

St. Ann's Hospice

# St Ann's Hospice Heald Green

## Inspection report

St Ann's Road North  
Heald Green  
Cheadle  
Cheshire  
SK8 3SZ

Tel: 01614983657  
Website: [www.sah.org.uk](http://www.sah.org.uk)

Date of inspection visit:  
05 October 2016

Date of publication:  
14 November 2016

## 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

St Ann's Hospice provides in-patient hospice care and a day hospice from one site. It is part of a wider organisation with two other sites in the Greater Manchester area providing hospice care. The hospice holds condition specific clinics, has a bereavement support service, therapy services, a fundraising department and a team of volunteers all based on-site.

The service is a registered charity with a board of trustees. Day to day the service is run by an executive management team drawn from all departments within the hospice. There was a new chief executive who had been in post for several months who had been meeting with all staff and users of the service as part of their induction into the role.

There was a registered manager employed for this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was experienced in providing palliative care and had joined the organisation within the last two years.

People and professionals spoke highly of the complementary therapies that were available to both people who used the service and relatives. The hospice provided family support, counselling and bereavement support and we saw the service helped people carry out specific wishes such as providing a Christmas party for someone with their family at the family's request.

People told us that staff were caring, compassionate and listened to them. People we spoke with who received personal care felt the staff were knowledgeable, skilled and their care and support met their needs.

The service had recently introduced a new electronic recording tool called EMIS (Egton Medical Information System). Although this was still relatively new, staff we spoke with were positive about the training they had to support this new approach and stated it was, "useful and efficient."

People's health care needs were met by the in-house medical team. This included consultants, GP's with a special interest in palliative care, an occupational therapy team, a physiotherapist, social worker, dietician and chaplain.

Care plans were personalised to include people's wishes and views. People and relatives told us they were consulted about their care and treatment and that they regularly had the opportunity to speak to medical and nursing staff. Care plans were regularly reviewed in a multi-disciplinary framework. We observed staff caring for patients in a way that respected their individual choices and beliefs.

Staff recruitment processes were followed with the appropriate checks being carried out. There were sufficient staff on duty to meet people's needs. The hospice had experienced some shortness of staff

recently although this had not impacted detrimentally on the people using the service. The hospice had a bank of staff who they could contact if they needed additional staff. The registered manager told us they had recently tried to recruit additional nursing staff but felt the calibre of applicants wasn't right. They were going to review their advert and recruitment process to try and attract further applicants. Staff and volunteers received a thorough induction and regular training to ensure they had the knowledge and skills to deliver high quality care and support.

Staff followed risk assessments and guidance in management plans when providing care and support for people in order to maintain people's safety.

People were protected by the service's approach to safeguarding and whistle blowing. People who used the service told us that they were safe, could raise concerns if they needed to and were listened to by staff. Staff were aware of safeguarding procedures, could describe what they would do if they thought somebody was being mistreated and said that management listened and acted on staff feedback.

Staff told us they were very supported by the management team and could get help and support if they needed it at any time. Staff received regular and meaningful supervision and appraisals. Staff members told us they felt part of a team and were proud to work for the hospice.

Staff worked within the principles of the Mental Capacity Act where appropriate. People had choices about their care and their consent was sought by staff.

People were supported to receive a nutritious diet at the service. Their appetite was assessed through talking to them, which guided staff to give the person the type and amount of food they would be able to eat. There was a choice of menu on the day we inspected and drinks and snacks were available at any time. The service also provided a café for people, families and staff to enjoy a drink or snack. All food was freshly prepared on site and we saw people being given the opportunity to choose what they wanted to eat or drink.

The staff undertook the management of medicines safely and in line with people's care plans. The service had health and safety related procedures, including systems for reporting and recording accidents and incidents. The care records we looked at included risk assessments, which had been completed to identify any risks associated with delivering the person's care and their environment.

The registered provider had a system in place for responding to people's concerns and complaints. People and carers and families were asked for their views and were involved in a group that considered ideas and developments at the service.

There were effective systems in place to monitor and improve the quality of the service provided. The service was going through a period of transition with new staff members at senior levels and new service developments such as the EMIS care planning system and the implementation of the Outcome Assessment and Complexity Collaborative (OACC) tool. This will enhance the care planning process by ensuring that outcomes for people are clearly recorded. The service also had other new ideas they were developing such as introducing a dementia champion and they had introduced a management training programme. Staff told us that the service had an open, inclusive and positive culture.

Accidents and incidents were clearly recorded. There was an embedded culture of learning from mistakes and sharing of action plans for improvement work within the service.

## 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.

Checks of the building and equipment were completed to make sure it was safe.

Staff we spoke with could explain indicators of abuse and the action they would take to ensure people's safety was maintained. This meant there were systems in place to protect people from the risk of harm and abuse.

On the day of our visit we saw staffing numbers and skills mix were sufficient to provide a good level of care to keep people safe. Robust recruitment procedures were in place to make sure staff were suitable to work with vulnerable adults.

### Is the service effective?

Good ●

The service was effective.

People's healthcare needs were carefully monitored and discussed with people who used the service and their family members.

Staff told us they felt supported by the service and had appropriate clinical supervision.

Staff of all levels had access to on-going training to meet the individual and diverse needs of the people they supported. Staff were trained to provide the specialist care people required.

People were assessed to identify risks associated with poor nutrition and hydration and spoke highly about the quality and choice of food.

