

Overgate 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 was carried out on 20 September 2016 and was unannounced. This meant the provider and staff did not know we would be visiting. At the time of the inspection there were seven people receiving care and treatment on the in-patient unit.

Overgate Hospice provides specialist palliative care for adults in the Calderdale area. The hospice supports people with cancer and life limiting, progressive illnesses and helps people with symptom control as well as providing end of life care.

The hospice provides in-patient accommodation for up to 12 people and day hospice services. The day hospice services did not form part of this inspection.

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

Everyone told us they felt the hospice was a safe place where care and treatment was delivered by kind, compassionate and competent staff. There were systems in place to make sure people were protected from harm and staff knew how to report any concerns about people's safety and welfare.

The hospice employed a range of medical and nursing staff and health and social care professionals such as social workers. There were enough staff to ensure people received the right care and treatment in a timely way. The hospice did not employ an occupational therapist but worked closely with the community based team of occupational therapists to make sure people got the support they needed. Everyone told us staff were quick to respond to their changing needs.

New staff did not start work until all the required checks had been completed satisfactorily. This helped to protect people from the risks of being cared for by staff unsuitable to work with vulnerable people.

We found risks to people's health, safety and welfare were well managed. People's care records included information about individual risks and how these were managed.

The hospice was clean and well maintained and equipped to meet people's needs. Checks were carried out on equipment and installations which helped to ensure the premises were safe for people to use. There were clear systems and processes in place to deal with emergencies, both medical and non-medical emergencies.

Incidents and accidents were recorded and reviewed and whenever possible action was taken to reduce the risk of recurrence.

People's medicines were handled safely. However, some of the storage arrangements needed to be reviewed to make sure they were secure enough.

People told us the staff were well trained and knew how to meet their specialist needs. Staff received training on safe working practices and were supported to develop their knowledge and skills. Staff received support to cope with the emotional challenges of their work.

Management and staff demonstrated a good understanding of their responsibilities in relation to The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. This helped to make sure people's rights were protected and promoted.

People were offered a choice of food which took account of their ethnic, cultural and dietary needs and preferences. Nutritional assessments were carried out and people received support from dieticians and speech and language therapists where necessary.

People received support to maintain their wellbeing from a multi-disciplinary team and they spoke very highly about the nursing and medical staff. They told us how staff had helped to allay their fears and make their lives more comfortable.

Without exception people told us the staff were extremely caring and kind. They told us they were always involved in decisions about care and treatment and staff always asked for their consent before providing support.

The hospice had a calm and relaxed atmosphere. We observed people who used the service, relatives and staff were comfortable in each other's company. We saw staff were kind and patient when supporting people.

People's privacy and dignity was always respected despite the limitations of the shared four bed rooms. The management team had identified this as an area for improvement.

Staff knew about people's individual needs and preferences and spoke about people and their relatives with warmth and compassion. Relatives and carers were offered support when their family members were receiving care and treatment and post bereavement. People were supported to meet their spiritual needs and were offered the opportunity to attend memorial services.

Everyone told us the service was responsive to their needs and we found care and treatment was delivered in a person centred way. However, this was not always reflected in people's care plans.

People were supported to share their views of the service and there was a complaints procedure in place.

There were systems and process in place to monitor and assess the safety and quality of the services provided. We found the management team was open and enthusiastic and constantly looking at ways to improve the service.

The service worked in partnership with other health and social care providers to improve the standards of end of life care across Calderdale.

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 were protected from harm. Staff knew how to report concerns about people's safety and welfare. Checks were carried out on new staff to make sure they were suitable to work with vulnerable people.

There were enough staff to meet people's needs in a timely way.

People's medicines were managed safely and people received the medicines when they needed them. Some of the arrangements for the storage of medicines needed to be reviewed.

Risks to people's safety and welfare were managed.

The hospice was clean, well maintained and suitably equipped to meet people's needs.

Is the service effective?

Good ●

The service was effective.

People received care and treatment from staff who were trained and competent.

