Wirral Hospice St John's

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Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Not all staff administering medicines through a syringe driver had completed a competency assessment as part of training updates.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good 	Our rating of this service stayed the same. We rated it as good. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Page

Background to Wirral Hospice St John's 5

Information about Wirral Hospice St John's 5

Our findings from this inspection

Overview of ratings 6

Our findings by main service 7

Summary of this inspection

Background to Wirral Hospice St John's

Wirral Hospice St John's is a hospice providing palliative and end of life care to adults with life limiting conditions. The hospice is situated in Higher Bebington, on the site of the Clatterbridge Hospital and services the Wirral community. The hospice has 16 inpatient beds. At the time of the inspection 10 patients were being cared for on the inpatient unit.

Facilities include an inpatient unit, hospice at home service, outpatient services and wellbeing and family support services. The director of clinical services was the registered manager.

The service is registered with the CQC to provide:

Treatment of disease, disorder and injury

Diagnostic and screening procedures

How we carried out this inspection

We visited the hospice and spoke with staff delivering services. We held interviews with service leads. We spoke with 13 staff including the chief executive officer, the medical director, clinical services lead, director of workforce, learning and development leads, the community services manager, facilities staff, registered nurses, clinical pharmacist, medicines management technician and healthcare assistants. We also spoke with one patient who was being supported by the service. We observed care and treatment provided, reviewed data about the service and reviewed seven patient care records.

We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed to seek assurance about this decision and to identify learning about the DMA process. This was a focused inspection of the safe and well-led key questions.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service SHOULD take to improve:

- The service should ensure that the syringe driver competency assessments introduced by the hospice are routinely carried out as part of regular training updates.
- Managers should continue with plans to ensure that learning disability awareness training is completed at the earliest opportunity once this is available.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospice services for adults	Good	Not inspected	Not inspected	Not inspected	Good	Good
Overall	Good	Not inspected	Not inspected	Not inspected	Good	Good

Good

Hospice services for adults

Safe	Good
Well-led	Good

Are Hospice services for adults safe?

Good

Our rating of safe stayed the same. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. Overall mandatory training compliance was 91%, against a target of 85%.

The mandatory training was comprehensive and met the needs of patients and staff. This included infection control, information governance, fire safety, manual handling and equality and diversity.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Training for learning disability awareness was low at 37% completion, however, this was due to the online module being under maintenance. Managers had clear plans to ensure all staff completed this training as soon as possible.

Managers monitored mandatory training and alerted staff when they needed to update their training. We saw that staff were given time to complete their training and managers had target dates for completion, they followed this up with staff.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. All clinical staff had received level two safeguarding training for both vulnerable adults and children. Senior staff and consultants had completed level three safeguarding adults training. Social work staff had completed level three safeguarding for both adults and children.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The safeguarding policy included clear guidance and contact details for escalating concerns to the appropriate agencies.

Good

Hospice services for adults

Cleanliness, infection control and hygiene

Staff used infection control measures when caring for patients

The inpatient unit was clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. Infection control and cleaning audits were carried out as part of routine monitoring of cleanliness.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Patient areas were cleaned daily, including deep cleaning as required. Records demonstrated that cleaning was undertaken as scheduled.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff in clinical areas using PPE, including face masks when in contact with patients and visitors. There were hand washing facilities throughout the hospice, and we observed staff and visitors washing their hands.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. We observed staff closely monitoring patients in their care.

The design of the environment followed national guidance. The inpatient unit consisted of seven single rooms with en suite facilities. There were three bays, each made up of three beds, with bathrooms close by. Room spaces had been reduced to enable Covid-19 social distancing restrictions. Rooms were designed to provide comfort and privacy.

Staff carried out daily safety checks of specialist equipment. This included emergency equipment such as a defibrillator.

The service had suitable facilities to meet the needs of patients' families. They had a family room that could accommodate overnight stays when patients were at the end of life.

The service had enough suitable equipment to help them to safely care for patients. Syringe pumps (for the continuous administration of some medicines) were available in line with recommended guidelines and were appropriately checked during administration. Staff had received training in the use of syringe pumps. The arrangements for assessing the competency of staff in the administration of medicines through this method had not been implemented in a timely way. However, immediately following the inspection managers took action to ensure assessments were completed. Records showed that approximately 75% of nursing staff had received a competency assessment and there were clear plans to carry out the assessments on the remaining staff at the earliest opportunity.