### Is the service caring?

Good ●

The service was caring.

People told us that staff were kind and compassionate at all times and treated everyone with dignity and respect.

The service provided emotional support to people, their family and friends via a team of dedicated counsellors, nurses and healthcare staff on an on-going basis.

People were supported spiritually. People were encouraged and supported to make decisions about their care and given time to make their own choices; this included their end of life care.

### **Is the service responsive?**

**Good** ●

The service was responsive.

People told us they felt confident they could express any concerns or complaints about the service they received.

People and their families were fully involved in assessing their needs and planning how their care should be given.

Staff delivered people's care in a person-centred way, treating them as individuals and encouraging them to make choices about their daily lives.

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

**Good** ●

The service was well led.

The management team gave effective leadership and provided a clear strategy for the long term development of the service.

There were clear management structures and lines of accountability. Staff told us the service was well managed, that they were treated with respect and were actively involved in decision-making.

Systems were in place to monitor the quality of the service provided to ensure it was run in the best interest of people.

Staff and volunteers told us they felt part of a team and that management at all levels were accessible and approachable.

# St Ann's Hospice Heald Green

## **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 provider was given 48 hours' notice because we did not wish to impact on the day to day running of the service and wanted to enable nursing staff to be available to speak with us.

On day of the inspection there were two adult social care inspectors, a specialist advisor in end of life and palliative care and an expert by experience who had experience of caring for someone at the end of their life.

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. Before the inspection we reviewed the information in the PIR as well as all the information we held about the service, this included notifications of significant changes or events.

Prior to the inspection we contacted external health care professionals and commissioners of the service from the Clinical Commissioning Group (CCG) by email. Their views can be found in the main body of the report.

At the time of our inspection visit there were 21 people who used the in-patient service and there were people using the day hospice on a sessional basis.

During the visits we spoke with 20 staff and volunteers, this included the registered manager, the medical director, human resources manager, the clinical audit and quality assurance lead, the practice development

centre manager, the chef, the head of day services, nurses, health care assistants and volunteers.

During the inspection we reviewed a range of records. This included people's electronic care records including their care planning documentation and medication records. We also looked at staff files, including staff recruitment and training records, records relating to the management of the hospice and a variety of policies and procedures developed and implemented by the registered provider.

## Is the service safe?

### Our findings

People and their relatives told us they felt safe in the hospice. One relative told us, "I feel reassured my relative was well looked after."

Staff we spoke with also felt the hospice was a safe place. Staff told us, "My duty of care is to make sure everyone is in a safe environment" and "My first port of call would be to my line manager, but I know I could go higher."

Staff displayed a good knowledge of safeguarding adults and children, including how to report any concerns they had. Staff knew about various types of abuse and potential warning signs to look out for. Staff said if they had any concerns they would report them straightaway to the person in charge.

Staff were aware of the provider's whistle blowing procedure. None of the staff we spoke with had previously had cause to use the procedure. One staff member told us, "You would be encouraged to raise concerns." All of the staff we spoke with said they would not hesitate to use the procedure if they had concerns about people's safety. One staff member told us, "We are a good team here and we can recognise and support each other in times of stress or distress."

The staff files we looked at showed us that the provider operated a safe and effective recruitment system. The staff recruitment process included completion of an application form, a formal interview, previous employer reference and a Disclosure and Barring Service check (DBS) which was carried out before staff started work at the hospice. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults. The human resources manager who supported the recruitment process explained the additional measures the service took to check the identity of applicants and their right to practice in terms of current professional registration status for nurses and doctors, therapy team, social workers and counsellors.

Through our observations and discussions with people and staff members, we found there were enough staff with the right experience and skills to meet the needs of the people who used the service. We reviewed duty rotas and spoke with the staff team about staffing levels and shift patterns. All of the staff we spoke with during the inspection told us they thought there was sufficient staff on duty that day to meet people's needs. Three staff members we spoke with told us staffing levels had been "stretched" recently due to staff sickness and people leaving. One person said, "Sometimes we don't have time just to sit with people." They told us they felt the hospice was changing and that they were getting many more people with more complex needs, which was more time-consuming. Another staff member said, "Staff shortages mean that sometimes people wait for pain relief longer than they should e.g.15 minutes or so." All staff we spoke with told us everyone worked well together as a team to pull together to ensure the service was staffed appropriately. We discussed the concerns raised with the registered manager who explained they were trying to recruit additional nursing staff, but a recent selection process had not found the right calibre of applicant. The registered manager told us they were going to review their process again before re-advertising and we saw



that the staffing levels were monitored on a risk register that was discussed regularly at senior management levels. An action had also included discussion with and potential for nursing staff coming across from other sites within the organisation to support the inpatient service at Heald Green as an interim measure.

One person we spoke with told us, "I definitely feel I'm in safe hands. I feel if I need any help, I can always get it." One relative we spoke with told us, "Staffing is adequate. They seem to be coping quite well. This is how it should be everywhere. Call bell is answered quickly. Help is always on hand. Never had to wait long."

The service had a good level of medical cover and we spoke with the medical director for the organisation. They told us they worked across the three sites managed by the registered provider and this enabled them to "see the bigger picture across the Manchester area". They told us how medical cover was provided, which included an on call service at weekends but in reality medical staff were present at weekends for admissions and to support emergency situations should they arise. They told us the service was working towards more robust seven day working arrangements for its medical team.

