Wirral Hospice St John's

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Inspection report

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Ratings

Overall rating for this service	Good ●

Is the service safe?	**Good** ●
Is the service effective?	**Good** ●
Is the service caring?	**Good** ●
Is the service responsive?	**Good** ●
Is the service well-led?	**Good** ●

Summary of findings

Overall summary

Wirral Hospice St John's provides specialist palliative care and support for adults with severe and progressive disease, when treatment to cure the disease is no longer possible. The service works in conjunction with Wirral hospital and community specialist palliative care teams to provide an integrated service for people. People are referred to Wirral Hospice St John's by their GP, hospital consultant, or Integrated Specialist Palliative Care Team. The hospice service is available to all, free of charge. We last inspected Wirral Hospice St John's on 28 November 2013 when we found the service to be compliant in all of the areas we looked at.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of our visit the service had a registered manager and a number of other senior staff with responsibility for various aspects of the organisation.

The service provides an in-patient service for a maximum of 16 people and day services for a maximum of 12 people per day. They also provide social and emotional support in people's own homes but this does not include nursing or personal care. People are admitted to the hospice for assessment and management of complex symptoms and rehabilitation following treatment. The average length of stay is approximately two weeks.

Care is provided by a specialist team of doctors, nurses, healthcare assistants, a social worker, physiotherapist, occupational therapist, psychologist and aromatherapist. They are supported by a creative therapist, a chaplain, bereavement counsellors, housekeeping and maintenance teams, education staff, finance, administration and fundraising staff. At the time of the inspection, the service had 502 volunteers working in various roles throughout the organisation.

During our visits we saw that the premises were safe and clean and a programme of regular planned maintenance was in place. We observed that medicines were stored, checked, administered, recorded and disposed of safely.

Staff and volunteers received annual mandatory training and were supported in their roles by the management team. People who used the service had a choice of nutritious meals and every effort was made to accommodate individual dietary needs and preferences. People's capacity to make decisions and give consent was assessed and recorded.

People were treated with kindness, compassion and respect. The specialist professional advisor commented 'General observations of interactions between staff, patients, and family members during the visit demonstrated caring, trusting relationships built on genuine respect, and person centred care was being delivered. Patients openly praised staff during introductions and interactions observed, and spoke very highly of the care they received. They all said they felt safe at the hospice and symptom management was effective.'

The quality of the service was assessed and monitored regularly by a series of external and internal auditing tools. People who used the service, and their families, were encouraged to give feedback and their observations and comments were acted on.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

The premises were clean and well maintained.

There were enough staff to support people and keep them safe. The required employment checks had been carried out when new staff were recruited to ensure they were suitable to work with vulnerable people

Medicines were managed safely.

Is the service effective?

Good ●

The service was effective.

A training programme was in place with regular updates for all staff.

People's capacity to make decisions and give consent was assessed and recorded.

Menus were planned to suit the individual needs and preferences of the people who used the service.

Is the service caring?

Good ●

The service was caring.

People spoke very highly of the kindness of the staff team.

Staff were attentive to people's needs and choices and treated them with respect.

Staff protected people's dignity and privacy when providing care for them.

Is the service responsive?

Good ●

The service was responsive.

People were encouraged to be involved in making choices regarding their care and treatment.

The care plans we looked at recorded people's needs and gave accurate and up to date information about their treatment regimes.

The hospice staff worked closely with community-based professionals to provide an integrated end of life care service.

A copy of the complaints procedure was displayed and complaints records were maintained.

Is the service well-led?

Good ●

The service was well led.

The service had a registered manager and other senior management staff had responsibility for specific aspects of the hospice service.

There was a positive, open and inclusive culture and people expressed confidence in the staff team.

Regular audits were carried out and recorded to monitor the quality of the service and people were encouraged to share their experience of the service.

Wirral Hospice St John's

Detailed findings

Background to this inspection

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

The inspection took place on 22 and 23 March 2016 and was announced. The inspection team consisted of an adult social care inspector and a specialist professional advisor (SPA). The SPA had considerable experience in providing hospice services.

Before our inspection we reviewed the information we held about the home, including the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications of incidents that the provider had sent us since the last inspection.