The hospice worked in accordance with the Mental Capacity Act 2005 which helped to make sure people's rights were protected.

People were offered a variety of food and their dietary needs and preferences were catered for.

People were supported to maintain their physical and psychological wellbeing by a team of health and social care professionals.

Is the service caring?

Good ●

The service was caring.

Everyone told us the staff were very caring, considerate and

compassionate. This was supported by our observations and we saw staff took great care to make sure people's needs and wishes were accommodated.

People were treated as individuals and their privacy and dignity was respected.

People were involved in making decisions about all aspects of their current and future care and treatment.

Is the service responsive?

Good ●

The service was responsive.

People experienced care and treatment which was responsive and adapted to meet their individual needs. However, this was not always recorded in their care plans.

People were supported to raise concerns or make a complaint if they were unhappy with any aspect of the service.

Is the service well-led?

Good ●

The service was well led.

There was a culture of openness and a clear commitment to continuously improving the service. The management team were highly motivated and passionate about improving people's experiences of end of life care.

There were effective systems in place to monitor and assess the safety and quality of the services provided.

People who used the service, their family and carers were given opportunities to say what they felt about the service and to make suggestions for improvements.

Overgate 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 was carried out on 20 September 2016 and was unannounced.

Before the visit we reviewed the information we held about the service, this included notifications of significant changes or events. We contacted Healthwatch and the local Clinical Commissioning Groups (CCGs) to ask for their views of the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The provider completed a provider information return (PIR) prior to the inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used information from the PIR to help inform our judgements.

The inspection was carried out by two adult social care inspectors, a pharmacy inspector, a specialist advisor in palliative care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case palliative care services.

During the inspection we spoke with five people who used the service and seven relatives. We looked at three people's care records and seven people's medication records. We listened to the handover when the staff for the afternoon shift came on duty and observed the meal service at lunch time. We looked around the communal areas, some bedrooms and the gardens. We looked at other records related to the day to day running of the service such as staff files, training records, maintenance records, meeting notes, survey results and audits.

We spoke with various staff including the registered manager, the chief executive, the clinical service manager, the human resources manager, the ward sister, the ward clerk, two doctors, three nurses, the chef,

two social workers and the facilities manager.

Is the service safe?

Our findings

Everyone we spoke with told us they felt the hospice was a safe place and the staff were approachable and accommodating. One person said, "I feel very safe here." Another person said, "I can just ask if I want anything and they get it for you." A relative said, "I can go home and know she is cared for and safe." Another relative told us they had no concerns about safety, they said, "They go at her pace and give her time."

There were policies and procedures in place to protect people from harm. The social work team had the lead role for safeguarding within the hospice. They provided training for all staff and were available to offer advice and guidance for staff if they had any concerns about people's safety and welfare. The social workers told us they were in the process of sourcing up to date training on safeguarding children. The hospice did not provide care and treatment directly to children but the nature of the services provided meant they often had indirect involvement with children.

The hospice maintained a clear record of all safeguarding concerns and we saw they worked with other agencies such as the local authority when any safeguarding concerns were identified. We talked to the social workers about two safeguarding concerns and found they had been dealt with in a sensitive, safe and effective way.

This demonstrated the provider had suitable arrangements in place to protect people from harm and should abuse take place to reduce the likelihood of it going unnoticed.

We asked people if they felt there were enough staff to look after them. Without exception the answer was positive, one person said, "I don't have to wait, I can just ask if I want things." People's relatives also said they felt there were enough staff, one relative said, "There are plenty of staff on duty." And another said, "Yes, there are enough staff."

We discussed staffing with the senior management team. They told us nursing staffing levels were continuously monitored using a risk assessment which took account of the needs of people who used the service. The registered nurses and nursing assistants worked to a rota and the majority of staff rotated between day and night duties. At the time of our inspection the usual staffing numbers on the in-patient unit were four nurses and three nursing assistants on an early shift, three nurses and two nursing assistants on the afternoon/evening shift and two nurses and one nursing assistant overnight. The registered manager told us they had no vacancies for registered nurses or nursing assistants and very rarely used agency staff. This helped to ensure people experienced continuity of care.