Risks to people's safety were appropriately assessed, managed and reviewed. Care records we looked at during the inspection contained a number of risk assessments specific to the needs of each person. We saw risk assessments were in place for falls, moving and handling, bed rails and skin integrity. One care record looked at identified the person was at risk of bleeds. Staff were able to describe in detail the action needed to support the person and what action was needed to manage the situation, and this was recorded in their care record.

During our inspection we spoke with nurses on the ward and the hospice's own pharmacist. We also spoke with the registered manager who was the hospice's Accountable Officer about the hospice's arrangements for handling controlled drugs (drugs liable to misuse). The Accountable Officer is a person designated under The Controlled Drugs (Supervision of Management and Use) Regulations 2013 by the registered provider to ensure that appropriate arrangements are in place for the secure and safe management of controlled drugs in the hospice.

We looked at how medicines were handled on the ward and saw appropriate arrangements were in place for checking and confirming people's medicines on first admission to the hospice which was carried out by two members of staff. When patients were discharged we saw that detailed information about their current medicines, including changes made during their stay in the hospice were given to the patient and their community healthcare supporters such as district nurses and their G.P. This meant that people had up to date information about their medicines.

There were clear, comprehensive and up to date policies and procedures covering all aspects of medicines management.

We saw that a lockable cabinet was located in each room for the secure storage of medicines. However we were told by staff that no one was managing their own medicines and that people were not routinely asked if they wanted to manage their own medicines on admission to the unit. The hospice had a self-medication policy. As the pharmacy was not on-site there was no labelling facility with the hospice pharmacy to store these difficult to obtain labelled supplies for patients to use and this would create an additional risk. For this reason self-medication was not a process actively encouraged. The service did however encourage patient involvement in administration of medication and prior to discharge preparation.

Appropriate arrangements were in place for the recording of medicines. The medication records we checked showed that patients received their medicines as prescribed. The hospice used a prescription chart rather

than a medicine administration record. The latter is purely a record of administration, whereas the former is also signed by the prescriber.

Medicines were kept safely. Medicines were kept securely and only accessible to staff authorised to handle medicines. Medicines were stored at the correct temperature and therefore were suitable for use. There was a system in place for checking expiry dates of medicines. Controlled drugs were ordered, received, stored, checked and disposed of in accordance with the required legislation. We observed two nurses dispensing a controlled drug and examined the prescription charts of five people who used the service and found no issues. Each person's chart contained information relating to the function of each medication prescribed which was good practice.

Nurses and healthcare assistants told us that they received training in medicines management and also specialist equipment used by nurses such as syringe drivers. One nurse told us, "Someone checked my competency with them before I was allowed to do them myself." Their competency for administering medicines was assessed at regular intervals.

Arrangements were in place to ensure that medicines incidents were reported and fully investigated and we found there was an open culture around reporting medicine errors. All the staff members we spoke with were aware of how to report any medicines incidents. We saw that a recent medication error had been fully investigated and additional medication training had been undertaken and changes to procedures had been introduced promptly to reduce the risk of reoccurrence.

We asked about the arrangements for auditing medicines handling and storage in the hospice. We saw that controlled drugs were checked frequently. We were also told that the registered provider completed a full audit of all prescription charts. These checks helped to identify any issues in order to learn and prevent the errors happening.

There was also a system to receive and act upon national drug safety alerts.

We met with the maintenance staff who oversaw the health and safety checks undertaken at the service. We looked at records which confirmed that checks of the building and equipment were carried out to ensure health and safety. We saw documentation and certificates to show that relevant checks had been carried out on the fire alarm, fire extinguishers, nurse call system, emergency lighting and gas and electrical safety. We saw records that showed water temperatures were taken regularly. We saw that all water temperatures were within safe limits.

We saw that checks in relation to moving and handling equipment under LOLER regulations had been carried out and people and staff were also protected by a plan to monitor infection control risks. This plan to cover health care acquired infections covered staff training, cleanliness audits, clinical governance, deep cleaning and waste disposal measures. We saw any action points were recorded and addressed straight away. Staff working in each area of the hospice were nominated as risk assessment champions so that there was a more individualised approach to health and safety for each working area and risks and measures in place to reduce them were monitored regularly by the senior management team. This showed the service had procedures to keep people safe.

Tests of the fire alarm were completed on a regular basis to make sure it was in safe working order and we saw that recently nursing staff had received additional training to ensure they were competent with the fire panel and emergency procedures.

We looked at the arrangements in place for managing accidents and incidents and preventing the risk of reoccurrence. The registered manager said that accidents and incidents were not common occurrences; however they had appropriate documentation in which to record and review them should they occur. The registered manager stated the service was hoping to implement an electronic recording system which would ensure managers reviewed incidents and would contribute to the quarterly summary that was undertaken for senior management review, in a more effective manner.

## Is the service effective?

### Our findings

The hospice employed a range of staff. This included doctors, nurses, healthcare assistants, a dietician, social workers, pharmacists, a chaplain as team of people who provided family support and counselling. There were also physiotherapy and occupational therapy professionals and complementary therapists to help to ensure people's needs were met.