During the inspection we spoke with four people who were using the service and two relatives. We observed the care and support provided to people. We spoke with the registered manager, twelve members of staff, and three volunteers. We looked all around the premises. We looked at care records for three people who were receiving care and treatment at the hospice. We also looked at staff rotas, recruitment records for three new members of staff and staff training records. We looked at how medicines were managed and recorded and how the quality of the service was monitored. The registered manager, who was also the Chief Executive of the organisation, gave us an overview of local strategy and policy.

Good ●

Is the service safe?

Our findings

One person using the service told us "I am safe, I am well cared for - it is like a five star hotel. I'd upgrade that to a six star. The treatment has been amazing. The nurses are wonderful night and day. Every need they have been there." Another person told us if they asked for help of any kind the response was "pretty immediate. If I call they come."

Records showed that all staff received training about safeguarding vulnerable adults and children and this was updated every three years. A safeguarding forum had been set up to review and develop policy, practice and training. We were able to attend a meeting of the safeguarding forum. During the meeting it was confirmed that safeguarding training was up to date for all staff and volunteers who worked directly with people who used the service. A safeguarding log had been set up recently to keep track of any issues that occurred. We were told that previously, any safeguarding issues had been recorded only in the individual person's records.

The hospice employed a range of health and social care staff to meet people's physical, psychological and social needs. Care was provided by a specialist team of doctors, nurses, healthcare assistants, a social worker, physiotherapist, occupational therapist, psychologist and aromatherapist. They were supported by a creative therapist, a chaplain, bereavement counsellors, housekeeping and maintenance teams, education staff, finance, administration and fundraising staff. The service had 502 volunteers working in various roles throughout the organisation.

On the days of our inspection, 14 people were receiving in-patient treatment. The in-patient unit had a minimum of five nurses on duty in the morning, one or two of whom were senior nurses, and two healthcare assistants; three nurses and two healthcare assistants in the afternoon and evening; and three nurses and one healthcare assistant at night. The senior nurse who prepared the staff rotas told us that the flexibility of the team was "amazing" and this meant that additional staff could be deployed as and when needed. There were also medical staff, a pharmacist, nursing students, and volunteers working on the in-patient unit, with a doctor on call 24 hours a day, seven days a week. There were some bank staff and occasional use of agency staff. All of the healthcare assistants had a national vocational qualification (NVQ) level 2 and some had level 3.

Most staff were rotational, covering night and day shifts. The members of staff we spoke with felt staffing levels were good on the unit. Staffing levels were monitored at monthly establishment meetings and were displayed daily in the in-patient area. There was a six monthly staffing report to the Clinical Governance group.

We were told that there was no problem with recruiting new staff. Staff, including volunteers, were employed after a rigorous recruitment process. We looked at personnel records for three new members of staff. The files contained completed application forms, full details of previous employment, interview notes, at least two references including an employer reference, a record of medical screening, and a Disclosure and Barring Service check. These helped to ensure that the person would be suitable to work with vulnerable people.

In the Provider Information Return (PIR), the provider told us that a risk register was in use that identified organisational and clinical risk and was reviewed monthly by senior managers and trustees. Policies were reviewed regularly and new or revised policies were brought to staff attention in a monthly team brief. A 'serious untoward incident' policy and plan were in place. The hospice had a 'slips, trips and falls' multi-professional group who met quarterly to review all incidents involving slips, trips and falls and to consider and implement any necessary actions to prevent further mishaps. A falls policy had been developed and the group were looking at easier ways of completing falls care plans on the electronic patient records system.

Staff we spoke with could describe the accident and incident reporting process. A senior nurse described an example of an incident and how it had been managed and demonstrated understanding of the incident reporting procedures, how these linked to the risk assessment process, and how action was taken and feedback given. In the care files we looked at, relevant risk assessments had been carried out including the use of bedrails, falls, manual handling, nutrition, and skin integrity.

