CareQuality Commission

Marie Curie

Marie Curie Hospice Liverpool

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

The Marie Curie Hospice, Liverpool provides specialist palliative care and support for adults with a terminal illness. The hospice service is available to all, free of charge. We last inspected Marie Curie Hospice, Liverpool on 19 September 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 hospice had a registered manager and a number of other senior staff with responsibility for various aspects of the service.

The hospice provides an in-patient service for a maximum of 30 people, also day services and out-patient clinics. They provide social and emotional support in people's own homes but this does not include nursing or personal care.

In-patient care is provided by a specialist team of doctors, nurses, healthcare assistants, therapists and social workers. They are supported by housekeeping and maintenance teams, administration staff and volunteers.

During our visits we saw that the premises were safe and clean and a programme of regular planned maintenance was in place. The hospice was supported by a comprehensive pharmacy service and policies, procedures and support documentation were in place to ensure that medicines were stored, handled, administered and disposed of in a safe and appropriate manner.

Staff 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 in accordance with the Mental Capacity Act (2005).

People who used the service, and their families, told us that they were treated with kindness, compassion and respect.

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

Care Quality Commission

Marie Curie Hospice Liverpool

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 12 and 17 May 2016 and we gave 48 hours notice of the inspection to the manager. The inspection team consisted of two adult social care inspectors, a pharmacist and a specialist professional advisor (SPA). The SPA had considerable experience as a nurse working in hospice services.

Before our inspection we reviewed the information we held about the hospice, 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 three people who were using the service and two relatives. We observed the care and support provided to people. We spoke with the registered manager and 13 members of staff. 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 six new members of staff and staff training records. We looked at how the quality of the service was monitored. We inspected the storage of medicines, the paperwork used to record the ordering, disposal and administration of medicines, and carried out stock checks of controlled drugs.

Good

Is the service safe?

Our findings

People told us that they felt safe staying at the hospice. They said there were always staff available to support them when needed. People told us that when they used their call bell staff responded quickly. They also told us that there were always enough staff available to meet their needs including supporting them with their personal care and spending time listening and explaining information to them. One person said "They are there. Never in a rush, never a bother."

People told us that they always received their medication on time. We observed people being asked if they needed pain relief medication and people told us that this was offered to them regularly. One person explained "They look after them but it's two way, I keep them and say when I have taken them." Another person said "I buzz them when I get break-through pain,." and said staff responded quickly to their request.

Records we looked at showed that the hospice staff had identified and reported safeguarding incidents to the appropriate authorities. Staff we spoke with were fully informed of areas of abuse, when to raise a safeguarding concern, and who they needed to escalate it to. Staff we spoke with also said they felt confident to speak with team members if they witnessed areas of poor practice, and to escalate their concerns if they witnessed the situation again. Records showed that all staff received training about safeguarding vulnerable adults and children and this was updated every two years. The manager told us that senior managers had attended local authority 'Safeguarding Alerter' training.

The manager told us that all staff had received a copy of the whistle-blowing policy and that a training session on whistle-blowing was due to be delivered to staff in June 2016. She also explained that the organisation had an identified national lead person for dealing with whistle- blowing and that it was discussed at regional staff forums.

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 and healthcare assistants, with support from social workers, pharmacy staff, therapy staff, psychologist, chaplains, housekeeping, maintenance, and administration teams. The manager explained that was finance was managed centrally from London, and fundraising and human resources were managed regionally.

On the days of our inspection, 11 people were receiving in-patient treatment. There was a senior nurse, three other nurses, and two healthcare assistants on duty. Staff we spoke with felt they had time to reflect on their work; they didn't feel rushed and had time to talk with the people they were supporting. The manager told us that staffing levels was determined nationally to provide a minimum ratio of one registered nurse to 4.5 patients during the daytime and one nurse to 7.5 patients at night.

Staffing levels were reviewed daily by senior staff and any gaps in the rota were filled by overtime, bank staff or agency workers. There was also a daily walk-through by the senior nurse and senior doctor to review staffing levels, patient dependency and complexity, and assess the capacity to accept new admissions. Most staff were rotational, covering night and day shifts. All of the healthcare assistants had a national vocational

qualification (NVQ) level 2; 57% had a BTEC qualification in end of life care and 65% had NVQ level 3. The others were working towards a level 3 qualification in end of life care.