The provider had robust recruitment procedures in place for the employment of new staff. The records showed prospective staff members completed application forms covering areas such as their previous experience and qualifications and a full employment history. Pre-employment checks were carried out, which included written references and checks with the Disclosure and Barring Service (DBS). DBS checks are carried out to confirm whether prospective new care workers have a criminal record or have been barred

from working with vulnerable people. Professional registration checks were carried out and recorded where appropriate, for example for nursing and medical staff.

We looked at the way medicines were prescribed and managed at the hospice. We asked a person who used the service if their pain was being controlled well and they said, "I am satisfied with everything they are doing."

We watched one nurse administer medicines before lunch and saw that a safe procedure was followed. We looked at the medicine charts for the seven people who used the service and saw the prescribing and administration of medicines was recorded in a safe way. Any known allergies were recorded and this reduced the risk of people having adverse reactions to medicines. When people were prescribed a medicine to be taken 'when required' the maximum dose that could be administered was recorded. It was also clear on the medication charts when a medicine was stopped or the prescription was changed. This helped to reduce the risk of medicine errors

Medicines were ordered from the local NHS hospital pharmacy. A palliative care specialist pharmacist visited twice a week to provide a clinical service and check prescription charts. The hospice doctor told us that the pharmacist was very helpful and it was easy to contact a pharmacist at the hospital for advice by telephone.

Medicines and equipment that might be needed in an emergency were easily accessible and regularly checked to make sure they were ready to use.

Medicines were stored in locked cupboards or in a locked medicine trolley. We asked the hospice to assess whether the arrangements for storing medicines were secure enough. This did not include controlled drugs which were stored securely in cupboards that met legal requirements. Medicines classified as controlled drugs have more risks associated with them and have, by law, to be managed in a particular way. We found medicines were kept at the right temperatures and the temperature of the medicines refrigerator was monitored in the right way.

We found that hazard warning signs were not displayed in all the areas where oxygen cylinders were kept. This was a health and safety risk. We also noticed that three oxygen cylinders were kept next to flammable materials. We brought this to the attention of the registered manager and it was dealt with immediately.

There was a clearly written medicine policy covering the different aspects of medicines management, including controlled drugs. The stock balances of the four controlled drugs we checked were correct. Nurses regularly checked stocks of controlled drugs and additional checks and audits were carried out by the accountable officer and visiting pharmacist. The accountable officer is the person who has a legal responsibility to ensure controlled drugs are properly managed.

We concluded people were protected from the risks associated with medicines because medicines were handled safely.

Risks to people's safety had been assessed with people's consent and as part of their plan of care. We saw records which confirmed that if people were admitted with confusion or an increased risk of falls then a falls risk assessment would be completed. We saw examples of these assessments along with assessments for monitoring nutrition, moving and handling and skin integrity. The risk assessments helped to mitigate those risks and to protect people from unnecessary harm. Records showed that risks were updated and reviewed regularly. Staff demonstrated to us they were knowledgeable about the level of risk related to the people

they were caring for. Regular multi-disciplinary meetings took place on site to discuss and review the rapidly changing care needs of people using the hospice.

The service did not employ an occupational therapist. Staff told us they worked very closely with community based team of occupational therapists who were responsible for assessing risks to people before they returned home. They told us that for those people who needed the input of an occupational therapist an environmental risk assessment of the person's home and the person would be completed before discharge home. Staff told us how they worked with the occupational therapist to make sure any equipment or adaptations to the person's home were completed in a timely way. They told us how equipment such as commodes, raised toilet seats and specialist beds were ordered prior to discharge. This helped to ensure a smooth transition from the hospice environment to home.

We looked around and found the hospice was clean, well maintained and suitably equipped to meet people's needs.

The kitchens were inspected by the local environmental health department and had achieved a score of 5 (the highest) for hygiene and food safety.