We spoke with the housekeeping manager who showed us the daily cleaning schedules that were completed by staff, and evidence of audits of the cleaning service. There was a comprehensive housekeeping schedule for each part of the premises with details of equipment and cleaning substances used. Housekeeping staff working on the in-patient unit read a communication diary in the nurses' office to find out any special requirements each day. Additional tasks, for example the cleaning of door handles, were done by volunteers. The hospice was awarded a five star food hygiene rating in May 2015.

Infection prevention and control policies and procedures were rewritten in 2012 and were reviewed annually. One of the hospice nurses worked three days a week in a clinical role and two days a week as infection control lead nurse. The in-patient unit had seven single bedrooms that could accommodate people who had an infection or who were particularly vulnerable to infection. Information about infection prevention and control was available for people who used the service and their visitors and staff received training every two years. People were screened for infection on admission to the hospice and 'alert' warnings were displayed if special precautions were needed. We observed that single use equipment was provided wherever possible.

We spoke with the facilities manager and looked at health and safety records. A schedule of planned maintenance was in place provided by the Wirral University Teaching Hospital NHS Trust. This included regular checks for Legionella and water treatment; maintenance of the piped oxygen supply; maintenance of the fire alarm system; servicing of boilers; testing and maintenance of the electrical installation, emergency lighting, and ventilation systems; annual gas safety check; and portable appliance testing. This was all costed and planned for the forthcoming year. The contract also included an out of hours service. We also saw contracts in place for maintenance of automatic doors, moving and handling equipment, fire extinguishers, catering equipment, passenger lift, specialist beds and mattresses. Contracts were in place for the disposal of various types of waste. A specialist company provided a maintenance service for clinical equipment.

A team of staff provided 24 hour cover for minor maintenance tasks, portering, transport, security, and some housekeeping tasks. Night workers carried out and recorded various checks, for example of car park barriers, waste bins, trolleys, emergency lighting, and security equipment. Members of the maintenance team were qualified to carry out portable appliance testing. The premises fire policy had been updated in January 2016. The fire risk assessment had been reviewed in September 2015 and areas for attention were identified and signed off as completed.

Pharmacy support was contracted from local acute services and provided a pharmacist on duty in the hospice five days a week plus a medicines management technician. The pharmacist was a palliative care specialist and explained that they supported the complex symptom management programmes to optimise care, ensure prescriptions were transparent, legal, and kept up to date, and help with patient engagement and discharge planning. They provided tutorials for nursing staff.

The pharmacist on duty described the medicines procedures from admission to discharge. Before admission, information about a person's medication was obtained from the person or their relative, their consultant and/or GP. On admission, a doctor at the hospice carried out a clinical assessment and decided on a medication regime for the person, which was reviewed by the pharmacist. A medication care plan and prescription were drawn up. The prescription included anticipatory medicines which nurses may need to administer if the person's condition worsened. People were prescribed variable doses of some medication for use as required to control their symptoms, with the aim being to keep the person as comfortable as possible without over-sedating them. The medication care plan provided information for nurses on a priority order for medicines if people were having difficulty taking all of their medication.

Each person had a medication folder containing medicine charts and a number of detailed guidance sheets. Medication charts in people's folders were different colours to identify the different types and routes of administration. We looked at three medication folders and they contained personalised guidance for each person.

Stock medication was stored in a locked clinical room in locked cupboards or fridges. Fridge temperatures were recorded daily. People's prescribed medication was kept in a locked drawer by their bed. We observed medication being administered by a nurse via a syringe driver. The nurse told us she had been on syringe driver training when she started working at the hospice in 2015. The medication was checked, recorded on pink syringe driver medicine chart, additional syringe driver sheet and on the notice board in the nursing office. We saw that the procedure was carried out safely.

When people went home from the hospice they were provided with two weeks supply of medication and a personalised information sheet that listed all their medications, with directions and information on what each medication was for. A nurse or the pharmacist went through this with the person and/or their carer. A copy was also sent to the person's GP and community pharmacist.

There was a rolling programme of medication audits including: prescription audits covering writing legibility, dates, amendments signed correctly; storage audits; and controlled drugs audits. The pharmacist was able to give an example of how learning occurred from audits and incident reports.

Is the service effective?

