Dr Kershaw's 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

This inspection took place on 27 October 2016 and was announced.

Dr Kershaw's Hospice provides care for people with life limiting illnesses through its inpatient unit, day care unit and hospice at home service.

There was a manager in place who had recently had their interview with the Care Quality Commission (CQC) to become the registered manager of the service. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People felt safe and had no concerns about their safety or wellbeing. Staff had received training in safeguarding vulnerable adults and were knowledgeable about recognising the signs of abuse and how to report and deal with them.

Staff received training and management support to perform their roles effectively and to deliver high quality care. Sufficient numbers of staff, with the right experience and skill mix were available to provide people with the support and care they needed.

Care plans and associated documentation were person centred and provided the details staff would require to provide effective support in accordance with the person's needs and preferences. We saw care plans had been reviewed on a regular basis and that the reviews had involved the person and their relative(s) where appropriate. People consented to their care being provided.

We observed staff being kind, considerate and compassionate to people and also responding to requests for assistance quickly and in a sensitive manner. We also saw staff treat people and their visitors with respect and dignity and provide privacy where needed.

Medicines were handled safely and were stored, administered to people and disposed of following clear clinical guidance and in line with current regulations and guidance.

People were supported to receive end of life care. This care took account of the person's wishes and needs and enabled them to achieve a dignified, private and pain free death. During this difficult time, the person, their family members and staff were offered and provided with bereavement support.

Contingency plans, including emergency procedures were in place for, fire, gas leak, water loss, electrical failure, loss of nursing support, major disaster and contained emergency contact numbers and details.

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 supported and kept safe by sufficient numbers of staff to meet their assessed needs.

Medicines were stored, administered and recorded safely.

All grades of staff were recruited following a robust recruitment and selection process.

Is the service effective?

Good

The service was effective.

People consented to their care being provided.

Staff received appropriate training, regular supervision and an annual appraisal.

Pain management for people with a life limiting illness was an important part of the service provided by Dr Kershaw's Hospice.

Is the service caring?

Good

The service was caring.

Staff knew people well and treated them with respect and kindness and maintained the person's dignity at all times.

People were actively involved in their care.

Visitors were welcomed at any time and could stay as long as they wanted.

Is the service responsive?

Good

The service was responsive.

People were involved in the development of their care plan.

A bereavement service was available which offered support to individuals and families who were facing life limiting illnesses or bereavement.

Care notes seen demonstrated that full consultation had taken place with one person and their next of kin before any decisions were taken to enter the hospice.

Is the service well-led?

Good

The service was well-led.

Appropriate action had been taken regarding accidents and incidents.

Effective quality monitoring systems were in place.

Staff told us that the manager and management team were approachable and supportive.

The management team and staff worked in close partnership with other key organisations to help ensure a consistency of service could be provided to both people in the hospice and people in the community.

Dr Kershaw's Hospice

Detailed findings

Background to this inspection

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

This inspection took place on 27 October 2016. We gave the provider notice of our visit to make sure the provider or the registered manager could be available for the inspection process and to make sure our visit did not impact on the day-to-day running of the service and the support and care of people using the service at that time.

The inspection team consisted of two adult social care inspectors.

We checked the information we held about the service and the provider, including statutory notifications. Statutory notifications include information about important events which the provider is required to send to us. We also sought feedback about the service from the local authority safeguarding team and Oldham Healthwatch. Healthwatch is the national consumer champion in health and care. We did not receive feedback from either party.

A Day Service was offered as part of the facilities at Dr Kershaw's Hospice. This facility was called 'Sunfields Day Hospice' and provided a day service to help meet the needs of people and their families living with life limiting illnesses. People could access the day services in two ways, dependent on needs and preferences. A 12 week programme was offered as well as shorter wellbeing sessions.