Robust corporate recruitment and selection procedures were in place. The manager described the process for recruitment of new staff, which involved pre-employment checks being undertaken by a regional recruitment team. The manager was responsible for short-listing, interviewing and selection. Recruitment information was not kept on site, and the manager arranged for files relating to the staff who had started working at the hospice most recently to be sent from the regional office for us to see.

We looked at the records for six 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. Professional registration checks were recorded where appropriate. The majority of medical staff were employed by the NHS.

Accident and incident reporting procedures were in place and all clinical incidents were reviewed at a weekly meeting attended by senior staff. Trends were reported quarterly at governance meetings and were posted on noticeboards. Clinical risk assessments and relevant care plans were in place, covering for example falls and pressure sores. Additional assessments were undertaken by a physiotherapist, occupational therapist or social worker as required. Policies and procedures were in place to manage medical emergencies such as major haemorrhage and anaphylaxis.

The manager told us that managers had undertaken risk management awareness training and risk assessments were written for each department and activity and reviewed annually by the 'Environment and Risk Group'. The group met bi-monthly, with the most recent meeting being on 11 May 2016. Minutes of this meeting showed a summary of all health and safety incidents that had happened over the last year. Business continuity plans and procedures were in place.

We spoke with the facilities manager and they showed us the schedule of planned maintenance which included all services and equipment used in the hospice premises. There was a maintenance team of three people who carried out routine tests and maintenance tasks, including portable appliance testing. We looked at safety certificates including passenger lift, hoists and slings, adjustable beds, pressure relieving mattresses, gas, electrical installations, boilers and laundry equipment, and these were all up to date. There were also records of regular checks for Legionella and water treatment. Contracts were in place for the disposal of various types of waste. Clinical equipment was serviced and maintained through the hospital and there were detailed records of each piece of equipment. There were also details of vehicles used by hospice staff.

An annual health and safety inspection was undertaken by an external auditor, and this had been done the week before our inspection, and previously in July 2015. A report and action plan was produced and monitored by the Environment and Risk, and Governance groups. The manager told us that all new staff completed a health and safety workbook as part of their induction and all staff received refresher training every two years.

The premises fire risk assessment had been written in September 2015 by a suitably qualified person and areas for attention were identified and subsequently signed off as completed. Quarterly fire drills were undertaken including a simulated patient evacuation each year. This had been done most recently in March 2016. We saw records of regular fire alarm, fire extinguisher and emergency lighting tests.

The facilities manager showed us the daily cleaning schedules that were completed by housekeeping staff, and evidence of monthly audits of the cleaning service. Infection prevention and control policies and procedures were in place and infection control support was provided by Liverpool Community NHS Trust. Single bedrooms were available to 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 year. Adequate personal protective equipment and handwashing facilities were provided. A hand hygiene audit carried out in April 2016 found 75% compliance. The areas of non-compliance and the reasons for non-compliance were identified and addressed. The hospice was awarded a five star food hygiene rating in 2015.

The hospice was supported by a comprehensive pharmacy service provided by the NHS. This included the employment of a full time pharmacy technician on a rotational basis and a part-time pharmacist who visited every morning during the week. An out of hours service was provided via the hospital. The pharmacist attended the weekly incidents review meeting and medicines management meetings took place every two months.

Corporate policies and procedures were in place covering all aspects of medicines management. Comprehensive standard operating procedures had been developed by the pharmacist to reflect local practice within the hospice. There was access to appropriate guidelines and resources.

Medicines were stored in cabinets and a fridge in a medicines room. There was appropriate storage for both stock and people's own controlled drugs. Access to the medicines room was via a key code lock and keys to the cupboards in the room were held by appropriately qualified staff. The temperature of the medicines room and fridge were monitored and recorded on a regular basis. Emergency medicines were kept securely but in a manner that allowed access in an emergency. Medical gases were stored in a dedicated room which had appropriate signage.

When a person was due to be admitted to the hospice, the pharmacist and technician obtained details of their regular medication so that they could carry out a medicines reconciliation with the medicines the person brought in with them. Specific documentation was used to record the medicines received from the patient on admission and the prescription of medicines on discharge. These clearly presented the information to the person as well as recording all the necessary details for the medical and pharmacy staff. Registers were used to record the receipt, administration and disposal of both stock and people's own controlled drugs.

Stock medicines were ordered from the hospital in a timely manner and delivered weekly. Medicines administration record charts were completed appropriately. There were separate charts to record administration using a syringe driver and application of patches. The medicines charts included a 'when required' medicines list and anticipatory prescribing was also recorded to ensure that they were available as symptoms occurred. Disposal of expired medicines was carried out weekly by the pharmacy technician and records were completed.