Good ●

Our findings

One person told us they were now able to enjoy food again. They said "The food is abundant, huge, it is tasty and you always have a choice." Another person said "If I don't want what is on the menu I can have anything I want." This person asked for bananas and custard, which was not on the menu and this was provided for them. Another person said they couldn't eat very much as they didn't feel very hungry. They told us the team had been very helpful at finding light, tasty things including a variety of clear soups and liquidised puddings such as jelly and ice cream and custard. Another person said "The meals are lovely. Just had soup and mincemeat tart and custard - it was gorgeous." Another person said "I can't fault the food and the staff are marvellous, every single one of them, you couldn't ask for better."

A multi-professional nutrition and hydration group had overseen the development of a hospice nutrition policy and met quarterly to identify any developments required. A nutritional screening tool was used to identify any specific nutritional concerns and referrals were made to a dietician if required. We spoke with the housekeeping manager who had responsibility for catering. She told us that a cook was on duty between 8am and 8pm. All of the cooks were trained to the same standard and worked between the Hub cafe and the main kitchen. The housekeeping manager told us that fresh meat, fruit and vegetables, and milk could all be delivered daily. She said "Anything we want, we can get." They were able to access already prepared meals for any special diets. They had copies of the recipes for all the meals with details of any allergens and alternative ingredients that could be used.

At lunchtime, people had a choice of two main meals or soup and/or sandwiches. People could choose to have their meal by their bedside, in the hospice café or in the in-patient lounge. Protected meal-times ensured that people were given the time to eat without interruption. A 'red tray' system was in place to indicate people who required support with their meal. There was a kitchen in the in-patient area and food was available throughout the 24 hour period. Sandwiches, light snacks, yogurts, and fresh fruit were available at all times. There was also a vending machine.

The human resources and facilities teams co-ordinated an annual training programme which was compulsory for all staff. This programme of training had been provided during February and March 2016. It comprised half a day for non-clinical staff and a full day for clinical staff. Some of the training was provided by the hospice's own staff and some was brought in. Between 95% and 98% attendance was recorded and plans were in place to update staff who had missed any of the training. There were also learning opportunities during team meetings held on a Tuesday or Friday afternoon. This time was also used for audit feedback, debriefs and reflection. The hospice also accessed training available from Wirral Hospital University Trust, including training about any new equipment or specific medical procedures.

The hospice had a training department staffed by two part-time trainers. A training calendar showed a number of specialist courses available at the hospice including 'Individualised care planning in the last days of life'; 'Management of breathlessness at the end of life'; 'Anxiety management in palliative care and the use of relaxation'. These were available for staff working in the hospice and for other professionals.

We were told that induction training for new nurses lasted two weeks and for healthcare assistants one week. The housekeeping manager told us that a new, part-time member of the housekeeping staff would have three weeks training working alongside an experienced member of staff. We spoke with a nurse who started working at the hospice in 2015. She told us she had undertaken a full induction programme, which included two weeks supernumerary working when she had shadowed two mentors. She had the opportunity to observe all aspects of the organisation and had attended the mandatory training programme. She said support was good and she had attended some of the reflection/ supervision meetings on Fridays. In addition to the mandatory training, she had been on syringe driver training during her induction. The nurse said she had attended her appraisal and six month review meetings.

Two other nurses told us they had an annual appraisal with a follow-up meeting. They had both attended the annual mandatory training programme. They said "The clinical educators are really good." and "Training is brilliant." They had been on the following clinical training courses: communication around end of life care; dementia friendly training; advanced care planning; mental capacity; syringe driver training; tissue viability training. They said all the training had been really good.

The inpatient manager told us that clinical supervision had been delivered in the past, but the model had become out-dated and no formal clinical supervision system was running at the current time. Reflection often happened at team meetings on Tuesday or Friday afternoon. Debriefs were organised for the team after challenging events. All of the nurses have had a 'revalidation' meeting to support them in maintaining their nurse registration, and some had already completed the revalidation process.

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

The Head of Clinical Services told us that, in most cases, consent to receive care and treatment at the hospice was established before admission. If the person was not able to indicate consent then a best interest meeting was held prior to admission. A doctor we spoke with described how consent was obtained for the care and treatment to be provided as part of the initial medical assessment and showed us how this was recorded on the electronic records system. They told us that there were no invasive procedures that required specific written consent to be obtained. We saw 'do not resuscitate' orders in place and these were completed in full, signed by a doctor, and recorded that discussion had taken place with the person and a close family member.

