Springhill Hospice (Rochdale)

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Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Outstanding
Is the service caring?	Outstanding
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected Springhill Hospice on the 16 and 17 August 2016. The first day of the inspection was unannounced. We last inspected Springhill Hospice on 15 October 2013 where we found all the regulations that we looked at had been complied with.

Springhill Hospice is a charitable organisation that provides a range of hospice services for adults with a life-limiting illness. The hospice is purpose built and provides accommodation on the Inpatient Ward for up to 16 people. The hospice also has a Specialist Palliative Care Community Service, a Day Hospice, and a Hospice at Home service. In addition the hospice offers a 24 hour telephone advice line for professionals, people who use the service and their families. The hospice is close to public transport routes and is situated in a residential area of Rochdale, not too far from the town centre. It is set in large well-maintained gardens with adequate parking and clearly defined parking areas for disabled visitors. Services are free to people, with Springhill Hospice receiving some NHS funding and the remaining funds achieved through fundraising and charitable donations.

There were 16 people being cared for in the Inpatient Ward during our inspection, 16 people in the Day Hospice and approximately 240 people in the community.

The hospice had a manager registered with the Care Quality Commission (CQC) who was present during the inspection. A registered manager is a person who has registered with 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 and associated regulations about how the service is run.

We found there was one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Medicines were not always given as prescribed, appropriate systems were not in place for the management of medicines requiring refrigeration and relevant information to enable staff to administer 'when required' medicine safely was not in place. You can see what action we have told the provider to take at the back of the full version of the report.

The expressions of gratitude relayed to us demonstrated that people were cared for with the utmost compassion, kindness, dignity and respect. People spoke highly of the kindness and caring attitude of the staff. People told us they received the care they needed when they needed it and that staff were knowledgeable and committed. Visitors were made welcome and the staff recognised and considered the importance of caring for the needs of family members and friends.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. The nursing and medical staff showed they were highly skilled in pain and symptom control. Staff were passionate about the need to spread awareness and knowledge of end of life care by introducing an innovative and creative programme of training for staff caring for people in care homes.

We found that people received outstanding care. People's privacy was respected and people were assisted in a way that respected their dignity. We observed respectful, kindly and caring interactions between the staff, the people who used the service and visitors. People looked well cared for and there was enough equipment available to ensure people's safety, comfort and independence were protected.

The way that the hospice staff worked in partnership with other organisations was outstandingly effective. The staff were passionate about the need to spread awareness and share their knowledge of end of life care with other services that were involved in supporting people in the community.

We saw how the cultural and religious needs of all faiths was considered and respected. Staff told us they strived to ensure that people's spiritual needs were met. There was a Spiritual and Pastoral Care Co-ordinator who was available to spend time with people in the Day Hospice, the Inpatient Ward and to people in the community.

The care records showed people were involved in the assessment of their needs. A person's preferred place of care at all stages of their illness and the arrangements in the event of their death were documented. The care records we looked at showed that risks to people's health and well-being had been identified, such as poor nutrition, the risk of developing pressure ulcers and the risk of falls. We saw care plans had been put into place to help reduce or eliminate the identified risks.

Suitable arrangements were in place to help safeguard people from abuse. Staff knew what to do if an allegation of abuse was made to them or if they suspected that abuse had occurred.

We found people and their families were cared for and supported by sufficient numbers of suitably skilled, competent and experienced staff that were safely recruited. Staff received the essential training and support necessary to enable them to do their job effectively and care for people safely.

All areas of the hospice were secure, well maintained and accessible for people with limited mobility. In addition good infection control procedures were in place;, making it a safe environment for people to live and work in. We saw that appropriate environmental risk assessments had been completed in order to promote the safety of people who used the service, members of staff and visitors. Systems were in place for carrying out regular health and safety checks and equipment was serviced and maintained regularly.

Staff were able to demonstrate their understanding of the principles of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be unable to make their own decisions. Staff sought people's consent before they supported them. The staff we spoke with had an in depth knowledge of the care and support the people who used the service required.

People were provided with a choice of suitable and nutritious food and drink to ensure their health care needs were met. People who were at risk of malnutrition and poor hydration had their food and fluid intake monitored to help ensure their well- being.

The management structure within the hospice enabled staff and volunteers to understand the clear levels of responsibility and accountability. Management sought feedback from people who used the service and also sought feedback from staff and volunteers. Action plans were implemented to address any issues of dissatisfaction that were raised.

To help ensure that people received safe, effective care and support, systems were in place to monitor the quality of the service provided. Systems were also in place for receiving, handling and responding

appropriately to complaints.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always given as prescribed, appropriate systems were not in place for the management of medicines requiring refrigeration and relevant information to enable staff to administer 'when required' medicine safely was not in place.

Sufficient suitably qualified and competent staff that had been safely recruited were available at all times to meet people's needs. Suitable arrangements were in place to help safeguard people from abuse.

All areas of the hospice were secure, well maintained and accessible for people with limited mobility. In addition good infection control procedures were in place;, making it a safe environment for people to live and work in.

Is the service effective?

Outstanding ☆

The service was very effective.

Staff were passionate about the need to spread awareness and knowledge of end of life care by introducing an innovative and creative programme of training for staff caring for people in care homes. The education provided by the hospice also extended to other professionals in the community caring for people with a life limiting illness; helping to ensure the best possible care for people and for their families.

Staff were able to demonstrate their understanding of the principles of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty
Safeguards (DoLS). People were involved in making decisions about all aspects of their treatment and care.

People were provided with a choice of suitable nutritious food and drink to ensure their health care needs were met. People were supported to eat and drink and maintain a balanced diet.

Is the service caring?

Outstanding ☆

The service was very caring.

People told us they received the care they needed when they needed it and that staff were knowledgeable and committed. People spoke highly of the kindness and caring attitude of the staff. People were cared for with the utmost compassion, kindness, dignity and respect.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. The nursing and medical staff showed they were highly skilled in pain and symptom control and provided outstanding end of life care

Is the service responsive?

Good

The service was responsive.

The care records showed people were involved in the assessment of their needs. A person's preferred place of care at all stages of their illness and the arrangements in the event of their death were documented.