Staff disposed of clinical waste safely. Clinical waste areas were secure. Sharps bins were correctly labelled and disposed of within the appropriate timeline in line with national guidance.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Good

Hospice services for adults

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff identified patients at risk of deterioration and used treatment escalation plans and levels of treatment as appropriate to the needs and wishes of the patient and their family. This included identifying if and when patients may be transferred to an acute setting should their condition deteriorate.

Staff knew about and dealt with any specific risk issues. This included identifying and monitoring infections. Risk assessments helped staff to identify the risk of falls and pressure ulcers, and support required for areas such as nutrition, hydration and mobilisation.

The hospice had a sepsis protocol and staff had received training. We saw posters with prompts to remind staff what symptoms and red flags to be aware of. Clinicians were in the process of carrying out a retrospective audit of intravenous antibiotic prescribing of patients who met the sepsis criteria.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff had received training in suicide prevention as part of learning from a specific incident.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. They held daily safety huddles where specific risks were reviewed, and new risks identified. The huddles included contribution from a range of hospice staff.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. They had their own bank of staff to cover shifts when required. The managers could adjust staffing levels daily according to the needs of patients.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. The number of nurses and healthcare assistants matched the planned numbers. At the time of our inspection there were three registered nurses and three healthcare assistants working during the day, there were two registered nurses and two healthcare assistants working at night. We viewed rotas that showed these staffing levels were consistent.

The service had low and reducing vacancy rates. The vacancy rate for nurses working on the inpatient unit was 0.7% in August 2022, an improvement from 1.85% in June 2022. The unit had a 1.48% over establishment of healthcare assistants. The vacancy rate for registered nurses in the hospice community services team had improved from 1.73% to 0.93% in August 2022.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. There were seven specialist palliative care consultants employed by the local NHS trust, of which two (1.4 whole time equivalents) were funded by the hospice. One of the consultants was the medical director for the hospice. All the consultants worked across the hospice, hospital and community palliative care service and worked at least one session a week at the hospice.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. There were three junior doctors based at the hospice, including one GP and two speciality doctors. They received direct supervision from the consultants. In addition, there were GP trainees and specialist palliative registrar trainees rotating through the services.

The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. The service used an electronic patient record that could be accessed by staff on the inpatient unit and the community services. We reviewed seven patient records and found these were contemporaneous and reflected the needs and wishes of patients. There was appropriate information within the records to keep patients safe and ensure information was recorded to meet their care needs.

When patients transferred to the hospice or other teams in the community, there were no delays in staff accessing their records. There were appropriate security and consent protocols in place for this.

Records were stored securely. The electronic record system was password protected and computers were appropriately shut down when unattended.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The service employed a palliative care pharmacist five days per week and a medicines management technician for five afternoons each week who ensured medicines were managed safely.

The service had electronic prescribing and administration which linked directly to the patients GP and local pharmacy. The pharmacist had produced a doctor's induction guide for prescribing at the hospice and was involved in training and competency checking staff who managed and administered medicines.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. Pharmacy staff prepared for patient's needs in advance of them being admitted to the hospice, using electronic records and details were accessible to all appropriate staff. An individualised pharmaceutical care plan was created for each patient, which included how patients preferred to take their medicines and guides for patients when they went home. Prescribing was clear, safe and appropriate which enabled staff to respond to symptoms that patients may experience during their stay including making sure patients had adequate pain relief.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. We found medicines were stored securely, and regular checks were done to ensure medicines were safe to use. Patients were able to administer their own medicines, once assessed as safe to do so and safe storage was provided.

Staff followed current national practice to check patients had the correct medicines, which began by checking prescriptions prior to admission, and was followed with regular patient consultation by the medicines team on the ward.

A quarterly summary of incidents and a medicines team brief was produced by the pharmacy team, which ensured staff knew about safety alerts and incidents. We saw examples of improvements made following incidents and near miss investigations which ensured continuing patient safety. For example, after one incident, an additional policy regarding illicit substances was written and a copy of the emergency recovery guidance was placed with the required medicine.

Medicines audits were carried out on a rolling cycle and included controlled drugs storage, medicines security, opiate prescribing, late dose administration and expiry date checks. This ensured continuous improvements could be made and staff had assurance that medicines were managed safely.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. This included falls, pressure ulcers, medication errors and other incidents.

Staff raised concerns and reported incidents and near misses in line with the service's policy. Staff understood how to raise a concern and felt confident doing so. There were processes in place to support staff to complete appropriate records and all incidents and near misses were reviewed by senior staff.