Staff and volunteers we spoke with told us about the very good support received to carry out their role. One staff member told us, "We get on so well it's like working with your friends really. The management are very supportive." Another staff member commented, "I've felt very supported since I started", and that the, "Doctors were approachable." A new member said, "I asked questions, and everyone was really helpful." One volunteer said, "I am training to be an ambassador, to tell people about the hospice. I am going to a church group next week to tell them about the work we do here." We saw records of group discussions and clinical supervision. Staff told us they regularly spent time with other staff and management during handovers, at the beginning and end of a shift and whenever else they needed to talk and provide support to each other. We saw records to confirm staff received an annual appraisal which included a review of performance and progress within a 12 month period. This process also identified any strengths or weaknesses or areas for growth and would be shared with the practice development team in terms of planning future training or support events.

Staff told us they received the training they required to care for people effectively. One staff member said, "We do get a lot of training."

The hospice had its own practice development centre that not only provided training to staff and volunteers working within the hospice but also provided training to other healthcare professionals. The manager of the service had been in post since January 2016 and we saw they were implementing certified training for all clinical staff in end of life care and developing training and a champion in relation to dementia care. The service had reviewed its induction programme so that people had a 1:1 mentor and used a self-assessment tool to reflect on their learning in that initial three month induction. Themes for education for 2016 included bespoke leadership courses, mandatory training courses started in April 2016 for volunteers and face to face safeguarding training at Level 1 and 2 for all staff. A training programme was available on a month by month basis for staff to attend non mandatory sessions which included lymphoedema, spirituality and enhanced communication skills. Training the service provided externally included nutrition and catering in relation to care homes and specific training in end of life care for domiciliary care staff. A healthcare professional we consulted prior to the inspection told us, "St Ann's does have input into regular training events, both through involvement of senior clinicians and through hosting education events at the hospice. They were extremely supportive when I ran a practice nurse education course, which was partially run at the hospice." This showed the service was keen to work with other stakeholders to improve the knowledge of palliative care in the local area.

Induction events were also planned and delivered and we saw that all staff and volunteers received role specific induction that included an introduction into the hospice and service, moving and handling, food

hygiene and nutrition, fire and health and safety procedures as well as palliative care, and communication in challenging situations. We saw the service had addressed an identified issue in its training programme, and a commissioner told us, "St Ann's has worked hard to ensure staff and volunteers have received safeguarding training, after this area was highlighted as needing improvement earlier in the year. They embraced this challenge and within a few months had ensured that almost all permanent staff and the majority of volunteers had had appropriate training." This showed staff and volunteers received training to understand the role they were to perform in a safe and effective way.

The staff spoken to demonstrated a sound knowledge base in specialist palliative care in-keeping with roles and responsibilities and the service specification. Senior clinical leads were qualified to academic degree level in palliative care and all staff spoken to were well supported with personal and professional development via in-house or externally sourced education.

Nurses were organised regarding revalidation and there was a system in place to support individual staff with a designated confirmer to sign off evidence within the process of revalidation. Revalidation is a new process that all nurses in the UK need to follow to maintain their registration with the Nursing and Midwifery Council.

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 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. When people were first admitted to the hospice they were asked if they consented to be cared for at the hospice. At the time of our visit, there had been no applications to place a restriction on a person's liberty. We spoke with staff to check their understanding of MCA and DoLS. Staff demonstrated a good awareness of the code of practice and confirmed they had received training in these areas. Procedures were in place to enable staff to assess peoples' mental capacity, should there be concerns about their ability to make decisions for themselves, or to support those who lacked capacity to manage risk.

We saw evidence that mental capacity assessments were conducted and recorded and also evidenced in relation to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions. Mental Capacity Act assessment forms were available in paper format and were used to evidence assessment of capacity and decisions taken in patients' best interests. There was also a psychological support nurse available to support people with feelings of anxiety or other mental health issues.

The patient records reviewed included Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. In all cases the decisions were dated and approved by a lead clinician or G.P [when DNACPR was initiated in the community] and on all of these there was a clearly documented reason for the decision recorded on the form with clinical information included. All DNACPR forms included a review having taken place on admission to the hospice.

Discussions about DNACPR with patients and relatives were recorded in sufficient detail within the patient's record. 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 if their conditions changed or deteriorated. We saw that people's treatment wishes were documented in their records. It was clearly recorded what people's end of life preferences and preferred place of care were and these decisions had been reviewed.

Staff we spoke with understood the importance of seeking consent before providing any care or support. Staff confirmed they would respect people's right to refuse. One relative told us, "The doctor always makes a point of talking to [name] even when they were not fully aware, so I felt they were kept informed the best way possible." A patient told us, "Everything is explained to me and I see the doctor at least every two days and they discuss my treatment with me so I always feel involved."

People told us they were very happy with their meals. One person told us, "I enjoyed the chicken main course. We had a choice of menu. The portion was just right, not too big. Another person said, smiling, "The ice-cream was too cold."

We observed a staff member taking people's meal orders. People were given a choice of a starter, main course and dessert. Where people did not want the options on the menu a wide range of alternatives were offered. The staff member made certain people had something to eat which they really wanted. We spoke with one nurse who told us, "I am the nutritional link nurse, which means I worked with the dieticians to make sure people get the right food. If someone has lost interest in food, I try to encourage them, the food here is amazing." People could also eat at the coffee shop with their family or visitors.

Food and nutritional needs were met with individualised care and evidence of care planning involving multi-disciplinary team members including a dietician was evident from care plans we viewed. There was evidence of red trays to identify people who may need additional support or extra nutritional requirements specifically around meal times.