Staff were skilled in recognising when a person was in the last days of life and were able to provide the appropriate care.

Suitable arrangements were in place for reporting and responding to any complaints or concerns.

Is the service well-led?

Good

The service was well led.

The service had a manager in post who was registered with the CQC,

Clear lines of accountability and effective methods of communication were in place to ensure people received the best possible service. Systems were in place to monitor the quality of the service provided to help ensure that people received safe, effective care and support.

Accidents or incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.

Springhill Hospice (Rochdale)

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.'

We inspected Springhill Hospice on the 16 and 17 August 2016. The first day of the inspection was unannounced. The inspection team comprised of two adult social care inspectors and a pharmacist inspector.

Before our inspection we looked at the previous inspection report and records that were sent to us by the registered manager to inform us of any incidents and significant events. Prior to our inspection of the service we were provided with a copy of a completed provider information return (PIR); this is a document that asked the provider to give us some key information about the service, what the service does well and any improvements they are planning to make.

We spoke with two people on the Inpatient Ward, one person in the Day Hospice, four relatives, a hospice doctor, three registered nurses, an education facilitator, the community service manager, two counsellors and three volunteers. In addition we spent time with the registered manager and the chief executive of the hospice. We also spoke with two healthcare professionals who had involvement with the hospice.

We looked around all areas of the hospice, looked at how staff cared for and supported people, looked at food provision, two people's care records, the medicine management system, four staff recruitment and training records and records about the management of the hospice.

Requires Improvement

Is the service safe?

Our findings

Comments made by visitors demonstrated to us that people felt safe. Their comments included; "Absolutely wonderful, how can you not feel safe here?" and "There are plenty of wonderful staff to look after [relative] needs".

We looked at the systems in place for medicines management. We assessed four prescription records and spoke with staff including three nurses, a doctor, and the registered manager. Medicines were supplied by a local pharmacy under a service level agreement. The service was available Monday to Friday; doctors and nurse prescribers issued NHS prescriptions outside of normal working hours which could be taken to any pharmacy. Medicines were stored securely with access restricted to authorised staff. There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and we saw evidence of routine balance checks.

Medicines requiring refrigeration were stored securely and records were maintained in accordance with national guidance, however staff did not always take appropriate action. For example, we saw the fridge temperature had been outside of the recommended range from 20 June 2016 to 16 August 2016 and staff had not escalated this in accordance with the service policy. Therefore, we could not be sure medicines stored in this fridge were safe to use. We discussed our concerns with the registered manager who took immediate action to remove and replace these medicines.

Following the inspection we received information from the chief executive of the hospice who informed us of the following: 'We had determined that the thermometer reset button had not been pressed after each reading. All nursing staff have been informed of this requirement, but also of the requirement to report when the range is exceeded. A note has been placed on the fridge stipulating the temperature ranges and the requirement to report any discrepancies. A new and more modern thermometer has been ordered'.

Medicines were not always given as prescribed; we saw one person had not received a medicine for strengthening bones that should be taken once weekly. There was a lack of information to enable staff to administer as and when required medicines safely. For example, we saw maximum doses and minimum dose intervals had not been stated by the prescriber on four of the prescription charts we reviewed. We saw that doses of when required medicines had been pre-printed on a separate medicines card, which meant there was a risk that doses being prescribed may not be suitable for some patients. For example, we saw one person who had low body weight had been prescribed the usual full adult dose of paracetamol. Medical staff had not recorded any rationale for choosing this dose which is not recommended in national guidance. Medical staff checked (reconciled) patients' medicines on admission to the service by checking with their GP.

Following the inspection we received information from the chief executive of the hospice who informed us of the following: 'Doctors at the hospice have confirmed that routine training takes place with all nursing staff on a regular basis, and that all nurses have been assessed as being competent in relation to PRN (when

required) prescribing. The medication prescription record is in the process of being amended, and will incorporate some additional guidance'.

Failing to give medicines as prescribed, failing to ensure appropriate systems are in place for the management of medicines requiring refrigeration and failing to ensure relevant information is in place to enable staff to administer when required medicines safely is a breach of Regulation 12 (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were supplies of emergency medicines and oxygen, however not all staff on the inpatient ward were aware of their location. In addition, there was no system in place to give assurance these were fit for use. On the inpatient ward emergency medicines were not kept in the designated emergency box as per the service policy. The service had recently acquired an automated emergency defibrillator, however this was not available for use at the time of our inspection.

We have recommended the hospice reviews the provision of medicines and equipment for use in an emergency.

Following the inspection we received information from the chief executive of the hospice who informed us of the following: 'The medicines which were not in place have been replaced, and our pharmacy technician has been tasked with checking this on weekly visits. A policy is in development for use of our new defibrillator, and a comprehensive risk assessment on the use of emergency equipment/medicines will be undertaken alongside our Health and Safety Advisor during the week commencing 19th September 2016'.

Blank prescription pads were stored securely; doctors recorded when prescriptions were issued but there was no log of prescriptions received into the service as set out in national guidance. We have recommended the hospice reviews the record keeping arrangements for blank prescription pads.

Following the inspection we received information from the chief executive of the hospice who informed us of the following: 'We have checked the medical directors' records and determined that all prescriptions are photocopied and recorded by hand. We are reassured that there are no missing prescriptions, and can safely account for all prescriptions issued to us and by our doctors to patients. We do acknowledge that the recording, whilst satisfactory to ensure safety, was not robust enough to meet national guidance. We have consulted the NHS Protect guidance for security of prescriptions, and have devised forms for future recording and security of prescriptions'.

Policies and procedures were regularly reviewed and covered most aspects of medicines management. There was also a self-medication policy in place, and we saw how this was used to support patients to manage their own medicines. Arrangements were in place to ensure medicines incidents were reported and investigated through the service's governance arrangements. We reviewed records which showed staff undertook annual medicines management training

We found that some aspects of medicines management were audited annually, however the resulting action plans lacked detail and the audits had failed to detect the shortcomings we identified during our inspection. During the inspection we were told that the audit tool had been amended to reflect this for the future.