We spoke with the Clinical Services Manager for Patient and Family Support, who had an in-depth knowledge of mental capacity and DoLS. She explained the specific palliative care guidance around DoLS, which may be applied when the person had consented to hospice care, received treatment as planned, then subsequently lost capacity, or if death or discharge was expected within seven days. If the care provided deviated from what was anticipated, then a DoLS application may be appropriate. To date, four emergency DOLS applications had been made for people receiving in-patient care at the hospice. Three resulted in standard DOLS authorisations by supervisory body and one person regained capacity before the supervisory body had completed their assessment. We were shown the new mental capacity assessment that was being added to the service's IT system.

We looked all around the premises which were bright and spacious, well-furnished and well-equipped, with suitable facilities and resources to meet the needs of people receiving palliative and end of life care, and after death. There were spacious storerooms for equipment and medicines and a room for charging large electrical equipment. There was a therapy room where people could be supported to achieve optimum independence before going home.

The hospice had a café, known as The Hub, which could be used by people receiving a service, relatives, and staff from the hospice and other services across the Clatterbridge site. A visitors' room was available for overnight stays. There was a quiet reflection room where memorial services could take place. Outside there were well-maintained gardens which were managed with help from volunteers. Education and conference facilities were available for hospice staff and for outside organisations to use.

The in-patient area was a clinical environment and a piped oxygen supply had been installed to all parts. People were provided with fully adjustable beds and pressure relieving equipment as required. There were two large bathrooms with accessible, adjustable therapy baths. There was a smoke room which was well ventilated and fitted with CCTV and a nurse call point. There was also a kitchen where drinks and snacks could be prepared and a lounge. There was TV access to all bed spaces.

Good ●

Is the service caring?

Our findings

People who were using the service told us "This is real care. They are so dedicated, they want to do the work."; "The girls are lovely - the care is good"; "Marvellous care, no complaints whatsoever"; "They are the kindest nurses." and "I can't believe how kind they have been." One person told us they had just had a bath and they were always offered a choice of a wash in bed, a shower or a bath. They described the bath "It's unbelievable. There is piped music - it is so tranquil. The girls are so caring and they will leave you on your own if you want them to. It is like heaven." Another person told us "The shower was lovely."

People told us that their visitors could come and go as they wished as there were no visiting time restrictions. A visitor told us "Open visiting is encouraged and welcomed and the team help me if I want to take [person's name] out into the grounds for a short while." One person told us they had a single room with en-suite shower room. They told us they were grateful for the peace and quiet. A designated quiet time had been introduced in the early afternoon to enable people to rest. One person told us "The quiet hour is absolutely wonderful." She liked getting on the bed and having a rest. She pointed out how quiet it was in the hospice in comparison to hospital.

We spoke with a relative of a person who received end of life care at the hospice in 2015. He told us that the hospice had provided "safety and security" and was able to respond very quickly to the person's changing needs. He said "The caring ethos goes right the way through the staff team, not just the nurses but the kitchen and domestic staff, and volunteers too." He was involved in everything that happened but they always respected the wishes of the patient first and foremost. He had greatly appreciated the bereavement counselling provided by the hospice after his relative's death.

We observed the interaction between a nurse and a person who was receiving medication via a syringe driver. The nurse greeted the person kindly asking "How are you doing?" and "What did you have for lunch?" She then clearly explained what she was doing as she changed and recharged the syringe driver. This demonstrated a caring, trusting relationships built on genuine respect. We asked two nurses about working at the hospice. One said "It is a privilege. It is an honour to work with such a caring team, we do very well by our patients." The other nurse said "You couldn't really have a better job - to give the care needed by people when they most need it."

The care provided included spiritual and emotional support for the person and their family. This included the services of a chaplain, counselling support, social worker, peer support groups and practical advice around legal and financial matters. A carers' support group met fortnightly. A bereavement counselling service was available. Group and individual bereavement support was offered to the family and friends of people who had been known to the hospice and was available for a period of up to thirteen months following the death.