Staff reported serious incidents clearly and in line with the service's policy. We saw an example of a comprehensive report of a serious incident with analysis of the root cause. Managers debriefed and supported staff after any serious incident.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. We saw evidence that they involved patients and families in actions to improve safety as a result.

Staff received feedback from investigation of incidents. There was evidence that changes had been made as a result of feedback. This included the use of safety huddles to discuss safety incidents and concerns and improve safety for patients. Specific action included moving patients at risk of falls closer to the nursing station.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers collated incident reports into quarterly reviews of all incidents and near misses. Data relating to falls, pressure ulcers and medicine incidents was submitted to Hospice UK as part of national benchmarking. At the time of the inspection, the benchmarking data report had not been received.

Good

Hospice services for adults

Are Hospice services for adults well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Senior staff and managers had clear leadership roles. They demonstrated the skills, capacity and capability to deliver a sustainable service. Service leads understood the issues and challenges within the service and demonstrated a comprehensive understanding of the priorities for supporting patients within the local community. They worked collaboratively with partner organisations and professionals to deliver high-quality, patient centred services.

Staff told us that leaders were visible and approachable, and there was a clear focus on the needs of patients and the wellbeing of staff.

Staff had opportunities to develop their leadership skills. For example, ward sisters had taken part in a leadership training programme.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Wirral Hospice St John's aimed to offer care and support for patients and their families living with a life limiting illness, based around what was important for them. They had a 2020 – 2023 strategy with strategic aims that included increasing the reach of the service, securing sustainable income for service delivery and developments, being an employer of choice and being recognised as an effective, efficient and thriving organisation.

An annual delivery plan was in place, providing an overview of key projects to deliver the strategy. Key performance indicators had been established and progress was closely monitored by the senior leadership team and board of trustees. We viewed an integrated monitoring report that demonstrated progress against the plan. Progress was measured using a red, amber, green (RAG) rating.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke to told us they enjoyed working at the service and felt supported by the registered manager and senior staff. They were proud to work for the service and there was a collaborative approach to supporting patients and those close to them. Staff were valued within their roles and had opportunities to develop their careers. Training was available, including in relation to career progression and part of the hospice's ongoing strategy was to build an organisational culture that supported the delivery of high quality care.

Staff told us they were able to raise concerns and they felt confident they would be addressed. They had access to an employee assist programme and the hospice provided staff and volunteer wellbeing events that included alternative therapies and tea and cake. One of the trustees was a freedom to speak up guardian, providing staff with advice and support should they wish to raise concerns. There was also a staff forum where teams and departments were represented and where staff had input into decision making within the hospice.

The provider fostered a culture of openness and honesty. Staff had an understanding of the duty of candour and understood the requirement for openness and honesty with patients and those close to them when things went wrong.

The service promoted equality and diversity in daily work. Staff had completed equality and diversity training. They had an equality policy and diversity statement with a commitment to promoting workforce equality. Examples of work relating to this included a review of trustee recruitment to ensure the community was represented. Advertisements had been written to appeal to a broader representation of the community and an open evening was held to meet with more of the community. In addition, work was underway to ensure appropriate representation across the staff group and this was an area being looked at with the staff forum.

The registered manager was the equality and diversity lead and they were responsible for ensuring compliance with equality, diversity and inclusion legislation. Areas of specific action included promoting equality for people with disabilities, those with dementia and people from different ethnic backgrounds. The hospice had previously had LGBTQ+ leads within the service who had left, managers were in the process of replacing them.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective governance structures, processes and systems of accountability and a clear governance framework to support the delivery of the hospice strategy. The hospice senior leadership team were accountable to the board of trustees. Information was shared at board of trustee's meetings where chief executive officer and director reports were reviewed.

Members of the board of trustees committee also chaired specific sub committees. This included clinical governance, income generation and marketing, workforce governance and finance and infrastructure governance. We saw that issues around quality and risk were discussed at these meetings. A quarterly quality group meeting was chaired by the registered manager, with attendance from managers and senior staff. We saw that issues such as clinical audit, health and safety, training compliance, service development and policy approvals were discussed at these meetings.

Staff were clear about their roles and accountabilities and who to report to. Staff were committed to improving the quality of service and maintaining high standards of care. They were involved in discussions about the performance of the service and were encouraged to work collaboratively to develop the service.