We met with the catering manager for the service. They told us they were a member of the North West Hospice catering group who met regularly to share best dishes and ideas about menus. They told us how after receiving a nutritional assessment carried out by the nursing staff that they also went and spoke with people about what they would like to eat. They told us how they had a four week menu plan but people had choices at all mealtimes and freezers in the in-patient area were stocked with items such as ice cream in case people fancied a snack at night time for example. We saw that all food was freshly prepared and the service worked to ensure that food was fortified with extra calories where possible. For example, the service had an ice cream maker which could be used to make very fortified flavoured ice cream for people. We saw that food was provided on small plates so as not to over-face people when their appetite was small. This showed the service tried different ways to ensure people were supported to have access to whatever nutritional support they needed.

We saw people's food and fluid intakes were recorded on the electronic record system but staff were aware not to make a huge issue regarding weight loss which often was of concern to family members but which may be actually be part of the end of life process. We saw that menus were available in a range of languages and the catering manager was knowledgeable about providing food to meet people's cultural needs. For example, the service had used Kosher and Halal supermarkets where needed and had recently used a Lithuanian supermarket for someone.

The catering manager had also developed the services provided at the hospice to include a comfortable

café dining area for people and families and a three course meal for people attending the day hospice services. They had also ensured that special celebrations were supported and had recently baked a Superheroes cake for a young relative of a patient. A volunteer told us, "The chef always accommodates special requests. It is like a restaurant here!" This showed the service provided caring support to meet the nutritional needs of everyone using the hospice; patients, visitors and carers.

Weekly multi-disciplinary team meetings were held where a full review of the person's care was undertaken. These meetings helped ensure that people's care was individual and person centred. One professional we contacted about the service told us, "Discharge summaries resulting from patient stays in the hospice are communicated quickly and efficiently. Communication within the hospice seems excellent and efficient, with regular team meetings to discuss patients, disseminate learning and discuss management plans."

The registered manager told us the service had improved communication across the hospice as part of their on-going improvement work. A handover meeting had been developed which was a taped recording and provided an updated summary of each patient in handover mornings and evenings, one staff told us, "I like the taped version, rather than face to face, it stops interruptions." We also asked staff about consistency of care. One staff member told us about continuity of care and if they regularly looked after the same patients, "I do get some choice and we are often asked who we looked after yesterday, it means you get to know your patients and that's nice for the patients and nice for us. I like to get to know the relatives." The service had also put out a weekly Chief Executive's bulletin that every staff member and volunteer received via email and which gave updates on things happening across the hospice.

The hospice was developing its services to provide a greater range of disease specific clinics at the hospice. This included respiratory sessions and a new motor neurone disease clinic that had just commenced. The day programme running three days a week gave people a care plan to enable them to participate in a variety of therapeutic activities with qualified staff such as a physiotherapist, nurses and other trained therapists. There was also a drop-in clinic available each Monday to support people thinking about using the hospice's facilities or perhaps who just wanted some advice from nurses and medical staff. Sessions include complementary therapies such as massage, aromatherapy and reflexology as well as sessions such as crafts. We met with the day hospice nurse manager who explained the service offered bespoke sessions each week rather than a set programme, so for example they might put on a session about fatigue or breathlessness if that was the request coming in from people who used the service. One person told us, "I have been coming since August this year, which is planned weekly for 12 weeks. A volunteer driver from St. Ann's picks me up from my home. I have tea and toast here, read the paper, go to the hairdresser on site sometimes. I enjoy the company. Sometimes we have quizzes in the afternoon. Then I will be taken back by the same driver at 3 pm. The staff are lovely. I didn't think I would enjoy coming here, but I have."

We saw the hospice, through its five year strategic plan, was addressing the issue of the whole building environment at Heald Green, which was not conducive to excellent hospice care. It was an old building and it had restrictions in terms of corridor width and the lack of single person occupancy space. The service currently had some single occupancy space, but beds were mainly provided in single sex bays. Whilst we saw at times these were sometimes crowded with visitors, we saw staff were respectful of people's dignity, ensuring curtains were drawn before providing any personal care. One relative told us, "Would be better if she can have her own room. I was told a room could be available if she became very poorly." The service was environmentally not very dementia friendly but we saw the service had identified this themselves as an area for improvement and were planning a training programme and dementia champion to ensure people with dementia were supported by knowledgeable staff.



## Is the service caring?

### Our findings

People gave us only positive feedback about the care they received at the hospice. One person said, "I feel if I need any help, I can always get it. They went on to say, "I am very happy with the service received." Another person commented, "Everything is fantastic. Honestly. I do not want for anything else." Family members confirmed their relatives were well looked after in the hospice. One family member said, "Staff are all very pleasant, polite, caring and helpful. It is great." Another relative said, "I feel reassured he was well looked after. I think he is better cared for here than at home!"

People and family members told us they were cared for by kind, considerate and caring staff. One person commented, "I know I am going to die. I feel my wishes are well understood. I have good communications with doctors and nurses every day. I feel well looked after. I am not in pain or discomfort." Another person told us, "Staff are lovely. I didn't think I would enjoy coming here, but I have!" A relative told us, "[Name] is going to have Christmas brought forward, as the doctors from the hospital had warned us that they would not live to see Christmas. We are going to have a Christmas party on Saturday, with the help of the staff. Our family, daughters and partners, and children will be at the party". This showed the service supported people to have their wishes met.