There was an information pack at each bedside which contained a series of leaflets. These included a patients' guide; information for families, friends and carers; infection prevention and control information for patients and a separate one for visitors; information about falls prevention, information about the role of

CQC; and details of car parking arrangements and cost. This information was also available for people on the hospice's website. A visitor told us how their relative had first attended day care and from there they had been shown the in-patient area and been told all about it before admission, so they knew what to expect.

Within the hospice building there was an 'information hub', a new development that was staffed by volunteers four days a week. The hospice had been supporting the development of a Wirral-wide 'Find Me Help/Dying Matters' website with on-line resources. The website contained a directory of local palliative/ end of life services and resources and was aimed at the public and professionals.

We were informed that the hospice training team were leading work on Advance Care Planning with a training programme based on work from the North West and the National Council of Palliative Care. In the introductory meeting with the manager, she explained that the hospice used a Wirral-wide Palliative Care Strategy. This had been developed from 'Priorities for Care of the Dying Person' national guidance developed by the Palliative Care Leadership Alliance. The hospice did not have an end of life care plan but the principles of the priorities of care were incorporated into the care planning process. The hospice team had been closely involved in producing the 'Wirral End of Life Care Charter' launched in 2015. This set out 12 pledges of care people should expect to receive when they are terminally ill.

Good ●

Is the service responsive?

Our findings

One person we spoke with said that the hospice had managed her sickness very well and although she felt very tired, she was able to drink and enjoy food. She was in a three bedded room and was happy to chat with the other people. She had no pain or other symptoms. She had had conversations with the team about what would happen next and was hoping to get home if at all possible.

Another person told us they had been assessed when they arrived and their symptoms were being managed better with the medication that had been prescribed. They had a syringe driver in place for the administration of pain management medication. This person told us "They have controlled the pain since I came here." The hospice team were helping to put a care package in place so that the person could go home with a syringe driver and medication, supported by district nurses.

A family member told us "They listen to you and give you advice. The doctors give you time and keep you in the loop as to what is happening."

We looked at comments made on a satisfaction survey carried out in September 2015. One person had written 'This has been the best experience of all the medical facilities I have been to since I was diagnosed.' Another person had commented 'I received a full explanation of what was up with me which helped me to understand why I was having the problems I was.'

The Head of Clinical Services told us that the hospice may have a waiting list of up to ten people who had specialist palliative care needs. People's needs may be social, psychological or physical and they might be at home or in a general hospital. Day therapy services may be offered to enable people to have on-going care and support on a weekly basis whilst staying in their own home. Following assessment and treatment in the hospice, the aim was for the person to be able to go home, or to a nursing home if they required further support.

Consultants in palliative medicine provided clinician leadership, with complex packages of care and interventions being delivered. People were seen daily by the medical team, with consultant visits twice weekly. Multi-disciplinary team meetings took place with health and social care professionals every day to review each person's care. People were encouraged to make decisions about their care in discussion with staff, including personal care, medication, beliefs and preferences. There were also a range of complimentary therapies that could be accessed including aromatherapy and therapeutic massage.

We looked in detail at the care being provided for three people and gained permission from them to see their care plans. On the electronic care planning system, known as SystmOne, people's care plans were chosen from a standardised list and adapted to their individual needs. Specific care plans had been selected for each person based on their medical and nursing assessments and risk assessments. The care plans we looked at reflected the care required by the individuals, for example use of syringe driver, nausea and vomiting, constipation, mobility, fatigue, skin integrity, low mood, psychological distress, pain, allergy, potential hyperglycaemia, bedrails, falls, steroid treatment. The care plans had been reviewed regularly and updated as needed to respond to the person's changing needs.

We observed the lunchtime handover meeting with one of the three nursing teams. The individualised care of the people they were supporting was reflected well in the discussions that took place, including on-going symptom management. They also discussed plans to enable a person to go home using fast track continuing health care. The nurses in the meeting said that they worked with district nurses to prepare people for discharge home for palliative/ end of life care. District nurses sometimes came into the hospice to help prepare a person for discharge and to set up a management plan. The nurses discussed the families involved with these people and discussed the spiritual, psychological, and emotional support being offered.