The day service provided access to a variety of activities including; Complementary therapies, Yoga and Tai Chi, FAB management classes (Fatigue, Anxiety and Breathlessness) to enable people to manage these symptoms associated with long term disease, Art classes, Craft classes, Relaxation and mindfulness classes, Looking good, Feeling good sessions and Exercise classes.

A Hospice at Home Service was launched on 1 February 2016 to provide a home visiting service to people

who are in the last days of life. The main aim of the service is to provide people and their families with the appropriate level of additional care needed to help the person remain in their own home and prevent any unnecessary admissions to hospital.

We spoke with one person who used the service, the manager of the service, the senior nursing sister, the practice development facilitator, one health care assistant and the medical executive director who is also a palliative care specialist.

We looked at four people's care documentation, four staff personnel files, medicine records, management records including complaints, accidents and incidents, quality audits, feedback information from people using the service and their families and records of the servicing and maintenance of premises and equipment.

Good

Is the service safe?

Our findings

At the time of this inspection, five people were in-patients at this service but only one was able to speak with us. This was because people were asleep or receiving treatment or were not well enough to speak with us. We were told by this person that they had no concerns about their safety and wellbeing whilst staying in the hospice and that staff responded quickly to their needs. They also said, "Staff have been very nice and pleasant."

Staff told us about how they would protect people's safety from the risks of potential harm and abuse. One staff member we spoke with explained how they would recognise, deal with and report any instances of abuse. Other staff spoken with also told us they would report any harm or abuse they may witness to the appropriate member of the senior team on duty. They also said they were confident that appropriate actions would be taken to make sure people's safety was maintained at all times.

Staff spoken with confirmed they had received safeguarding training and that this training was updated on an annual basis. We saw records to indicate that all mandatory training such as safeguarding vulnerable adults, moving and handling and infection control had been completed. Training was done via e-learning (computer based training) and face to face training with in-house or external trainers. A new computer based programme had just been purchased which meant that all staff's training records would be accessible to all management staff and each member of staff would have access to their individual record, which would highlight when specific training was due.

Information seen indicated that each person would be assessed on admission. This assessment included a full risk assessment that covered moving and handling, skin integrity, pain, nutrition and falls. This was carried out in order to keep people as safe as possible during their stay at the hospice. We saw that following an assessment of individual clinical and non-clinical risks a plan of care would then be developed in partnership with the person and those people important to them (with the approval of the person).

Within the returned Provider Information Record (PIR) we were also told that such an assessment would be carried out and that these would be updated weekly or as the person's condition changed. We saw evidence where such assessments had been updated.

People using the services of the hospice were nursed and supported in single sex wards / accommodation. This not only helped to maintain people's privacy and dignity but helped people to feel safe and comfortable when receiving treatments.

People's physical abilities were also assessed to make sure staff were aware of how to assist and support each person safely and consistently. Staff we spoke with were able to explain how people's physical abilities were included as part of the initial assessment process and how this information was then put in care plans to make sure all staff knew how to support and assist a person so that they received consistent and safe care. We saw that staff had access to specialised equipment in order to meet people's needs and reduce risks, such as the use of bed rails.

We looked at the staffing rotas which showed a good skill mix of staffing were available on each shift and staff on duty at the time of our inspection did not appear rushed and we saw they were able to spend some quality time with people using the service.

We looked at records of staff recruitment and saw evidence that processes were in place to make sure only people of a suitable background and character were employed. The recruitment of clinical staff was carried out by the Pennine Acute Hospitals Trust recruitment services with non-clinical appointments being managed in house. We saw that pre-employment checks had been carried out and no new staff started work until all checks had been thoroughly completed. Disclosure and barring service (DBS) checks had been carried out. DBS checks tell an employer whether an applicant has a police record or is barred from working with vulnerable people. Any volunteers used had to go through the same rigorous checks before assisting in the hospice.

Medicines were handled safely and were stored, administered to people and disposed of following clear clinical guidance and in line with current regulations and guidance. People's individual medicine regimes were subject to a daily review by the medical staff on duty. This was done in liaison with the person, family and carers. All clinical staff had undertaken medicines management training.