We spoke with several volunteers who worked at the hospice. They told us, "The hospice is a beautiful place. Everyone is kind, helpful, lovely. To me St. Ann's stands for a caring environment offering safe care to the entire family. I will have no hesitation to have any of my family to come in as a patient." We spoke with another volunteer who had lost their spouse the previous year at St Ann's. They told us, "I started doing two hours a week and now I do six days a week, I love working in the coffee shop and talking to people. I mentioned to the kitchen staff I loved the coconut and cherry cake and a lady baked me one at home and brought it in for me today – isn't that lovely, it's those little things the staff here do that's so important." This showed that all staff at the hospice, not just nursing staff were committed to supporting people in a caring way.

People were treated with dignity and respect by staff who listened to them. Staff gave us examples of how they provided care in a dignified and respectful way. This included telling people what they were doing, keeping people covered up as much as possible during personal care. One staff member said, "I always check it is okay. I always give people the option of doing things first and double check that I have their permission." Staff all spoke about person centred care being a priority and individual care was centred around the patient's wishes and choices. Evidence of people being left undisturbed whilst sleeping and care managed around the patients agenda was evident. One patient told us, "I am treated politely, people are caring on the whole. I think that staff are planning for my discharge home. I am consulted though I don't know when it will happen."

People said staff were attentive to their needs and supported their choices. We observed one patient pressed their nurse call buzzer. A healthcare assistant (HCA) came to answer the buzzer in less than a minute, spoke to the patient, then told a qualified nurse nearby that the person was in pain. The nurse asked the HCA to take over their support to another patient and explained to us they needed to find another



nurse to administer a controlled drug for the patient's pain relief.

One person said, "I feel if I need any help, I can always get it." They also said, "They come right away when I pull the nurse call." One family member commented, "Staffing is adequate. They seem to be coping quite well. This is how it should be everywhere. Call bell is answered quickly. Help is always on hand."

The service recognised the significance of family throughout people's involvement with the hospice services. People's family members, friends and pets were able to visit between 11am and 8pm. In addition a facility was available for relatives to stay overnight, although this was limited. One relative told us, "It has been a positive experience in a very difficult time. Staff will listen and are supportive as far as possible. Nurses made time for us, like making us a cup of tea. We are able to take a step back. This has brought us back together as a family." One family member commented, "We have been reassured that we will get support in the form of counselling, respite care, massage which is also available to our relative."

People told us they were given choice and involved in decisions about their care and treatment. They told us nursing and medical staff had explained treatment options to them in a consistent manner and then they had been given time to absorb the information before making a decision about choosing a syringe driver to help with pain relief, for example.

During our inspection we attended the patient / carers group run by the service. The lead for quality and audit told us, "I chair the Patient / Carers Group, which meets bi monthly. It is a mix of patients and current or ex-carers. There are 12 members in total, usually 8 to 10 turn up at each meeting. The purpose of the group is to help us develop and improve our services by listening to the views of the people who use them." The Chief Executive Officer also attended, explaining that the agenda would include a patient wrist bracelet programme to discreetly identify people with a certain condition or need such as someone susceptible to falls for example. He invited members to make suggestions on a fundraising activity being planned. Members attending this group told us about how much mutual support they had received. We heard people sharing information and ideas. This showed the service listened to the views of people who used the service.

We saw the service supported people's spiritual needs. The hospice had its own chaplain and staff had information to source support from a variety of faiths and cultures as and when required. The chapel provided multi faith opportunities and we were told that a funeral and wedding had been held there. Materials reflecting, Christian, Jewish and Muslim faiths were on display.

## Is the service responsive?

### Our findings

People and family members did not raise any concerns about their care. A volunteer told us, "Patients fill in surveys and we pass on constructive comments to staff. I have had patients who say to me 'I feel safe and supported. They do as much as they can to accommodate everybody, patients and relatives.'" One family member told us they had; "No concerns". Staff told us people were given information about the complaints procedure when they first came into the hospice. Information about how to complain was also contained in the information leaflet given out individually. People were given an information pack about the range of services and facilities available, such as family support, complementary therapies, physiotherapy and bereavement support amongst others. People told us they could express their views and were involved in making decisions about all aspects of their care. They told us they felt listened to.

Core care plans were used throughout the hospice using the new EMIS electronic care planning system to support care and management, with additional text added or text removed to personalise care plans in line with individual needs. We saw a holistic assessment covering each person's needs and preferences had been completed. This was available to view in care records. We were also told that every person had an assessment by a psychological support worker upon admission which enabled them to identify any underlying distress and trigger an immediate approach to counselling services.

Each person's care and treatment was fully discussed during the twice weekly multi-disciplinary team (MDT) meeting. This included changes in their health and care needs. The MDT meeting which comprised of a range of professionals including nursing staff, the chaplain, medical staff, an occupational therapist and a physiotherapist. Although we did not see documented advance care plans, the MDT included a discussion of future planning needs. The meeting was also an in-depth discussion of each person's placement, the person's wishes and goals, including whether the person's preferred place of care had been achieved. Discharge plans were also discussed. The MDT discussions were clearly documented in all of the care records we viewed.