We talked to the facilities manager about the management of the premises. They were relatively new and had been in post approximately four months at the time of our inspection. They explained they were in the process of reviewing and updating all the systems and processes related to the management of the premises.

The maintenance records showed regular health and safety checks were carried out to help keep the premises safe for people to use. These included checks of fire safety, gas and electrical safety, water safety and emergency lighting. The records confirmed specialist equipment, such as hoists were serviced regularly.

The service had a business continuity plan which gave details of the actions to be taken to continue the operation of the service in the event of an emergency. The facilities manager was in the process of reviewing and updating the plan. For example, they had put a new procedure in place for staff to follow when they needed to contact one of the management team outside of office hours. The new procedures guided staff to the person who was best placed to deal with the issue so that it could be dealt with as quickly as possible.

The fire alarms were monitored by an external contractor who contacted the hospice in the first instance when the alarm was activated. If they did not get a reply they alerted the fire service. The hospice carried out a minimum of three fire drills a year, one of which was out of hours. The fire procedures had been updated and the hospice followed a horizontal evacuation policy. This meant that in the event of a fire people were moved to a safe place within the building and only had to evacuate the building in extreme circumstances. The emergency plan identified a place of safety where people would be taken if it became necessary to evacuate the building.

The hospice had a robust approach to the identification and management of risks to the delivery of the service. Risk registers were completed by department heads looking at risks specific to their areas of responsibility and this information was fed into the organisational risk register. Risks were rated using a RAG (Red, Amber, Green) system and the organisational risk register was reviewed on a quarterly basis by the senior management team.

The hospice had several governance groups referred to as subcommittees and one of these was the Care, Quality and Safety (CQS) subcommittee. The CQS was responsible for monitoring accidents, incidents and

near misses. All incidents, accidents and near misses were recorded and reviewed on a monthly basis. The CQS explored themes or patterns and was responsible for ensuring any actions to reduce the risk of recurrence were implemented. This showed the provider was continuously looking at how they could improve the service by reducing the risks to people's safety and welfare.

Is the service effective?

Our findings

People told us they felt confident the staff knew how to care for them properly. One person said, "The nurses seem to be more trained, specialised and knowledgeable." Another person said, "They seem to be well trained."

All newly appointed staff and volunteers received induction training which was specific to their role. In the case of clinical staff, who were directly involved in providing care and treatment to people, this included a list of practical tasks to ensure safe working practices. New staff had a six month probation period and reviews took place at specified intervals during the six months to make sure they were receiving the right support. We spoke with one member of staff about their induction and they told us it had helped them to settle into their role.

The hospice had a programme of mandatory training for clinical staff which included fire safety, infection control, moving and handling, basic life support, equality and diversity, communication skills, safeguarding, dementia care and The Mental Capacity Act. The registered manager told us the appointment of an Educator in Specialist Palliative Care had helped them to maintain a skilled workforce by having a training programme that was responsive to people's needs. For example, they had recently identified the need for tracheostomy training, the Educator had been able to source this externally and the training had been delivered.

Staff were supported by means of one to one supervision, annual appraisals, debriefing sessions and 'Schwartz' rounds. 'Schwartz' rounds provide a safe and supportive environment within which staff of all disciplines can reflect on their own feelings, experiences and the emotional challenges of caring for people. The senior management team had access to external supervision and volunteers were supported by the Volunteer Services Coordinator.

The Human Resources (HR) manager had developed a leadership training package for staff and work had started on supporting nurses through the NMC (Nursing and Midwifery Council) revalidation process. This is a relatively new process which nurses are required to complete to maintain their registration and the right to practice.

The hospice had link nurse for key areas such as infection control. The link nurses were responsible for keeping updated and sharing best practice with other staff.

This demonstrated the provider had effective systems and processes in place to make sure staff were trained and supported to carry out their roles.