Policies and procedures for safeguarding people from harm were in place. These provided staff with guidance on identifying and responding to signs and allegations of abuse. The training records we looked at showed that all staff had received training in the protection of vulnerable adults. Staff we spoke with were able to tell us what action they would take if abuse was suspected or witnessed.

We saw the service had a whistleblowing policy. This told staff how they would be supported if they reported poor practice or other issues of concern. Staff we spoke with were familiar with the policy and knew how to escalate concerns within the service. They also knew they could contact people outside the service if they felt their concerns would not be listened to.

The care records we looked at showed that risks to people's health and well-being had been identified, such as poor nutrition, the risk of developing pressure ulcers and the risk of falls. We saw care plans had been put into place to help reduce or eliminate the identified risks.

We saw that appropriate environmental risk assessments had been completed in order to promote the safety of people who used the service, members of staff and visitors. These included risks in respect of fire, bathrooms, slips and trips, communal spaces, electrical appliances, hoists, medicines, control of hazardous substances and legionella. We noted that all risk assessments had been regularly reviewed.

We found that regular fire safety checks were carried out on fire alarms, emergency lighting, smoke detectors and fire extinguishers. We saw fire risk assessments were in place and records showed that staff had received training in fire safety awareness.

The hospice had an incident and accident reporting policy to guide staff on the action to take following an accident or incident. Records we looked at showed that accidents and incidents were accurately recorded. The record included a description of the incident and any injury, action taken by staff or managers and whether it was RIDDOR reportable. RIDDOR is the reporting of injuries, diseases and dangerous occurrences to the Health and Safety Executive. We saw that following one accident the persons' care records had been reviewed and updated, additional equipment had been provided and a referral had been made to the person's G.P. for a review. This demonstrated to us that management reviewed and analysed any accidents/ incidents and looked at ways of improving the quality of care people received to ensure they were kept safe.

The registered manager told us the service had a 'risk committee' that met monthly to review any accidents or incidents that had occurred. We were told the committee would assess to see if further action needed to be taken to prevent any reoccurrence and would also look at whether there were any common themes or patterns to the incidents that could be identified and acted upon.

We saw infection prevention and control policies and procedures were in place. These gave staff guidance on preventing, detecting and controlling the spread of infection. We looked at the infection control risk assessment which gave staff information and guidance on how to reduce or control any identified risks. They also provided guidance for staff on effective hand washing and the use of personal protective equipment (PPE) such as disposable gloves and aprons. We saw that staff wore appropriate PPE when carrying out personal care tasks. Training records showed that all staff had received training in infection control.

Colour coded mops, cloths and buckets were in use for cleaning; ensuring the risk from cross-contamination was kept to a minimum. Hand-wash sinks with liquid soap and paper towels were available in all clinical areas, ward areas, bathrooms, sluices, toilets, the kitchen and the laundry. Alcohol hand-gels were in place throughout the hospice. Good hand hygiene helps prevent the spread of infection. We saw that appropriate arrangements were in place for the safe handling, storage and disposal of clinical waste.

We looked at the on-site laundry facilities. The laundry looked clean, well-organised and secure; access to the laundry was by the use of an electronic fob held by staff. Hand-washing facilities and protective clothing of gloves and aprons were in place. We found there was sufficient equipment to ensure safe and effective

laundering. The washing machine had a sluicing facility to wash soiled linen. The service also used red alginate bags to safely wash heavily soiled linen. Heavily soiled linen can be placed in the bags which then dissolve when put into the washing machine. This helps to ensure that staff do not handle bodily fluids.

We looked around all areas of the hospice. It was clean, bright and looked well maintained. The car parking areas were well laid out with very clear signage and clearly defined parking areas for disabled visitors.

We saw staff used an electronic fob system which could be programmed to restrict access to certain areas. The registered manager told us this had replaced key pads as a more secure system of exit and entry. We saw that only staff who were able to administer medicines could gain access to the medicines treatment room using their fob.

We saw that, following a recent food hygiene inspection, the hospice had been rated a '5'; the highest award.

During the daytime hours up to 9pm, people were able to enter the hospice via the automatic doors and be greeted at the reception desk by a hospice volunteer. Out of hours the external doors were locked and people had to ring the doorbell for access. CCTV monitors were in place at .the nurse's station on the Inpatient Ward. The provision of CCTV enabled the staff to see who required admission to the building. This helped to keep people safe by ensuring the risk of entry into the building by unauthorised persons was reduced.

Records we looked at showed there was a system in place for carrying out regular health and safety checks and that equipment in the hospice was appropriately serviced and maintained in accordance with the manufacturers' instructions. We saw valid maintenance certificates were in place for portable electrical appliances, electrical fittings such as plug sockets and light switches, a gas safety certificate, thermostatic control valves, legionella and hoisting equipment. These checks help to ensure the safety and wellbeing of everybody living, working and visiting the hospice. Inspection of records showed that a fire risk assessment was in place and regular in-house fire safety checks had been carried out to check that the fire alarm, emergency lighting and fire extinguishers were in good working order and fire exits were kept clear.

We looked to see what systems were in place in the event of an emergency or an incident that could disrupt the service and/or endanger people who used the hospice. The hospice had a contingency plan in place. This informed staff what to do in the event of such an emergency or incident and included circumstances such as; the lack of availability of the building, staff, kitchen area, gas, electricity, heating, water, breakdown of essential equipment and severe weather. This meant that robust systems were in place to help protect the health and safety of people in the event of an emergency situation arising.

We asked if the hospice had personal emergency evacuation plans (PEEPs) in place for the people who used the service. This information assists the emergency services in the event of an emergency arising, such as a fire or flood. We were told there were no PEEPs in place as it had not been previously required or recommended by the Greater Manchester Fire and Rescue Service (GMFRS). The registered manager told us they would seek advice and guidance from the GMFRS. On the second day of the inspection we were informed that contact had been made with GMFRS and that the hospice was awaiting a return call from the fire prevention officer. The registered manager told us that they would act on any advice they were given.