From viewing the old written care records we saw medical staff completed a pain mapping tool to monitor people's pain levels. We discussed the use of pain scores with nursing staff and saw these were appropriately assessed. They told us people were asked to score their pain using a scale of 1-10. They then gave appropriate medicines or other therapies. People were then asked to re-score their pain level to assess whether the treatment had worked. Nursing staff told us that on the current electronic care plan EMIS system there wasn't a specific chart to complete this process so staff were writing the process as free text. A nurse told us; "We are having frequent meetings about the new EMIS system to make sure it is fit for purpose and suits the hospice's needs, we did have stool chart added to the system so perhaps this may also be something we request as a specific template." We observed throughout the inspection people's requests for pain relief were answered promptly.

Core care plans were in place to support individual plans of care for all people. The hospice were in the process of implementing the Outcome Assessment and Complexity Collaborative (OACC) tool which will enhance the care planning process by ensuring that outcomes for people are clearly recorded. The hospice

had recognised through their own clinical governance processes that they needed to improve the recording of outcomes for people in relation to managing palliative care and so were undertaking planning and training in relation to implementing OACC.

We saw for one person a specific care plan for caring for people in the last days of life was in place. We saw the patient had been given the opportunity to discuss their preferred place of care – however their condition deteriorated quite quickly and although given the opportunity to discuss their preferred place of death at the time they were not ready to discuss it. This was clearly captured in the care record we viewed.

We saw people's cultural and religious needs were recorded and nurses we spoke with described the need to explore spirituality further with the person capturing what was most important to them. Nurses we spoke with were aware of how to gain further support or advice regarding people's spiritual or cultural needs.

We saw weekly multi-disciplinary team meetings were held where a full review of the person's care was undertaken. These involved medical staff, nurses, therapists, and community team. The meeting discussion included a short case history on each individual and explored issues such as treatment options and a discussion about meeting people's holistic needs, such as checking that all therapy options had been explored as well other individual issues such as spiritual needs. This meeting ensured anyone either receiving inpatient or community support was reviewed by a multi-disciplinary team in a responsive manner. These meetings helped ensure that people's care was individual and person centred.

The service had a patient and family support team led by social workers. This was available if a person needed practical support or advice, for example, such as housing issues, benefits, legal advice and wills. They could make referrals to the local authority social work teams if necessary. Their support team remit was to offer support to anyone affected by a life limiting illness and the day hospice manager told us this was a purposely broad remit to ensure as many people as possible could access its services. They told us about other services available which included bereavement support that provided support to families after death. The service also worked with children to ensure a child was supported with any loss by the service.

We saw that the service provided transition services for people's families to offer them a bereavement support service and bi-monthly remembrance and thanksgiving services and then on-going counselling if this was needed by people. This meant that families were supported by the hospice and its service right through the journey of supporting someone with a life limiting illness and through the grieving process by trained and professional staff.

People told us they could express their views and were involved in making decisions about all aspects of their care. They told us they felt listened to. People and a relative told us they were aware of how to make a complaint and they would have no hesitation in making a complaint to staff or the registered manager.

We were shown a copy of the complaints procedure. The procedure gave people timescales for action and who to contact. Discussion with the registered manager confirmed that any concerns or complaints were taken seriously, although there had not been any formal complaints within the last 12 months.

## Is the service well-led?

### Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service.

St Ann's Hospice had a number of different ways in which it assessed and monitored the quality of service it delivered. We looked at performance reports, audits, the organisation's quality accounts, risk management / governance systems, meeting minutes and questionnaires carried out by people, families and staff.

There was a clear management and governance structure at the hospice. The staff we spoke with were aware of the roles of the management team and told us they were approachable and we saw they had a regular presence within the hospice. One senior nurse told us, "I have been in the job for 16 years, and feel well supported by management." All staff we spoke to demonstrated a positive culture and were all enthusiastic to work at the hospice. One staff member said, "I get along really well with them [management]." They all demonstrated in their conversation that they felt the organisation was well managed and led. There was a sense in speaking with senior clinical staff that they had autonomy in practice, with the structure and support to allow that to happen in a safe way. There was evidence of a weekly chief executive officer staff brief and exercises in preparing all staff and volunteers for the upcoming CQC inspection as a positive outcome.

The hospice had a robust risk management approach. The system was found to be comprehensive allowing staff in each area to report clinical and non-clinical incidents. Accidents and incidents were reviewed and the registered manager told us they were keen to pursue a more effective electronic recording system in order to improve effectiveness of monitoring. A quarterly report was then produced with recommendations and an action plan drawn up. This was then passed down to areas for implementing a "lessons learnt" approach.

Staff members told us they had opportunities to give their views about the care provided at the hospice. Staff also said there were regular team meetings, practice development days and a daily handover meeting for each shift which took place on three occasions.

We met with the registered manager and quality and audit lead for the hospice. They explained the documents provided by the hospice showed how trends and themes of concern were monitored and acted upon by the clinical governance group. For example we discussed the issue of recent nurse staffing shortages. We saw that this risk was reviewed regularly and actions the hospice had taken to mitigate any risks from this were recruitment, and utilising staff from other hospice sites such as Little Hulton. The ward manager told us, "There were some challenges. For example, I had two newly qualified staff starting, who were supernumerary and would have a one week induction. I did not perceive any safety risk, and would call on own bank nurses and healthcare assistants. Meanwhile patients increasingly come in with complexities so we do need to keep things under constant review." We saw minutes of these meetings where actions were clearly identified, delegated and given timescales for completion. There was also a quarterly review of the key performance indicators and targets, the aim of which was to review information relating to outliers,

which would aid the hospice in focusing on improvements in quality and safety. Other important feedback from patients and people using the hospice was sought via Friends and Family Questionnaires and other direct interviews which were sent each week to the relevant area manager for review and monthly summaries fed into organisational meetings. This meant that as well as the regular patient / carer meetings, that people's views were considered by the hospice.