A weekly multi-professional team meeting of hospital, community and hospice staff ensured effective communication and continuity of care. The hospice staff worked closely with the Wirral Macmillan Integrated Specialist Palliative Care team in supporting people in the last days and weeks of life. The hospice had good links with local health and social care services to provide a smooth transition between home care and hospice care.

A 'How to make a complaint' leaflet was available throughout the hospice. The complaints procedure gave people the name and contact details of the registered manager of the service and advised them about how to make a complaint and how their complaint would be dealt with. We saw evidence that people who used the service, and their families, were encouraged to give feedback on the service they had received and to report any concerns.

We looked at complaints records, which showed that seven complaints had been logged during the last year. Six of the complaints related to aspects of fundraising activities and one was regarding a member of the hospice staff. There were no complaints about the care or treatment people had received. Records showed that the complaints had been responded to in an appropriate manner.

Good ●

Is the service well-led?

Our findings

The hospice was governed by a Board of Trustees who brought a wide range of clinical and business skills and experience to the organisation. The Chief Executive Office was also the registered manager. The senior management team was made up of the Consultant Medical Director, the Head of Clinical Services, the Operations Director, the Finance Manager, and the Head of Fundraising.

The hospice had a Clinical Governance Manager and the work of the Clinical Governance group included reviewing and updating the risk register, review and development of policies, development and implementation of the audit programme, patient and family experience processes, and staff development, supervision and training.

An annual audit planner was in place and covered all aspects of the service including: a finance audit by an external accountancy company; audit of staff files; policies and procedures review; falls monthly audit; controlled drugs quarterly audit; various other medication checks; monthly tissue viability audit and audits of various elements of the care documentation. In addition, there were other 'medically led' audits. A rolling programme of medication audits included: prescription audits covering writing legibility, dates, amendments signed correctly; storage audits; and controlled drugs audits. The Infection Control lead nurse carried out regular audits against 23 policies including responsibilities, hygiene, clinical care and procedures, laboratory specimens, linen laundry, cleaning/decontamination, sharps, and isolation procedures.

A 'Patient Led Assessment of the Care Environment' (PLACE assessment) carried out by patient representatives and Healthwatch scored 88.87% for food, 100% for cleanliness, 95.16% for the condition, appearance and maintenance of the building, 95.74% for privacy, dignity and well-being, and 82.12% for dementia care. Following this, a 'Dementia environmental audit' made several recommendations for improvements to the hospice environment in relation to the care of people living with dementia. An 'Admission processes audit' was undertaken to ascertain compliance with completion of admission documentation. The audit highlighted some gaps in completion of the assessment tools.

In addition to the internal quality assurance processes, the hospice participated in a number of external audits. Some were part of a regional or national audit or linked with the local integrated Palliative Care Team. 'Family satisfaction with end of life care provided by specialist palliative care services' questionnaires had been sent to the relatives of people who had received end of life care at Wirral Hospice St John's. People who responded to the questionnaire were either satisfied or very satisfied with the service.

Action plans were written following all of these audits and communicated to managers, staff and volunteers monthly. Actions required from audits were reported to, and monitored by, the Clinical Governance group.

The hospice team implemented various methods of gaining feedback from people who used the service and their families. These included questionnaires, face to face discussions, focus group meetings, suggestion boxes and bereavement care questionnaires. A number of volunteers had been trained in assisting people who use the service in completion of the satisfaction surveys. This had led to a significant increase in the number of comments received. We saw that any negative comments received were logged by the quality team and referred on to the relevant manager to decide if any action needed to be taken. 'Your comments/Our actions' information was displayed on notice boards to show people how comments had been acted on.

'Patient stories' were collected on a one to one basis and consent for sharing was obtained. These were shared with senior managers and the Board of Trustees. A 'Patient story' folder recorded individual's experiences of using the service. Any issues for improvement were identified, for example in October 2015 a person had mentioned that there were no staff photographs to aid identification of individual staff members and following this a large board had been put up with pictures and names of staff.