From our observations, inspection of staff rosters, discussions with staff, people who used the service and their relatives it was evident there were enough staff available to offer people and their families the care and support they needed. During both days of the inspection we saw there was a busy but calm atmosphere throughout both the Inpatient Ward and the Day Hospice.

We saw that people under the care of the hospice were looked after by a specialist palliative care team. The team comprised of medical, nursing, allied health care professionals such as physiotherapists and counsellors, therapists, ancillary and administrative staff. The team were supported by volunteers, both within the hospice and out in the community.

A full time medical director led the medical team of four doctors who specialised in palliative medicine. We were told the medical team cared for people on the Inpatient Ward, the Day Hospice and people who received care at home.

We were told that medical cover was provided routinely six days a week. Although there was no doctor on site at all times we were made aware that 24 hour medical cover was always provided. We were told that one weekend a month 'on call' cover was provided by a hospital consultant and one weekend was covered by a GP. The other two weekends and evenings were covered by the 'out of hours' doctor service if necessary.

The registered manager told us that a staffing dependency assessment was kept in each person's care file. They told us this was completed daily and that the information was then put onto a central board. This information was used each day to assess people's support needs and the staffing was then adjusted to ensure there was sufficient staff to meet people's needs. The registered manager told us the service operated a flexi-working system. This meant that staff could leave their shifts early when they were not needed but could work extra hours when people's support needs were higher.

We saw a safe system of recruitment was in place. We looked at four staff files. The staff files we looked at contained an application form including full employment history, professional references, proof of address and identity including a photograph of the person. We saw that checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. There was a system for regularly checking any nurses were up to date and remained validated with the Nursing and Midwifery Council (NMC.) These checks should help to ensure people are protected from the risk of being cared for by unsuitable staff.

Outstanding ☆

Is the service effective?

Our findings

People we spoke with told us their relatives received the care they needed when they needed it. Relatives' comments included; "It is 5 star; better than you could ever expect. They are looking after [relative] so well, always checking on [relative] and managing the pain. They are remarkable". Also, "I have to say from the first call for advice up to admission the care has been 'complete'. The way the doctors communicate with you is so professional and so understanding. Everybody, and I mean everybody, knows what they are doing and they give their all".

We looked at some of the responses from the 'feedback surveys' that had been given to families during the years of 2015 and 2016. There were no negative comments on the responses that we looked at. We saw that 186 cards were given out and 99 were returned. Comments included; "You did everything to a very high standard. I was 100% satisfied" and "The pain management was excellent. The care of Hospice at Home was brilliant. Everything was explained so we could understand it. In all I would say you have a wonderful service".

We looked at how staff were supported to develop their knowledge and skills. We looked at the induction programme that newly appointed staff had to undertake on commencement of their employment. Induction programmes help staff understand what is expected of them and what needs to be done to ensure the safety of the people who use the service, staff and visitors.

The induction programme included topics of information such as; confidentiality, safeguarding procedures, risk assessments, health and safety, infection control, incident reporting and the completion of essential training. Staff files we looked at contained a 'check list' which had been signed and dated by the staff member and the relevant manager to indicate that they had completed each topic. The registered manager told us that staff were fully supervised until their competency had been assessed. Staff we spoke with confirmed that this information was correct.

We were shown the detailed staff handbook that was given to staff when they started to work at the hospice. The handbook included information about confidentiality, expected standards of conduct and terms and conditions of employment. It also contained policies and procedures to guide staff on the company's expectation about disciplinary and grievance procedures and the handling of any complaints.

Situated in the grounds of the hospice was the Education Centre. The hospice staff and volunteers we spoke with told us they had undertaken the essential training necessary to enable them to do their work effectively and safely. Staff spoke positively about the amount and type of training and support they received both from the experienced staff within the hospice and from the education facilitators. A discussion with the qualified nursing staff showed they received regular clinical update training in topics such as; pain and symptom control, counselling, verification of death, medication management and syringe drivers. The training records we looked at confirmed that this information was correct.

We were made aware that in addition to the training that was undertaken in the Education Centre staff had

access to online training. We were told that training sessions could be undertaken at a convenient time, either in the workplace or at home.

The training records showed that staff had undertaken training in communication skills. This was to enable them to communicate effectively with people in a way that embodied compassion, dignity and respect and assist them to manage 'difficult 'conversations.

We spent time talking with one of the education facilitators. We were told that in addition to the Education Centre providing support and training for the hospice staff and volunteers, it also provided training for other professionals in the region who delivered palliative or end of life care. They told us about an innovative and creative programme of training, called The Palliative Care Education Passport that had been developed by the education staff at the hospice. The programme was developed to assist care homes within the region deliver quality end of life care. The training accredits the actual care worker rather than the organisation they work for so when staff changed their employment they took their skills, knowledge and accreditation with them.

This demonstrated to us that the staff were passionate about the need to spread awareness and share their knowledge of end of life care with other services that were involved in supporting people in the community.

The Palliative Care Education Passport programme is based on the Common Core Competencies and Principles for Health and Social Care Workers and the Care Certificate. The Care Certificate, developed by Skills for Care and Skills for Health is a set of minimum standards that social and health care workers should apply to their daily working life and must be covered as part of the induction training of new care workers. In addition to the core competencies and principles, staff when undertaking The Palliative Care Education Passport, were trained in recognising and meeting the physical, emotional and spiritual needs of the dying person and their family. Training covered the six core modules of difficult decisions and recognising advanced disease, communication skills, spirituality/ psychological needs and supporting families and carers, assessment and care planning, to include hydration and nutrition, end of life care, and care after death/bereavement care.

We were told the hospice had linked The Palliative Care Education Passport to the Dignity Champions Campaign, as many of the skills developed through the programme raised the level of dignity and compassion shown by staff to people in care homes. Dignity Champions are part of a nationwide movement to ensure people receive dignified and individualised care.

The education facilitators told us they had evaluated the training programme since its inception in June 2015 and had found encouraging signs of motivation, confidence and skills in those staff who had undertaken the training. They told us they felt this helped to ensure that a culture of care was in place that was compassionate and recognised the needs of the dying patient and their family. One of the care home providers had commented during a Celebration of Springhill Hospice Palliative Care Education Passport Event, held in February 2016, that the training had helped both the provider and their staff to develop their knowledge and confidence when caring for people in the last years of their life. Another care home provider told how they had implemented changes to their practice since undertaking the training by providing a room for visitors to stay during their relatives' last days. This showed that the care home recognised and considered the importance of also caring for the needs of family members and friends.