We found that medicines were safely stored within a purpose built room and access to the room was restricted to authorised personnel only, by the use of a key fob. The room had a medicines fridge and was air conditioned with daily temperature checks of both taking place. Medicines were administered and recorded and we found records appropriate and maintained up to date. A senior sister on duty showed us the processes and procedures of the medicines regime within the hospice and how the safe disposal of unwanted medicines was carried out. We saw evidence of completed documentation to confirm this.

We carried out a spot check of controlled drugs prescribed to a number of people using the service. We found the records had been checked and signed by two nursing staff and balances of such medicine were found to be correct. We cross checked one person's medicines care plan with the information contained with their Medicine Administration Record (MAR) and found all details and prescribed medicines to be correct, including administration of medicine via a syringe driver.

At the time of the inspection no person had their medicines administered covertly or self-administered their medicines.

Contingency plans, including emergency procedures were in place for, fire, gas leak, water loss, electrical failure, loss of nursing support, major disaster and emergency contact numbers and details. This demonstrated that consideration had been given to keeping both people using the service and staff safe as well as maintaining the safety of the premises.

Good

Is the service effective?

Our findings

The person we spoke with who was an in-patient at the hospice did not have any concerns about the ability of staff to meet their needs.

The daughter of a person using the Hospice at Home service told us, "From the minute I made that first phone call to them they were amazing. Nothing was too much trouble for them and they didn't just support dad, but me as well." This example demonstrated that people who supported a family member with a life limiting illness were also provided with effective support mechanisms to help them cope.

The staff team offered a consistency of support to people using the services and those staff spoken with told us they received a variety of on-going training including; moving and handling, fire awareness, cardiopulmonary resuscitation (CPR), infection control, safeguarding, mental capacity and deprivation of liberty safeguards (DoLS). Training records seen also confirmed that such training had taken place.

Within the service there was a multi-disciplinary team of staff, including, medical and nursing staff, health care assistants, complimentary therapists, physiotherapists and bereavement and psychological support workers. The employment of a range of staff with differing skills, knowledge and abilities helped to ensure the service was effective in meeting the needs of those people using its services.

The manager was provided with a dedicated educational budget. This enabled them to plan individual training and professional development for all grades of staff. This meant that staff could receive regular and ongoing support and training to maintain their knowledge and skills. This helped them provide effective support to people using the service.

Staff spoken with told us they received regular supervision and an annual appraisal and one member of staff told us, "We get excellent clinical and general training. If there is anything in particular we would like to know more about, the manager listens and wherever possible, provides it [training]." We saw evidence of completed supervision records and evidence of individual annual appraisal records.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack 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.

Within the completed Provider Information Return (PIR) we were told that, 'All treatment and care at Dr Kershaw's Hospice is fully compliant with the principles of the Mental Capacity Act 2005 (MCA). We obtain consent from patients with capacity for admission and any aspect of care and treatment. There is a general assumption of capacity and mental capacity assessment takes place where there is an indication of temporary or permanent impairment.'

We checked whether the service was working within the principles of the MCA. The registered manager told us that at the time of inspection no person using the service was being deprived of their liberty. Care files seen contained documentation to indicate that a full evaluation of a person's mental capacity had taken place. The staff we spoke with were able to demonstrate a reasonable understanding of matters around capacity, gaining consent and best interests.

To support those people using the service who may be living with a dementia related illness, all staff had undertaken dementia awareness training. Four members of the nursing staff team were 'Dementia Champions' and supported and provided staff with up to date information about caring and supporting people living with dementia.

We were also provided with the names of nursing staff who were 'champions' in various areas of care and support. These areas included, tissue viability / wound care, palliative care, infection control, dementia care, nutrition, student nurses, oral care and falls. Any member of the staff team could approach these named champions for further advice or guidance in the particular subject area they were champions for.