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 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, hospitals and hospices are called the Deprivation of Liberty Safeguards (DoLS). At the time of the inspection people who used the service had capacity and as such no applications had been made to deprive people of their liberty. The management team were able to describe in detail about aspects of the workings of the MCA and discuss other examples of its use when people had previously been deprived of their liberty.

Individual care records indicated that attention was paid to making sure that people were supported to give consent and make decisions about their care and treatment. We saw examples of this in respect of advance care planning in people's wishes for end of life care. For example, people were asked to give a first to third preference on their preferred place of death. We saw examples when people were supported and involved in decisions such as if they wanted to be resuscitated in case of a cardiac arrest. Do Not Attempt Cardio Respiratory Resuscitation forms had been signed by the person and only after it was explained what were the implications of having this in place. This meant that people were enabled to make informed choices and decisions regarding their life and treatment.

During the inspection we observed the meal service at lunch time. The meal time was calm and people were not rushed. There was a choice of food and people were offered a selection of hot and cold drinks. The food was served by the chef who knew about people's individual needs and preferences. For example, we saw one person had a sandwich which had been made especially for them. We observed staff offering people support and encouragement, for example one person was asked "Do you need any help with your lunch?"

We spoke with staff who told us people were supported to enjoy their food and were offered choice and variety, which respected people's dietary requirements. People were consulted regarding their preferences and choice of food. Staff showed us menus that provided choice at each meal time. They told us all food was home made on the premises from fresh ingredients. People told us they liked the food provided. One person said, "I enjoyed my porridge and toast this morning." They also said, "At first the portions were too big but I spoke to the nurse who mentioned she would sort out smaller portions for me today. The food is very good and very tasty."

Staff told us how they accommodated people's culture and ethnicity dietary needs and catered for other special diets such as vegetarian, renal and diabetic. They also explained food and drink could be liquidised or thickened if people were experiencing swallowing difficulties.

Records were available to confirm that nutritional assessments were carried out on people who used the service. The assessment was detailed focussing on people's nutritional status on admission, any allergies, the consistency of food required, religious requirements and if the person had any altered taste. The assessment also considered dietician involvement, if the person was suffering from any complications with the mouth such as ulceration or thrush or if there was any nausea or vomiting. The assessment also looked at the practical requirements to determine if people required any specialist equipment to help them eat or drink. If there were any cause for concern following the assessment process then an appropriate care plan was developed.

Relatives told us they were able to have meals at the hospice if they wished, one said, "You can order a three course meal and eat with your relative which is good and great value for money. I've been offered food when I'm here all day; they seem to worry about me as much as [person's name]." There was also a food fridge in the reception area which was kept stocked with snacks and drinks.

The hospice employed a range of staff, this included nurses, nursing assistants, doctors and two palliative care consultants. Medical cover was provided on a daily basis during the hours of 9am and 5pm and after that time there was an on call rota in which nursing staff could contact the doctor for advice or if needed a visit. At the time of the inspection the hospice did not employ a physiotherapist. The management team told us the physiotherapist had recently left the service and this post, which was for 12 hours a week was out to advertisement. The service did not employ an occupational therapist; however they worked very closely with the community team of occupational therapists who provided support and advice to people.

The relatives we spoke with during the inspection spoke very highly about the nursing and medical staff. One person who used the service said, "They [staff] are lovely and I mean every one of them. They are there with you every step of the way. I was frightened about taking some tablets but the consultant reassured me." They also said, "When I first came in I was in excruciating pain but they have nearly got that under control, which is a great relief." One relative said, "All of the staff here are first class."

Is the service caring?

Our findings

People who used the service and their relatives told us they were very happy and said the staff were extremely caring and kind. One person said, "I was worried about coming in but I shouldn't have been. They [staff] are so considerate." We asked this person if staff maintained their privacy and dignity and they responded, "In every way. They ask your permission and they ask if it's alright. They make you feel like a person."

Other comments from people who used the service, included, "They [staff] keep you informed." "They [staff] always ask if there is anything you want to ask after they have explained things." "There are no barriers, they are great listeners."