The proactive way in which the Education Centre staff trained and supported staff within community based settings such as care homes helped to ensure people received the best possible end of life care in their preferred familiar surroundings; their home. Therefore helping to avoid unnecessary hospital and hospice

admissions.

We were also told how the education provided by the hospice had expanded greatly by providing training sessions for GPs, the community nurses, local hospitals, the North West Ambulance Service, Greater Manchester Police and HM Prison Service; once again demonstrating to us how committed the staff were about sharing their knowledge and good practice with other professionals thereby helping to ensure the best possible care for people with a life limiting illness and for their families.

We were told how the hospice staff were currently working with Action on Hearing Loss to explore how they can best meet the needs of people with a degree of hearing loss, both within the hospice and in the community. They were also working with the Compassion in Dying project to raise awareness amongst people about the preferences and choices they could make in respect of their own end of life care.

The hospice also provided placements with in-house support and training to a variety of healthcare professionals, such as GP trainees and student nurses. We were told the placements were valued by both the hospice staff and the healthcare professionals and occasionally had resulted in some healthcare professionals wishing to work at the hospice.

We were also made aware of a further development within the hospice. This was the Specialist Palliative Care (SPCC) Community Service that was launched in July 2014. The purpose of the service was to provide, in addition to symptom management, social and psychological care and support for people and their families in the community. We saw the team was made up of a specialist palliative care doctor, specialist palliative care nurses, a physiotherapist, a community counsellor, spiritual care co-ordinator and a social worker. In addition we were made aware that the hospice worked in partnership with Marie Curie Cancer Care to provide a night sitting service. This was provided to offer support and enable people to stay in their own home whilst their carer could rest overnight.

Prior to this service being implemented the community palliative care service consisted of five Macmillan specialist palliative care nurses who worked from 9am to 5pm, Monday to Friday. There was no weekend and bank holiday cover. It was identified that due to limited resources there was sometimes a delay in the response to referrals and people were not always able to contact the Macmillan nurses, even during the core hours. The service was not always responsive to emergencies or to crisis intervention. It was also of concern that there was no designated palliative care medical cover.

The launch of the SPCC Community Service has had a significant positive impact on people with a life limiting illness. Having specialist palliative care medical and nursing services within the community enabled the team to act as a specialist resource to healthcare professionals who were caring for people with complex symptoms. It enabled people to be directly referred to the Community Service Outpatient Clinic and in certain circumstances the arrangement of domiciliary visits by the specialist palliative care doctor. The increase in the number of specialist palliative care nurses enabled the hours of availability to be extended during the week. In addition weekend and bank holiday cover is provided. We were made aware that three of the nine SPCC nurses were also nurse prescribers. This helps to ensure that the necessary medicines can be prescribed in a timely manner; helping to benefit people by addressing their pain and symptoms when it is needed.

The introduction of the community SPCC physiotherapist, social worker, counsellor and spiritual care co-ordinator acknowledged the holistic needs of people. Previously people were referred to these professionals via the local trust. Having the professionals on the SPC team avoided the delays for referral that had occurred previously.

We were made aware that the SPCC Service had further developed and since its launch the hospice had introduced complementary therapists and a community volunteer service. We were told the community volunteers supported people and their families by providing companionship and help with basic tasks around the house and garden.

We were told staff felt the SPCC service was extremely effective as it enabled people to have their wishes and choices respected regarding their preferred place of care in the last days of their life. We were told it had also led to a reduction in accident and emergency attendances, hospital and hospice admissions and also people could be more effectively and rapidly discharged from hospital.

We were shown the data from the year 2015 that had been collated in relation to the increase of people who had died at home (including care homes) and the reduction of inappropriate hospital admissions and A&E attendances. We were shown a comparison between the National Statistics and Springhill Hospice statistics. The statistics showed there was a significant difference in the percentages. Nationally, deaths in hospitals for people with a cancer diagnosis were significantly higher than those for the hospitals within the area served by Springhill Hospice. Deaths in people's own homes and care homes were significantly higher in the hospice statistics than the National figures. Hospice staff believe that the significant differences are due to the flexibility and responsiveness of the SPCC service and their ability to manage crisis situations. Hospice staff also believe that the increase in people dying in care homes reflects the increased confidence the care home staff had in caring for people at the end of their life.

We were told by the registered manager about the other services and facilities in place to support people's health care needs. A Hospice at Home service was available to deliver care and support for people during the last days of their life. The Hospice at Home provides a flexible and responsive nursing service in the person's own home, between the hours of 8am and 10pm and is staffed by the experienced registered nurses from the hospice Inpatient Ward.

There was also a 24 hour advice telephone line managed by the registered nurses on the Inpatient Ward. The nurses are able to offer advice to people, families and healthcare professionals on symptom control and/or signpost them to other relevant services. The registered manager told us there had actually been a decrease in the number of calls made to the 24 hour advice line since the launch of the SPCC service. Staff believe this is due to the fact the SPCC service is more accessible and responsive. We were told that previously people would ring the advice line because they were not always able to contact the Macmillan nurse service.

During the inspection we visited the Day Hospice. One of the nurses we spoke with told us that attending the Day Hospice gave people the opportunity to have a meal, talk about things that mattered to them and to join in, if they wished, with the activities that took place. We were told the Day Hospice was open four days a week and people usually attended once a week for a 12 week period. We spoke with one of the people attending. They told us, "It is absolutely magical. I can't praise them enough. They [staff] are so good and will take the time to sit and talk with me. I am not due back now until near Christmas and I shall miss them all". We also spoke with one of the volunteer drivers who told us, "People always seem happy to come here and happier when they leave. I have never heard anybody complain, ever".

Whilst attending the Day Hospice people were able to access the services available to the inpatients, such as; medical and nursing consultations, complementary therapies such as aromatherapy and massage, hairdressing, arts and crafts and spiritual and psychological support.