People consented to their care being provided. One person told us, "Staff always asks me what I would like to do, for example, what do you want to do, have a bath or shower."

In care files examined we saw some had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) in place. Evidence was on file to show that the doctors had discussed these with the person and their family. These were discussed at handovers with all staff teams to keep the information up to date.

In care files seen and other information provided, we saw that the service had access to a number of healthcare professionals who provided people using the service with their support and guidance. These professionals included dieticians, occupational therapist, safeguarding teams, speech and language therapists (SALT) and translation services. This meant that people continued to have access to other community health care services they may have used at home which offered a consistency of support as well as the services provided by the hospice.

Pain management for people with a life limiting illness was an important part of the service being provided by Dr Kershaw's Hospice and the Hospice at Home service. The medical team was led by an experienced Consultant in Palliative Care and Pain Medicine and a Senior Speciality Doctor with a Postgraduate Diploma in Palliative Medicine. Both the consultant and speciality doctor had responsibility for overseeing the service to ensure that clinical care for people using the service was both person-centred and evidence based. We saw that all medical staff had regular training to update their palliative care knowledge and skills followed by annual appraisals to monitor their progress. This meant that people using the service could feel confident that their levels of pain and any associated symptoms would be assessed at all times and appropriately managed to keep them comfortable and pain free, whenever possible.

People were supported to eat, drink and maintain a balanced diet. The one in-patient spoken with said, "Food is wonderful, everything is freshly cooked." Menus were varied and offered a number of choices at each meal and meals were prepared according to the likes and dislikes of the individual person. Where a person's cultural needs around their diet needed to be respected, such needs could be catered for. Staff had the knowledge and skills to request the support and services of dieticians and speech and language therapist if a person's food and fluid intake deteriorated or caused concern. Nutritional plans were in place and were monitored to make sure people's nutritional needs were being met effectively.

Good

Is the service caring?

Our findings

People using the services of both the hospice and hospice at home service spoke positively about the caring nature of the staff and the support they received. One in-patient told us, "On the first night I wanted to go home, I thought hospices were just places where people went to die, but this changed as I became familiar with what the hospice had to offer. You can do what you want; you can stay in bed all day if you want to". The relative of a person using the hospital at home service told us, "They [staff] respond to his personality – were intuitive about the sort of person he was and responded in a similar way."

Our observations of staff's interactions with people using the service demonstrated that they knew people well and treated them with respect and kindness and maintained the person's dignity at all times. The actions of the staffs interventions with people conveyed that they understood and cared for the person (and their family members). We observed staff speaking with people in a kind and respectful manner and acknowledged people's family and friends when they visited. We also heard staff informing people of what they were going to do whilst carrying out particular treatment and if the person was happy for them to do so.

Although we did not get to speak with people using the services of the day hospice (due to them receiving personal treatments) we saw positive interactions between the staff and it was evident that they knew the needs and personalities of each person being supported. We observed people chatting with staff who gave them the time and support they required and also enjoying a laugh and joke with them as well.

Each day multi-disciplinary team (MDT) handovers took place. The handovers acknowledged the individual person's preference and wishes regarding their care and ensured all staff were aware, respected and complied with these wishes wherever possible, within a risk management framework. Following the MDT handover, any decisions or updates about a persons on-going care would then be discussed with the person and / or their family, followed by staff being updated on any decisions taken and agreed upon.

A chapel room was available so that people could take time for private contemplation or to participate in services held by the volunteer chaplains who attend the hospice on a daily basis. Multi-faith leaders in the community could be contacted as the need arose, to support the individual faith needs of the person using the service. We saw a sign displayed on the alter in the chapel room wishing people 'Happy Diwali'. This example demonstrated that in this case the provider had demonstrated that the cultural needs and wishes of people using the service (and their families) were considered and respected.