One relative said, "Every one of the staff is so caring and patient." Other comments from relatives included, "I can't fault them, they have been so caring." "They [staff] inform us about everything."

Staff knew about people's individual needs and preferences. We saw lots of positive interactions and observed friendly banter and jokes between staff, relatives and people who used the service.

One person who used the service told us, "I like [staff name], she sings to me." Another person said, "They [staff] always introduce themselves and make you aware who is supporting you on every shift."

We observed how staff supported and encouraged one person with limited mobility to get from their chair to the toilet. Staff were observed to be extremely patient, provided a clear explanation of what the person needed to do whilst providing words of encouragement.

Everyone we spoke with told us staff respected their privacy and dignity. The in-patient unit consisted of two spacious four bed wards and four single rooms with en-suite facilities. The hospice had a single sex policy for the four bedded rooms which meant men and women would not be accommodated in the same room. This helped to protect people's privacy and dignity. The provider told us they had identified the need to make improvements to the in-patient unit as part of the 'Five Year Strategy' for the service.

We were invited to listen to the handover of staff from the morning to the late shift. We saw how the nurse in charge not only cared about people and relatives but also about the staff. The first thing they asked when handover began was asking staff if they were alright. The nurse in charge spoke affectionately as they gave a detailed handover of each person, an up to date account of how they were and their needs. One person had lost their appetite, but we heard at handover how the person had fancied some strawberries so staff had gone out to purchase these. Another person had mentioned to staff they would like to see the stars through a telescope (this was mentioned in their care plan) the nurse in charge spoke to staff about this and a staff member arranged to organise this. Staff also spoke about relatives and the support they needed.

The service recognised the significance of family during this difficult time. People's family members and friends were able to visit at any time. There were two quiet rooms where people could spend time with

family, friends or staff and a kitchen where visitors could make drinks. In addition, facilities were available for relatives to stay overnight. The hospice ran a group for carers of people who used the service every two weeks. Carers were able to pre book an appointment with the complementary therapist at this group. The complementary therapies available included aromatherapy, reflexology, massage and reiki.

The hospice had lovely lawns and gardens and had won a Yorkshire in Bloom Gold Award in 2015. They were fully accessible to people who used wheelchairs and had lots of places where people could sit and take in the extensive views over the valleys.

In the gardens there was a beautiful room, which was separate to the main hospice, and which they called the garden pod. We were told the chaplain who worked at the service 20 hours a week spent lots of time there with people, relatives and on occasions children of people who used the service. There was a book of reflections in which families and friends had written beautiful memories about people. The garden pod also served as a multi faith room and had a selection of faith literature available. This showed us people were supported to meet their religious and spiritual needs.

Religion or belief is one of the protected characteristics set out in the Equalities Act 2010. Other protected characteristics are age, disability, gender, gender reassignment, marital status, pregnancy and maternity status and race.

We talked with the registered manager about other examples of how the service took account of people's protected characteristics. They told us they had invited 'Action on Hearing Loss' to carry out a survey of the building and at the time of our inspection they were planning how they would implement the recommendations. For example, they were preparing an application for a grant to upgrade the 'Loop' system as the survey had identified the current 'Loop' was not very effective.

The registered manager told us they recognised the diverse culture of the community they served and had identified that this was not represented in the use of hospice services. They told us they were working with the local CCG (Clinical Commissioning Group) to explore ways of addressing this. For example, they told us they had recently held a conference at the Mosque in an attempt to raise awareness of the hospice services within the Muslim community.

In another example the relative of a person living with dementia told us about the lengths staff went to explain everything. They said, "The doctors explain everything and involve [person's name] all the time, they explain the pros and cons even though [person's name] does not understand some of things they still treat [person's name] with respect."

The hospice provided bereavement support to families and carers in a variety of ways which included helping people to create memory boxes. The Patient and Family Support team had developed a post bereavement support group called 'What happens next' which ran sessions on monthly basis. People were offered six sessions and the registered manager told us some of the people who had attended the group sessions had developed lasting friendships. The hospice employed a counsellor who led a team of volunteer counsellors. The counsellors offered people individual support. In addition, the social work team offered support to bereaved children as required. They had access to specialist materials from Winston's Wish which is a national charity for bereaved children.