The registered manager told us that the hospice had links with organisations such as Hospice UK Greater

Manchester, Lancashire and South Cumbria Clinical Network Groups and The National Council for Palliative Care. Having these links enabled them to share good practice, develop their skills and knowledge and offer support to each other; helping to ensure people received the best possible care. One of the examples of sharing good practice was the development of The Individual Plan of Care and Support for the Dying Person in the Last Days and Hours of Life.

We were told that people were supported at the end of their life to have a comfortable, dignified and pain free death. A discussion with the nursing staff and the education facilitators showed they were highly skilled in pain and symptom control. A relative told us, "I can't thank them enough. They are doing everything possible to make [relative] comfortable and pain free".

The registered manager told us that, in addition to staff having an annual appraisal, all staff had peer support supervisions and reflective practice sessions. Supervision meetings help staff discuss their performance, any learning and development needs they may have and raise good practice ideas. We saw records to confirm staff received an annual appraisal which included a review of performance and progress within a 12 month period. All the staff we spoke with told us they felt very well supported and valued by their managers.

We were told that verbal 'handover' meetings between the staff were undertaken on every shift. This was to help ensure that any change in a person's condition and subsequent alterations to their care and treatment were properly communicated and understood. We were also told that the palliative care doctors saw each person every day and that any subsequent change in their treatment and care was documented and also verbally relayed to the nursing staff. We saw two of the doctors attending to people on the ward throughout the day. We also saw the hospice community doctor in consultation with a person who was attending the day hospice.

We asked the registered manager to tell us what they understood about the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes, hospices and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

What the registered manager told us demonstrated they had a good understanding of the MCA and DoLS and knew the procedures to follow if an authorisation was required. We were told that no person in the hospice was subject to a DoLS.

From our discussions with people, our observations and a review of people's care records we saw that people were consulted with and, if able, consented to their care and support. We saw how staff requested people's consent before attending to their needs. One relative told us, "They [staff] do it in such a relaxed but informed way. So good". The registered manager told us that if people were not able to consent then a 'best interest' meeting would be held on their behalf. A 'best interest' meeting is where other professionals, and family where relevant, decide on the course of action to take to ensure the best outcome for the person using the service.

We checked to see if people were provided with a choice of suitable and nutritious food to ensure their health care needs were met. People we spoke with commented positively on the choice and quality of the

food available. Comments made included; "The food is wonderful and is always nicely presented. They will make anything that [relative] fancies" and "The meals are truly lovely. I feel a lot of care goes into making sure people enjoy their meals".

There was a dining room close to the Inpatient Ward that was for everybody's use. Visitors told us how they were encouraged by staff to make drinks for themselves. They told us how they were able to have meals and snacks and how the staff encouraged them to have refreshments and dine with their relative where possible. We saw that individual trays were prepared for people who chose to eat in their rooms. These were nicely decorated with paper tray cloths and had individual condiments so that people could season their food as they wished. We also observed how people were gently and patiently encouraged by staff to eat appetising meals and have nutritious drinks.

One of the volunteers we spoke with told us, "I tell people what's on the menu and I try to find something they like. There's a black book in the kitchen with people's likes and dislikes in". We were told that drinks and snacks were offered regularly throughout the day and during the night if required.

We were told none of the people who used the service had any religious or cultural dietary requirements. The registered manager told us there would be no problem accessing halal or kosher foods if they were required.

The two care records we looked at showed the people were assessed in relation to the risk of inadequate nutrition and hydration, and action, such as referral to a dietician or a speech and language therapist, was taken if a risk was identified.

We found that sufficient and suitable equipment and adaptations were available to meet people's' needs. Each person on the Inpatient Ward had a special type of bed that helped staff position them more easily. The beds and chairs had a pressure relieving mattress in place to promote comfort and help prevent pressure ulcers developing.

We saw that bathrooms and toilets had been planned to increase accessibility and promote people's independence and comfort. Each bathroom had a variety of different hoisting equipment and had different grab rails that patients could use to aid their movement. We saw the grab rails were red, making them more visible for people with a visual impairment.

The grounds were extensive, very well kept and well planned. There were outdoor covered areas so that people could, despite inclement weather, go outside at any time they wished to. There was plenty of outdoor seating; arranged in small cosy groups. The registered manager told us this was to promote people's privacy and allow people the opportunity to spend time either on their own or with their visitors. We saw the gardens were well used and people were involved in gardening groups and a 'Good to Grow' project.

We saw that visitors, including children, were made welcome by the staff and there were no restrictions on visiting times. In the event of a person nearing the end of their life, visitors who wished to stay close to them could stay in one of the two 'family suites' available. This showed to us that the hospice recognised and considered the importance of caring for the needs of all family members and friends during such a difficult time.

We also asked about the care provided to a person after they had died. We were shown the pleasantly furnished and decorated temperature controlled room where the person was taken. We were told family

and friends were able to spend quiet, private time with the person until they were taken to the funeral home.

Outstanding ☆

Is the service caring?

Our findings

The expressions of gratitude relayed to us, demonstrated that people were cared for with the utmost compassion, kindness, dignity and respect. Comments made included; "What an amazing place. The care [relative] receives is second to none. The staff are brilliant, especially [staff member]. She is phenomenal, absolutely phenomenal" and "They are so caring, approachable, kind and understanding. They care about us as well". Also, "From the first contact, nothing is too much trouble. They have boundless patience".

Comments from the 'feedback surveys' we looked at included; "Everything was done well with great love, care and attention. Not only did you look after [relative] you looked after me also", "End of life care was respectful and compassionate" and "Showed respect at all times. Always explained what they [the nurses] were doing. Asked if what they did was alright with me. Always talked to my [relative] and told [relative] what they were doing". Also, "The specialist nurses have been wonderful; helpful, factual and kind".

