spoke with the Chief Executive Officer (CEO), who was also the registered manager of the service. They explained the management arrangements and we saw a clear management structure through the service. Each member of the management team knew their place within the structure, who they were accountable to and what their line management duties were.

There was a board of trustees and the registered manager explained how members of the board were recruited, with appropriate checks carried out as with other staff members and volunteers, via targeted advertising. She also explained how the correct skill mix was represented on the board. New additions to the board met with the CEO, the chair and the treasurer in the first instance and were co-opted to the board prior to being formally appointed at the annual general meeting.

We discussed the responsibilities of the board, which included strategic oversight and scrutiny of the service, providing challenge to staff. An overarching strategic plan was delivered annually and quarterly meetings held and reports produced. In between these meetings there were three special topic meetings per year to look at issues in detail, for example, ethical fund raising and the implementation of new data and IT systems. The CEO also sat on the Bolton Health, Care and Wellbeing Forum and had links with Macmillan and The Christie Hospital (a local cancer treatment centre) for the provision of facilities to deliver cancer information and support and a Christie lymphoedema.

We asked how the service kept up to date with current best practice guidance and the registered manager told us they and other relevant staff members ensured they accessed the appropriate web sites to look at anything new. The service was a member of Hospice UK and part of the regional hospice network. These organisations met on a quarterly basis, the registered manager and the chair of the board of trustees attended, and shared information. The venue moved around between hospices so this gave attendees the chance to see other similar services and share good practice.

Other groups attended by senior staff included the palliative and end of life strategy group. The hospice's senior management group met on a weekly basis to share information. Clinical governance meetings were held on a monthly basis and quality and standards meetings two monthly. We saw meeting minutes which confirmed that issues such as estates and building, workforce planning, education and training, quality improvement, information and communication, clinical risk management, effectiveness and support, patient user involvement and research and development were discussed. All staff, in every department, attended regular monthly team meetings and managers attended management meetings, to ensure all had access to a forum where issues and practice could be discussed. This helped ensure the service continued to

challenge any poor practice within the service, promoted good practice and worked to current guidance.

We asked how the registered manager ensured their own personal development. They told us they were booked on a course in the near future at a local university regarding strategic leadership and culture. The registered manager, in discussion with senior management and the board, agreed this would be useful in addressing their own development needs.

We discussed the culture of the service. The registered manager explained they were promoting more shared ownership, working to ensure clinical and non-clinical staff were recognised and respected and knew where they fit in to the bigger picture. Volunteers made up a large proportion of the workforce, both within the hospice and in the hospice shops, and we saw they were valued and supported by the service. Volunteers we spoke with said they were given opportunities for training and development and felt they were shown appreciation and encouragement within the service. We saw there was an open culture where staff were encouraged to come forward and discuss issues and concerns with their line managers and we saw that staff were encouraged to contribute to the three year strategy and annual business plan. Staff supervisions took place on a regular basis and were complemented by team reflections and discussions around current issues.

The Equality, Diversity and Inclusion Charter, contributed to by staff during training sessions, encouraged staff to challenge poor practice. The Charter stated, "Don't be a bystander; challenge inappropriate behaviour, language, attitudes and actions". As there were posters around the building, these acted as a reminder to staff about the values agreed within the Charter. Staff we spoke with were aware of the values of the service and told us they would not hesitate to challenge poor practice if they witnessed it.

Staff we spoke with told us they enjoyed working at the hospice, they felt supported by the management team and the team were very supportive of each other. One staff member told us, "There couldn't be a nicer place to work". Another said, "They are supportive and inclusive with training, management support and emotional support". Staff were consulted about changes. Auto lighting had been introduced in some areas but staff did not like it, they said they preferred to be able to turn the lights off manually. This was reviewed after consultation and the service reverted back to manually adjusting the lights. There was a comment box in the reception area for staff, volunteers and visitors to use.

All appropriate policies and procedures were in place at the service. Many of these included references to other related policies and had flow charts as guidance for staff. Notifications were completed as required and sent to the relevant agencies, including CQC, in a timely manner.

The auditing programme at the service was robust and a significant number of audits were undertaken throughout the service. These included environmental audits, accidents and incidents, complaints, medication and risk assessments. The audit group met regularly to ensure all audits were analysed for patterns and trends and issues identified had been addressed in an appropriate and timely manner. We saw minutes of recent meetings that confirmed this. We also saw a quarterly audit report produced by the service, which evidenced actions completed.

There was a quality standards group which met every two months to discuss items on the risk register. This meant that the service was clearly working towards quality improvement in a proactive way.

The service had undergone an environmental assessment. Their aim was to be as environmentally friendly as possible. They had scored well and were now working towards having items such as biodegradable straws and other items used in plastic replaced.

The service had a fund raising department where money was raised in various ways, such as the hospice lottery and hospice shops. Many fund-raising events such as Light a Life and a Midnight Walk were held by the service throughout the year as well as an on-going hospice lottery and a number of shops throughout the local area. Fundraising was extremely important in ensuring the continued success of the hospice.