Other facilities within the hospice included a complimentary therapy room. This room was enhanced by the use of ambient lighting, candles (artificial flames), waterfall, and calming background music. A professional therapy couch was in place and the overall effect was of a very relaxing and comfortable environment. Complimentary therapies were also offered to carers of people who were inpatients and day hospice users. All staff were offered 'taster' sessions. This meant that people had the opportunity to vary their environment away from the clinical background of the hospice.

At end of life, cultural practices could be facilitated, such as cultural washing, mourning, positioning of the person and prayer facilities. The hospice also offered a bereavement counselling service to families, friends, staff and volunteers.

Visitors were welcomed at any time and could stay as long as they wanted. Staff made visitors welcome and provided drinks (and meals) as required and requested. There were also self-contained facilities available for people to stay at the hospice to be close to their relative. This meant that people using the services could have people that were important to them, close at hand whenever needed.

Good

Is the service responsive?

Our findings

Care records seen contained information to show that people using the services of the hospice had been involved in supportive discussions with both staff and family member(s). We saw evidence that the person had been involved in their care plan development and both the person and family had been told how 'things' may change unexpectedly.

Staff told us that many of the people using the inpatient service were already known to them as the person had also used either the day care or hospice from home service.

Within the returned Provider Information Record (PIR) we were told, 'We strive for true partnership working with the patient and invite their contribution to developing management objectives and plan, both for their immediate care and also with a view to planning for the future. Family and carers are encouraged to provide additional support and input in this process. An Advance Care Planning proforma is available if needed.' We saw written evidence that all decisions about a person's current health status was discussed with them, if they had the capacity to understand and also with their designated representative, which was usually a member of family or close relative. We saw information had been shared with people using the service about planning to return home and what services would then be available to support them, for example, the Hospice at Home service.

The PIR also told us, 'Changes to the patients' condition indicating the final days / hours of life are frequently assessed and rapidly responded to, with Multi-disciplinary Team (MDT) consensus. We use the individual Care Plan for the Dying Adult to review and modify the care plan appropriately and ensure effective communication with those close to the dying person. Anticipatory prescribing (medicines) is standard hospice practice to ensure that changing clinical need can be responded to without delay and appropriate 'anticipated' medicines would be readily available.

We saw that much of the care and treatment that was planned came from input provided by other healthcare professionals that were, or had been, involved in meeting the person's care needs. Such professionals included, doctors, consultants, district nursing services, specialist nursing teams and physiotherapists. Input was also provided by staff on the day care unit and the hospice at home service. Care plans also prepared for possible discharge home or to other services if appropriate and we saw that end of life care had also been discussed with the person and family. The information contained within end of life plans was detailed and described how best to ensure the person's wishes should and could be carried out. For example, some plans detailed how the person would wish to return home to die, whilst others, wished to be admitted into the hospice.

The Hospice at Home service is a service that provides people and families with the appropriate level of additional care required to make sure the person has the support they need to remain in their own home and to prevent any unnecessary admissions to hospital. The hours the service operates are between 7:30am – 9pm. Information provided to people using this service informs them that, 'The timing, length and frequency of visits during the day is flexible and is determined by the needs of the individual patient and this,

in turn, will enable District Nurses and Macmillan nurses to plan their visits, knowing their patients have an extra level of support.' One person using this service told us, "The service always responds quickly when we contact them. They [staff] are always on time and stay for as long as necessary. The hospice is really good at liaising with other services, such as district nurses."

A night sitting service could also be provided (subject to availability) for those people who need extra support and this would also allow family members to take a break from their caring duties and to get a good night's sleep, knowing that their loved one was being closely monitored and cared for.

On the day of our inspection, one person had recently been admitted, who had chosen to enter the hospice for end of life care following a period of support by the hospice at home service. Evidence was available in the care notes to demonstrate that full consultation had taken place with the person and their next of kin before any decisions were taken to enter the hospice.

The relative of one person who had used the hospice at home service told us that they were aware of what was likely to happen at the end of the person's life, which helped them a lot. They told us, "This gave us confidence and strength to look after [relative] at home."