The entrance area was spacious and had a reception area that was staffed by volunteers. During our inspection we heard people being greeted warmly by the volunteers at the reception desk. There was also a small shop in the reception area where people could buy sweets, cards and gifts. We saw there were lots of leaflets available for people. The information leaflets provided information on the facilities and services provided by the hospice and covered a range of topics such as; complementary therapies, bereavement services, counselling and psychotherapy services, information about advocacy services and information about other organisations that provided support and could possibly be of some benefit to them. This meant people were supported to have access to information to help them make decisions about their care.

We found the environment had been organised in a way that promoted people's privacy, dignity and confidentiality. There were several small lounges, each with a seating area. The seating was in a variety of styles and fabrics to ensure people could find a seat that they were comfortable with. Seats were arranged in small groups, allowing people to sit and talk privately to each other or to their visitors. We saw a children's play area in one lounge that had lots of toys for children of different ages.

There was a computer for people and their visitors to use. We were told about one occasion when the daughter of one of the people on the Inpatient Ward had got married abroad and the father had not been able to attend. To ensure the bride's father did not miss out totally a party had been arranged at the hospice and the guests had watched the wedding via the internet. Cakes and champagne had been provided.

We were shown a web camera that had been hidden in a nest box in the garden so that people could enjoy watching the nesting birds on the computer.

From our observations we saw that staff approached people in a kind and sensitive manner, although there was still plenty of friendly banter, both on the Inpatient Ward and the Day Hospice. Staff asked permission before entering bedrooms or going behind closed curtains. All the staff we spoke with, including volunteers, spoke passionately about ensuring that people and their families were cared for with dignity and compassion. Staff told us they felt proud to be working at the hospice and proud of the care they delivered.

One volunteer told us, "It's such a wonderful place. I love it as much now as the first day I came. If people want to chat then I do; there's nothing more important."

We found the hospice had placed great importance on ensuring that people's bathing experience was not just a task but was something that was pleasurable and relaxing. We were shown two Jacuzzi baths that could be accessed using hoisting equipment if it was needed. We saw that one of the baths was in a room that had lighting that could be dimmed. The bath had its own lights and people could put their own music on its integral music system. There was a beautiful outdoor scene made of glass on the wall, this was back-lit and gave the impression that you were looking out of a window. Staff told us that people loved using the bath as it created a peaceful calming experience. The bath also had a very comfortable padded armchair-like seat, a staff call system and secure harness strapping that people could use if they needed it. This enabled people to have time on their own and a relaxing bath in privacy.

We asked the registered manager to tell us what happened when a person was extremely ill but wished to spend their final days at home. We were told that everything possible would be done to ensure the person's wishes were respected. We were told about the partnership working in place between the Specialist Palliative Care Community Service and the community services to ensure that peoples' needs and wishes would be met.

We found that great care was taken to ensure people's spiritual needs were respected and promoted. The nursing staff we spoke with told us that the spiritual and pastoral support of people who used the service and their families was always considered and respected. We saw that information about the beliefs and practices of various religions was available for all staff and volunteers to read. This helped staff to meet the needs of the cultural and religious communities they cared for.

The hospice had a Spiritual and Pastoral Care Coordinator who was available Monday to Thursday, coinciding with the days the Day Hospice was open. We were told about the services that were available for people, regardless of their religious faith. We visited the chapel and the adjoining quiet room and saw how the needs of a multi faith community were met. Religious symbols and books from a variety of faiths were available for people to use. Both the chapel and the quiet room were open 24 hours a day and were available for people, including staff, to either sit and pray or just quietly reflect. We were told that people could choose to have their own clergy visit them and also take Holy Communion if they wished.

We saw there was a 'memorial beach' in the chapel where people who were bereaved could place a pebble with the name of their loved one on. We were told this gave people an opportunity to express their love and their loss through this symbolic act. There were many named pebbles in place on the 'beach'.

We were told the hospice had links with a 'Mind' professional. 'Mind' is a mental health charity that offers information and advice to people with mental health problems. We were told the professional was available, if needed, to offer advice and support for the staff when caring for any person living with dementia or any other mental health issue.

The hospice counselling service is a member of the British Association for Counselling and Psychotherapy (BACP). BACP accreditation is a widely-valued quality status for practitioners, organisations and training courses, designed to recognise the achievement of high standards of knowledge, experience and development. We spent some time speaking with staff from the counselling and psychotherapy department who told us they worked alongside the doctors and nurses to provide psychological support to people and their families. We were also told about the Bereavement Support Service that was available. The Bereavement Support Service is available to any family members or friends of someone who has died in the

care of any of the hospice services. We were told that bereavement support took many forms such as; on a one to one basis with a counsellor, weekly or monthly support groups meetings with a counsellor and volunteer and Grief and Well- Being Workshops. In addition we were told about the 'Ecotherapy Programme' that was available to all bereaved people who had already used the counselling or group services at the hospice. This is a programme where people undertake activities such as; gardening, willow weaving and cookery. Its aim is to improve people's well- being and bring about positive changes in their lives.

We were told that the hospice held regular remembrance services every second month. They are non-religious services and are dedicated to people who have recently died. Every Christmas the hospice has a 'Lights of Love' Christmas tree where bereaved people are able to hang a message on a branch in memory of their loved one.

Following the inspection we contacted external healthcare professionals to seek their views on the care and service provided. We received very positive feedback. One community nurse told us of an occasion when the hospice doctor stayed very late into the evening at a person's home to ensure that the person's pain and symptoms were well controlled; allowing them a peaceful and dignified death.

Good

Is the service responsive?

Our findings

People spoke about the responsiveness of both the nursing and medical staff to their questions, and their ability to give straightforward answers and information in a kind and sensitive way. A relative we spoke with on the Inpatient Ward told us that the response by staff to people's needs was, "Just unbelievable. I am so grateful to them all."

Comments from the 'feedback surveys' we looked at included; "The response time when we needed you was amazing. The way the staff dealt with all members of the family was amazing" and "Quick response when I called for help. You ensured that we had the night sitters whenever needed". Also, "There is nothing more that could have been done any better. The service was great".

We were told that that on receipt of a referral for attendance at the Day Hospice or admission to the Inpatient Ward an assessment of people's needs was undertaken by the hospice clinical team. The decision to admit a person to the Inpatient Ward was then prioritised according to their clinical need. We were told that on admission the person and their family were involved in the decision making about the treatment, care and therapies available to them. It was clear from the information contained within the care plans that people had been involved in the planning of their care.