We saw that the hospice shared its lessons learnt in order to identify any improvements which could be made to improve the outcomes for people using the service. We were given examples of improvements which included the recent merging of the two wards of the hospice to create one unit. The ward manager told us, "It was good for staff development, as previously some staff might have not had experience of certain things (e.g. tracheostomy care) as they were on one ward where there might not have been one for a while. Now there was more chance of getting experience of different things. Also, previously one staff nurse who worked primarily at night and wasn't getting the experience of the day staff. Now they do some days to ensure their skills are kept up-to-date." This showed the service was willing to implement change.

We also saw that a leadership walk around had been introduced that sought feedback from people and staff as well as viewing the environment from the perspective of the patient. There was evidence of senior leadership walk-rounds each month with action plans developed and monitored by the executive team. The service had also carried out a PLACE audit, one that was patient led and which identified issues with the hospice bathrooms as appearing tired and dated. Again we saw this had been passed onwards with costings being considered for refurbishing these areas.

We spoke with the hospice's Medical Director who explained about how the service was responding to changing demographic need. They told us, "We have set up a specific clinic for people with motor neurone disease that has been a year in the planning. We have ensured we have a specialist nurse and occupational therapist available for this. We want to increase the access for non-malignant diagnoses for our services and we have seen this increase recently." A commissioner told us, "The hospice, as a relatively small organisation, does seem to be responsive to changing local need; they are aware of the variability of access to their services across the local population, both through geographical factors, but also due to ethnicity, cultural and other lifestyle factors and work hard to address these. For example, they have recently set up a satellite palliative care clinic in a nearby CCG where access was previously quite poor and have been doing some outreach work into Lesbian Gay Bisexual and Transgender (LGBT) and homeless communities." This showed the hospice was working to increase its visibility and recognised the changing demographics of its population.

We saw the service was positively working toward change, which included having a clear five year strategy to explore issues such as the suitability of the building, as this was not currently conducive to excellent hospice care because of its shared wards and restrictions on the environment caused by it being an older building. Recent senior management changes had also brought in new ideas and new developments, such as the practice development centre, where training and development opportunities were provided for hospice staff and volunteers. They have recently set up The Hub satellite palliative care clinic. Collaborations with other stakeholder partners such as local care homes and Salford University had also increased the hospice's visibility within the community.

The hospice had very recently introduced a new electronic recording system called Egton Medical Information System (EMIS). We saw a clear plan of implementation that included training and support for staff was in place. We were told that the system would replace the manual medical and nursing records and consisted of a series of templates that staff could access and complete throughout the day. When we asked about the introduction of EMIS, one staff said they had received some training, but not much and just had to

'get on with it'. They did say they were happy with the new system "I like technology". They went on to say they felt that staff had been very supportive of each other during its introduction and had helped each other. One staff member told us they were becoming used to the new systems, and although some delay was experienced at first with data entry, they stated that they were becoming less frustrated. All staff said they felt it had been a positive move and would lead to greater efficiency with less time being spent writing notes and completing charts.

Staff members told us there was a good atmosphere in the hospice, "I like the atmosphere and the teamwork is much better here than anywhere else I've worked." We asked about non-qualified and qualified staff working together and we received nothing but positive comments about working relationships at all levels. Nurses told us that Healthcare Assistants worked quite independently i.e. "They use their initiative and don't just wait to be told what to do by trained staff."

Staff told us they felt consulted and included in planning and implementation of new services such as new day clinics or the plans for the future of the hospice building. Regular team meetings were held where staff were kept up to date with developments and could have discussions about the running of the service. We saw minutes of the meetings where staff had discussed their roles, training and health and safety.

As part of their contractual arrangements with the Clinical Commissioning Groups (CCG) the hospice provided an annual Quality Account, in which they gave information regarding their achievement against Performance Indicators and Quality Improvement and Innovation goals set with the CCGs. There were also sections to report on incidents; safeguarding compliance and patient experience feedback (patients provided excellent feedback in relation to the level of care and their experience via various methods). We spoke with one commissioner who told us, "I have always found St Ann's to offer an excellent service both to in-patients and out-patients for symptom control, support and palliative and end of life care. Feedback from patients, relatives and carers is consistently positive, complaints are rare, but appear to be dealt with thoroughly and with transparency."

We spoke with commissioners of the service from the local CCGs. They told us, "I was asked to do a 'walk around' visit on behalf of Stockport CCG last year and had the opportunity to speak to several patients and staff. Patients reported that they felt well cared for and supported, respected and that, 'Nothing seemed too much trouble.' Although, I have limited contact with patients in my commissioning role at St Ann's, as a local GP, I get excellent feedback from my own patients who have used their services."

We saw the service worked closely with other partners such as the NHS local hospitals and community services. We were given examples of how the service was working with a local NHS trust to give staff at the hospice training in working in the acute hospital sector in a short term job swap exercise. This enabled them to share their palliative care knowledge with staff at the health trust site. One commissioner told us, "St Ann's does have input into regular training events, both through involvement of senior clinicians and through hosting education events at the hospice. They were extremely supportive when I ran a practice nurse education course, which was partially run at the hospice."