The Day Hospice was a service that was used to provide people with a variety of sessions throughout the day specifically designed to promote wellbeing, safety, independence and survivorship. On the day of our inspection a number of people were receiving therapy treatments and we saw positive interactions taking place between the people using the service and the staff supporting them. One person told us, "Wonderful staff, I enjoy my time here, it takes my mind off things."

A 24 hour advice line was also available where people could access advice, be provided with contact details for other healthcare services, or just to have a chat. This meant that both people receiving a service and their family members could feel confident that support was available at all times of the day and night to meet their needs as different, and sometimes worrying situations arose. A bereavement service was also available which offered support to individuals and families who were facing life limiting illnesses or bereavement.

Throughout the inspection, we observed that staff interacted with people in a calm and unhurried manner. We saw examples of staff chatting with, or comforting people and their friends and relatives. We saw that the care offered and provided was person centred and geared specifically to the person's individual needs.

People were provided with access to a call system to request staffs help when needed. All call time responses were monitored and we were provided with a detailed call response report for two weeks in October 2016. The information demonstrated that the majority of calls had been responded to in less than one minute, which meant that the needs of people were taken seriously and dealt with efficiently.

Information about raising a concern or complaint were displayed throughout the hospice on various notice boards and 'How to make a complaint' leaflets were readily accessible to both people using the service and visitors. Details were clear and included timescales for a response to a complaint (20 working days). We saw that four complaints had been made in 2016 (to date) and all were logged and followed through in a timely manner and a full response sent to the complainant within the timescales stated in the complaints procedure. This meant that people's concerns and complaints were taken seriously and action taken to resolve them was conducted in a positive and timely manner.

As well as the small number of complaints received we saw that a high number of compliments and 'thank you' cards had also been received. Many of the letters and cards contained details that were far too long to

include in this report, however, here are some 'shorter' examples; "To all at Dr Kershaw's who made [name] last few days more peaceful and pain free that we ever could have done at home, [name, name, name and name] wish to say a very big thank you to everyone. We honestly could not have done without your help. Last but not least, thank you to the various ladies who constantly looked after [name] many visitors supplying refreshments etc. We will always be grateful to Dr Kershaw's."

"People say they look after their patients with the highest care but until you experience Dr Kershaw's for yourself you will never know just how much time and patience they have for their patients and family. Nothing was too much trouble for any member of staff and the care my dad received while in Dr Kershaw's was above and beyond any call of duty. Thank you from the bottom of our hearts."

The following examples are from the Hospice at Home service; "I would like to express my most sincere gratitude to your team, who provided the most wonderful care and support to my uncle [name] and his family. Your professionalism brought calm, peace and reassurance to a family who were feeling traumatised. You enable [name] to pass away in the comfort of his own home surrounded by those who loved him…" and "The service enabled me to keep my promise to my husband (for him to stay at home) whilst also affording the care and support he needed. The hospital is noisy, lights on, busy etc. and is no place for someone to pass away peacefully. My husband was comfortable, at home, in peace and quiet, with the people he loved. I had been unable to shower him for a couple of days due to him being so unwell, so them [staff] bathing him (without my asking) meant he was clean and fresh, something that was always important to him. Fabulous service that allowed us all dignity…"

Where people were receiving end of life care, staff were provided with bespoke information titled 'What to Expect as Death Approaches…' The information contained within the document gave advice on reduced requirement for food and drink during this time. A person at such a stage would also have an End of Life Care Plan in place that would also contain such information. A copy of one of these plans was seen.

Good

Is the service well-led?

Our findings

There was a manager in post who had recently attended an interview for registration with the Care Quality Commission (CQC) to become the registered manager of the service and was waiting to hear if their registration application / interview had been successful.