The hospice organised memorial services and there was a memory tree on the outside wall. This was made up of gold, silver and bronze leaves which people could have engraved with words of their choosing.

Is the service responsive?

Our findings

Without exception people told us the service was responsive to their needs. One relative said, "When you press the buzzer for the toilet, two staff come at once. They are competing to see who can get there the fastest." Another person told us staff were making arrangements for their relative to go home. They said staff were getting everything organised so that it was in place before the person went home. They said, "The social worker here is so good." People told us "Things get done." They said if they were promised something would be done it was, without them having to chase it up. The relative of a person living with dementia told us staff had encouraged them to bring familiar things from home to help the person feel more comfortable in the environment.

People were referred to the hospice by a range of professionals, including GP's, members of the palliative care team, and hospital and community teams. Staff told us the average length of stay at the hospice for symptom management was 10 to 12 days and then people would return home. The inpatient unit also provided end of life care.

We reviewed the assessment and care planning documentation for three people who were or had used the hospice. People and relatives told us they had been fully involved in drawing up the plan of care and making decisions. We noted the system of planning people's care included the use of 'core care plans'. These are pre-printed care plans into which the person's name was added. There was scope for individualising these care plans, by the addition of extra information unique to the person, but most of the care plans we looked at contained minimal individual information about the person. The core care plan included general care to be provided to people. For example, we looked at the mouth and oral care for one person who used the service. The core care plan informed to support with mouth care two to three times daily but didn't state what the actual mouth care was. Another care plan for eating and drinking informed to offer choice but did not detail the actual support the person needed. We discussed our findings about care plans with the management team.

People told us they could attend activities in the day hospice which was attached to the in-patient unit. The service employed two complementary therapists who specialised in massage, vibrational essence therapy and reflexology. One person told us they had received acupuncture from the doctor and described it as "Marvellous."

The registered manager told us they reviewed the waiting times for admission to the hospice annually and the data had shown a year on year improvement. This meant people that year on year people were able to get the care they needed in a more timely way. The hospice also had a dedicated respite bed; the registered manager told us this was available to anyone who met the admission criteria. They told us that a more flexible approach to its use had made it accessible to people and it was being used more and more. This showed the service was being responsive to the needs of the community which it served.

People told us the staff were approachable and listened to them, they said they felt confident any issues or concerns would be dealt with.

There was a complaints procedure in place and information about how to make a complaint was readily available to people who used the service. The registered manager told us every complaint was investigated and in most cases they offered to meet with people to try to resolve their concerns as quickly as possible. Complaints about people's care and treatment were monitored by the CQS (Care, Quality and Safety) subcommittee to ensure appropriate action was taken and lessons were learned to improve the service. The hospice had not received any complaints in the 12 months prior to the inspection.

The registered manager told us the service encouraged people to talk about concerns as and when they arose. However, the service had recognised this was often difficult for people and had therefore introduced a quick survey called "Just one more thing" The survey asked just two questions and allowed space for comments.

The hospice also kept a record of compliments and had received 144 in the last 12 months. The broad themes were thanking the staff for the care and support they had delivered.

One person commented, 'The excellent care and support you gave [person's name] was outstanding, the respect and dignity he was shown was wonderful and made his last days the best they could be.' Another person commented, 'The last few days of Mum's life were pain free and from settling in she seemed to find peace after a traumatic time.'

Other comments included, 'Your kindness and compassion extended to us will never be forgotten, you do a magnificent job.' "Thank you for making his last days so comfortable, you truly do an amazing job, you should be very proud.'

Is the service well-led?

Our findings

The people we spoke with told us the hospice was well managed and ran smoothly. During our inspection we found the atmosphere in the hospice was calm and staff went about their duties quietly and confidently.