We saw the admission documentation contained information that 'followed' the person throughout the service. The two care records we looked at contained sufficient information to show how the person was to be supported and cared for. We saw people were supported to make advanced care plans. The care and medical records showed where discussions had taken place with people about their wishes, especially in relation to whether they wished to be resuscitated or sent to hospital. A person's preferred place of care at all stages of their illness and the arrangements in the event of their death were documented.

A discussion with the staff showed they were passionate about providing good quality end of life care. Training records and discussions showed that the hospice staff were skilled in recognising when a person was in the last days of life. We were shown the 'Individual Plan of Care and Support for the Dying Person in the Last days and Hours of Life' document that had recently been introduced in the hospice Inpatient Ward. This document included information and guidance for staff in relation to the priorities of care in the last days of life. This included issues such as an individual plan of care covering aspects of food and drink, symptom control, psychological, social and spiritual support. Also the recognition of dying, preferences of care, advanced care plans and communication with the person and their family.

We saw that people had medical notes in addition to nursing care plans. Nursing staff told us they could access the medical notes at any time if they needed to.

We were told that people were discharged from the hospice Inpatient Ward if and when it was appropriate. The discharge of people involved an individual assessment of their needs, including needs of their family We were told a copy of their care documents and a written summary of their needs would accompany them. We were told that lines of communication were established with people, both past and present, by ensuring

that the hospice contact telephone number and 24hour advice line numbers were given to people who were to be involved in their care and support.

The hospice had a complaints procedure that was included in the Springhill Hospice Information Pack. The complaints procedure told people how they could complain and what the service would do about their complaint. It also told people what they could do if they were unhappy with how the service had dealt with their complaint. Records we looked at showed there was a system for recording complaints and any action taken.

Good

Is the service well-led?

Our findings

There was a well-defined management structure within the hospice consisting of a board of trustees, an executive management team, an operational management team and a service delivery team. We were told the management structure within the hospice enabled staff and volunteers to understand the clear levels of responsibility and accountability. The registered manager, whose title was Director of Clinical Services, had extensive nursing experience and had been working at the hospice for several years. The registered manager was present during the inspection.

A discussion with the registered manager and the chief executive showed they were clear about the aims and objectives of the hospice. This was to ensure that the hospice was run in a way that supported the need for people to have the best quality specialist palliative and end of life care. In addition to respect all cultural, religious and personal beliefs, placing the emphasis of care on individual need.

We found the registered manager and the chief executive to be compassionate, caring and committed to providing the best quality care and support possible. They were enthusiastic and looked for opportunities to improve the experience of people who used the service, their friends and their families. The registered manager told us they had an 'open door policy'. They told us they walked around the hospice at least twice a day so they could see what was happening, but also so that people could talk to them if they wanted to. The registered manager told us, "I know my staff" and "This is a supportive environment".

We were made aware that the Inpatient Ward was managed by a ward sister who had been working at the hospice for many years and had a wealth of nursing and palliative care experience. The Hospice at Home team was staffed by the experienced nurses from the Inpatient Ward and the Day Hospice was run by a Psychological and Supportive Care team. This team consisted of counsellors, therapists and nurses to meet the varied and individual needs of people and their families.

The hospice demonstrated partnership working through their implementation of The Palliative Care Education Passport and the Specialist Palliative Care Community Service. We were told about the monthly meetings held with other professionals such as; GPs, the Bury and Rochdale emergency doctor service (BARDOC), local hospital trusts, and the police and ambulance services. The purpose of these meetings was to discuss best practice, lessons learnt and to work towards reducing the number of people at the end of life who die in hospital; enabling them to be in their preferred place of care.

We were also told about the links the hospice had with groups representing minority ethnic communities and with the Prison Service. The links were formed in response to the report from the National Council for Palliative Care and the Dying Matters Coalition report that highlighted the inequalities in end of life care. We were told that because of these links, the education facilitators were able to communicate to other professionals the need for an equality- led approach that responded to people's individual needs and wishes.

Staff and volunteers spoke positively and passionately about working at the hospice. They told us they felt

valued and supported. Staff were eager to tell us about their role and their responsibilities. They told us they had regular staff meetings, normally every two months but felt able to talk to their manager or their peers at any time and about anything. The registered manager and the chief executive told us they felt it was important for their staff and volunteers to feel supported and valued and to know that their opinions, suggestions and comments were acted upon. In order to seek staff views they undertook an annual anonymous satisfaction survey. In total for the years of 2015/2016, 517 were sent out and 240 were returned. We looked at the responses and saw overall the responses were very positive in relation to training, team working, patient care and respect for people's dignity and equality. Where staff had expressed dissatisfaction, management had implemented action plans to address the issues raised.

We saw that management sought feedback from people who used the service, their families and visitors through the use of comments boxes and 'tell us what you think' cards that were placed throughout the building. 'Tell us what you think' cards, complete with a pre- paid envelope, were also contained within the information / welcome pack that was given to people being cared for within the community. These allowed people to give their views on the service and facilities provided.

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help registered providers to assess the safety and quality of their services. This helps to ensure they provide people with a good service and meet appropriate quality standards and legal obligations. The service had a good system of daily, weekly, monthly and annual audits such as; infection control, staff recruitment, clinical documentation, medication, falls and injuries.

Records we looked at showed there were operational managers meetings twice each month where managers from all departments of the hospice looked at audits and issues around the management of the hospice, such as training, health and safety, clinical issues and fund raising. We saw that issues raised were also taken to the governance meetings. These were committees which met each month to have an oversight of the running of the hospice. Records we looked at showed they included a risk committee that looked at risk assessments, complaints and accidents/ incidents. This demonstrated to us that the hospice had clear lines of accountability and effective methods of communication to ensure people received the best possible service.

We checked our records before the inspection and saw that accidents or incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always given their medicines as prescribed, appropriate systems were not in place for the management of medicines requiring refrigeration and relevant information was not in place to enable staff to administer when required medicines safely.