There was a clear and well defined structure to the organisation with a board of trustees being responsible for the governance of the hospice and they also formed the board of directors. Within the management structure were senior managers, managers, staff and various support services. Those staff we spoke with knew the various roles of the management team and told us that all senior staff, especially the manager and management team were approachable and supportive. They also told us that a regular presence on a daily basis was maintained at the hospice by such senior staff.

Within the Provider Information Return (PIR) we were told, "We have a high number of experienced nursing sisters who provide visible leadership, encouragement and advice in all clinical areas of the hospice, meeting on a monthly basis to discuss, develop and reflect on nursing care and practices, ensuring communication to the wider nursing team is up to date and consistent."

We saw evidence that the last 'Sisters meeting' (nurses) had taken place on 11 October 2016 where the following had been discussed, the deprivation of liberty safeguards (DoLS), clinical supervision and policies. This demonstrated that nursing staff were being provided with updated information to enable them to cascade such information to the rest of the staff team as part of good communication sharing within the service.

The Clinical Governance group also met on a monthly basis, the last meeting had taken place on 18 October 2016 where the following had been discussed, the bereavement group, audits, complaints, housekeeping, incidents and policies. Such meetings provided opportunity to maintain good communication throughout the service.

The manager and senior staff we spoke with all demonstrated they had a clear and knowledgeable understanding of the care being provided to each person using the service. This indicated that regular conversations and meetings had taken place where matters relating to people's needs had been reviewed and discussed. The manager was clear about their role in supporting staff and developing the service further. This was evident in the layout, decoration and signage used in the premises that took account of people using the service who may be living with a diagnosis of dementia.

There was a clear system in place to monitor, review and investigate all accidents and incidents. We saw that appropriate action had been taken regarding one recent accident that had taken place in the conservatory where a person using the service had tripped over weighing scales and fractured their wrist. A Significant Event analysis had been carried out, also a safety audit of the conservatory, which recommended some actions to be taken which we found had all been satisfactorily carried out and completed. Meetings were then held to share with other staff any learning from such accidents / incidents. This helped to

minimise the risk of these incidents happening again.

The management team and staff worked in close partnership with other key organisations to support people whilst using the service and then when returning to live back in the community. We saw evidence of communications and discussions with district and community nursing services in order to provide a consistent service to people both receiving treatment and end of life care in the hospice.

The manager told us how they encouraged staff to further develop their knowledge and skills and the service. For example, a 'star of the month' scheme had been developed which acknowledged staff and volunteers for their hard work and the star of the month received a certificate and a voucher for a complimentary therapy session as a reward.

Effective quality checks were undertaken to ensure the service continued to develop and improve for the benefit and wellbeing of people who used the service and staff team. These checks were used to review and measure the performance of the services provided to people. Some of these checks were monthly, weekly or daily and included safety audits of premises, medicines management, infection control, clinical audit, daily, weekly and monthly spot checks and fire safety audits.

We looked at the following random selection of completed audits, documentation audit May 2016 – 73% compliance, falls audit June 2016 – 82% compliant, Infection control audit September 2016 – 91% compliant, medicine audit July 2016 – 69% compliant. Each audit summary had been analysed and described what the service was doing well and where improvements were needed. Action plans and outcomes were in place for areas identified for improvement.

Information held by The Care Quality Commission (CQC) showed that we had received all required notifications. A notification is information provided in a document about important events which the service is required to send to the CQC in a timely manner.

The work of the hospice and staff working there have been recognised and acknowledged by various accreditation schemes and awards during the past 12 months and these included:

National Health Service Clinical Governance Group Innovation Award 2016

Macmillan Cancer Support David Millar Award 2016

University of Salford Student Mentorship Award

Pride of Oldham Award for Volunteers

Hospice Company Member awarded to 'Woman of Oldham' award 2016

University of Salford Certificate of Accreditation in Respect of a Suitable Learning Environment for Students and Midwifery.

Hospice at Home Testimony of Care from Oldham Transfer of Care Team 2016.

Such recognition of the service provided by the hospice and staff demonstrated good working partnerships were had to further support and develop patient care.