Good

Hospice services for adults

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There were clear processes for identifying and managing risks. Clinical and operational risk registers were maintained. Risks included those relating to staffing levels and we saw that action was comprehensively planned to mitigate the risk. We also saw outcomes of recent recruitment efforts had been successful and vacancy rates within the clinical service had reduced as a result. Health and safety risks were identified through regular walk arounds. Reports were collated of actions taken and these included pictures that were shared with staff to present a visual of risks as they were identified.

Performance was monitored by the senior leadership team. This included monitoring of ongoing risk areas such as falls, medicines, safeguarding and infection control. Information was used to monitor activities relating to incidents, performance indicators, activity levels, patient feedback, staffing and other areas. The hospice had developed key performance indicators across all services and departments, and these were monitored on a monthly basis, for example, in relation to the responsiveness of referrals to services.

The service had a business continuity plan in the event of disruption of service.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Information and data were used as part of ongoing monitoring of the service. Performance reports were comprehensive and provided enough detail and analysed data and this was used to demonstrate the effectiveness of services and identify areas for improvement.

Staff had up to date and comprehensive information about patient's treatment and care. They used an integrated patient record system that was accessible to other providers involved in their care who were using the same information system. There were clear and standardised information governance processes that ensured the security of patient information. Computers were encrypted and password protected, and we observed staff maintaining the confidentiality of patient records.

Managers understood their responsibilities to notify external organisations, including the Care Quality Commission of incidents that met the reporting threshold. Information was submitted to Hospice UK about incidents relating to falls, pressure ulcers and medicines incidents as part of national hospice benchmarking.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Patients were encouraged to provide feedback on services and service leads actively engaged with patients and those close to them to share their experience and make suggestions. The hospice engaged with stakeholders around specific

projects. For example, one area they were exploring was improving access to end of life care for homeless people. As part of the development of this they were engaging with a stakeholder group that included local staff and service users with experience of homelessness. Other areas of service development that came about following involvement with stakeholders included the development of bereavement services for children and young people.

There were a range of forums and networks that the service participated in to ensure engagement with the local community. Leads also worked closely with the council and other providers to develop the specialist palliative care input locally. In addition, the chief executive officer set up the local hospice chief executive officer's group, where ten hospice leads' meet regularly and collaborate. Other areas of local improvement that the hospice had been active in developing included setting up a local training hub, providing support for end of life care specialist staff working across the locality that involved other hospices within the area.

The hospice worked closely with the NHS trust community specialist palliative care team and hosted the service within the hospice. This included jointly providing the Wirral Palliative Care Advice Line, accessed by patients and professionals, where the community team staffed during the day and the hospice staffed this in the evening and overnight.

The service actively engaged staff in decision making and they were involved in monitoring and evaluating the performance of services. This included a staff forum where staff representatives met regularly with members of the senior leadership team.

New staff had 'breakfast with the chief executive' scheduled into their induction plan. Staff surveys were routinely carried out and leaders took action to prioritise areas for improvement. This included work to improve communication and morale. Specific activities included staff workshops for staff to have their say and comment boxes situated throughout the hospice so that staff could share their ideas.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There was a range of quality improvement activities within the hospice and staff actively participated in these. We saw that services were regularly reviewed to ensure they met the needs of patients and the local community. There were clear quality improvement aims identified. Examples included areas such as workforce development, advance care planning and the development of career pathways.

Specific service improvements had been developed in relation to improving patients' experience. These included the development of a service for people with motor neurone disease (MND). An MND key worker post and counselling provision was developed in partnership with the MND Association. The hospice worked with a local university services to evaluate the impact of the service. Results showed improved outcomes for patients and their families in terms of the positive benefits experienced. Project leads were scheduled to present the findings from this project at a national conference.

Other service developments included improving the transition from children to adults' palliative care services for young people with a life limiting condition, where the hospice worked collaboratively with the local children's hospice to support this transition for patients.

Good

Hospice services for adults

There were clear processes for learning from complaints and when things went wrong. All staff were involved in discussions and learning, including reviewing patient feedback. For example, following a multi-agency complaint where a patient did not access appropriate services because they were not aware of them led to the development of a local information leaflet for patients, families and carers.

The hospice was involved in research around palliative and end of life care. Examples included a National Institute of Health Research project to develop palliative and end of life care research partnerships and capacity in the North West. The hospice was also involved in research around clinically assisted hydration at the end of life and the development of a remote monitoring system for patients and their carers in the last six months of life.

Hospice staff set up the Wirral Palliative Care Education HUB in partnership with the local and acute health care trusts palliative care specialists, to jointly deliver education on palliative care issues to health and social care staff from the Wirral and surrounding areas.