People told us they felt staff and management listened to them and took notice of what they had to say. Everyone we spoke with was confident changes would be made in response to their comments, suggestions or concerns.

In our conversations with the management team we found they were passionate about providing the best possible care and were continuously looking at ways to improve the experiences of people who used the service.

People we spoke with told us they had been asked for their views and throughout the day we observed several situations where people were asked their views and opinions. One person we spoke with said, "We did a questionnaire after the first four days; it asked us about the service, it was a tick list we couldn't find anything bad to say about the place."

We asked people if they had any suggestions about how the service could be improved and they told us they were very happy with everything. Comments included, "Nothing needs changing." "I can't think of anything that needs changing." "Lovely doctors, they tell you about this and that and talk to you about your treatment and medication. It is just like a five star hotel." "I did some fundraising and I got a personal letter which made me feel valued."

The hospice used a variety of methods to obtain feedback from people who used the service, relatives and carers. These included real time surveys and postal satisfaction surveys. People were asked for their views all aspects of the service such as the care and treatment and the environment. The feedback people provided was monitored by the CQS (Care, Quality and Safety) subcommittee to make sure any actions needed were implemented. The registered manager told us and the surveys reports confirmed people's feedback was overwhelmingly positive. However, we saw when issues were identified they were dealt with. For example, the hospice had provided an additional car park in response to feedback about the shortage of parking spaces on site.

The registered manager told us they were moving away from postal surveys and focussing on getting more real time feedback from people so that any issues could be addressed immediately. The structured interview surveys carried out by trained volunteers were an example of this. The information was recorded electronically and this enabled the hospice to identify any immediate concerns. The registered manager told us the nature of the services provided meant people were often reluctant to appear critical and the 'One more thing...' survey had been introduced in an attempt to make it easier for people to suggest small changes which could enhance their experience.

The registered manager told us a lot of work had been done on developing and supporting the staff team. This had led to the introduction of 'Team Overgate' which set out the behaviours and principles staff agreed to adhere to in their day to day work. One member of staff told us they had worked at the hospice for several years and said, "It is a wonderful place to work." They went on to tell us they were supported and taken care of by the management team, saying, "You are made to feel valued."

There was a clearly defined management structure. There were five subcommittees which met at monthly or two monthly intervals and reported to the Board of Trustees. The hospice had well established processes for monitoring and assessing the safety and quality of the services provided. The audit programme set out clearly what was to be audited, how often, by whom and showed which of the governance sub committees was responsible for monitoring. For example, there was an annual health and safety audit carried out by the facilities manager, an annual pain management audit carried out by the quality and audit facilitator and a mandatory training audit carried out twice a year by the human resources manager.

In addition to testing compliance with legal requirements and policies and procedures the audits were used to identify areas for improvement. For example, through using the NICE (National Institute for Health and Care Excellence) the accountable officer had identified three ways of improving the oversight of controlled drugs.

At the time of our inspection the audit programme was being reviewed. The registered manager told us they were in the process of implementing more nationally validated audit tools such as those provided by Hospice UK. Hospice UK is a national charity which works with over 200 hospices across the UK to support and promote excellence in care.

We concluded the provider had effective systems and processes in place to assess, monitor and improve the safety and quality of the services provided.

The leadership team promoted strong values of person centred care within the hospice and worked in partnership with other organisations to improve End of Life for the people of Calderdale. The hospice had taken the lead role in forming an End of Life Network across Calderdale. This was helping to raise the standard of end of life care for everyone whether or not they were receiving hospice care.

The Educator in Specialist Palliative Care had worked with the local hospital trust and community health care providers in developing and delivering competency based training on nurse validation of expected death. This has won an award in the MDT (Multi-disciplinary team) category of the International Journal of Palliative Care Awards 2015.

In another example, the controlled drugs accountable office took an active part in the local networking group working with other agencies to reduce the risk of drug misuse.

The hospice supports the Dying Matters campaign and provides a range of literature on their website to support people in having conversations about death and dying.