Regular audits were carried out and incidents were monitored and discussed. The hospice had a policy of recording all incidents relating to medicines. This helped identify issues, allowed discussion at multidisciplinary meetings and enabled actions to be taken. Some minor issues relating to medicines management were identified during the inspection and were discussed with the manager and the pharmacist and actions agreed.

Good

Is the service effective?

Our findings

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

We checked whether the service was working within the principles of the MCA, and whether any conditions or authorisations to deprive a person of their liberty were being met. We found that they were. The hospice staff assessed people's capacity to understand information and make decisions as part of their multi-disciplinary team meetings. When a person was assessed as lacking capacity to agree to stay at the hospice, a member of the hospice's social work team contacted the person's local authority to establish whether a DoLS should be applied for given the person's current medical condition. Records we looked at provided evidence that, where needed, an application had been made appropriately for a DoLS for the person in order to ensure they had the legal protections in place that they were entitled to.

The staff working in the hospice had completed on-line training about the Mental Capacity Act and DoLS and this was revisited annually. In the PIR, the manager told us that the care of people with challenging behaviour was carefully planned involving family members where possible. One to one nursing was provided for people at risk of harming themselves. Documentation relating to 'do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions was present in people's in clinical notes. These showed that discussions had been held with the person, and their family where appropriate. The rationale for DNACPR decisions was clearly identified and recorded who had been involved in the discussion. If the person themselves had not been involved, the reason why was documented. The decisions were reviewed at weekly multi-disciplinary meetings.

People staying at the hospice told us they were offered a choice of meals. One person told us that they did not have much of an appetite but enjoyed ice-cream and had been given this regularly. Another person said they always had a choice of meals and found them very good, and drinks were always available in their room. They also told us that staff came around regularly to offer drinks and if they wanted a hot drink in between they would use their call bell and ask.

The manager told us that new menus were being trialled from March this year. A hot or cold breakfast was available, followed by a light lunch, and the main meal in the evening. The kitchen was staffed from 7am to 7pm and food such as bread, biscuits, yogurts, fruit, tinned items were available out of hours. The chef visited the ward daily to discuss menu options with people and additional meal options were available if people wished to have something other than what was on the menu. People's nutritional needs were identified on admission to the hospice and discussed with them and their family (or those close to them). Dietary advice was available from a community dietician on request. A food and drinks survey was offered to

everyone and people staying at the hospice or their visitors could give feedback on the menu cards.

People staying at the hospice said they thought staff had the knowledge and skills to support them. One person told us they knew staff had undertaken "a lot of study". Education was managed centrally by the Marie Curie organisation involving mandatory sessions for moving and handling, prevention and control of infection, mental capacity and DoLS, equality and diversity, moving and handling, safeguarding, food hygiene, medication, health and safety, and data protection. The training matrix showed a total of 90 staff, all of whom were up to date with the mandatory training applicable to their role. Most of the training was completed on-line, but there was face to face training for basic life support, syringe pumps (for the nurses), oxygen therapy, moving and handling.

An annual clinical skills day was held and ad hoc training was arranged to cover specific topics, which may be based on needs identified via staff feedback, or incidents or complaints that had occurred during the previous year. Marie Curie had identified three national priorities for training which were communications skills, dementia care and person-centred care. The manager told us that bursary and study leave policies supported staff in accessing external education and training. The hospice gave nurses the opportunity to 'act up' as ward sisters for a period of nine months to gain experience in management and leadership. Two healthcare assistants were undertaking 'assistant practitioner' training. The hospice's nurses were supported to revalidate their nurse registration. The hospice provided placements for medical, nursing, social work students.

An induction programme was in place for all new starters, including an overview of key policies and procedures, health and safety workbook, moving and handling training and drugs calculations tests for nurses. Each new starter was given an induction folder and pack and usually worked supernumerary for the first two weeks. Two new members of staff told us their induction was robust and supportive. They felt the medication maths test and supernumerary observations of drug rounds increased their confidence in the administration of controlled drugs. The manager told us that volunteers received tailored induction training and were required to attend the annual mandatory training programme.

Group or individual clinical supervision was available to all clinical staff every six weeks. One to one meetings were arranged as needed, for example following a clinical incident. We saw records of social work staff having a monthly one to one meetings with their manager. Each member of staff had an annual appraisal system, known as 'My Plan, My Review'. An identified 'Senior Doctor of the Day' was introduced in 2015 to provide additional support to junior medical staff. A confidential staff counselling service was available.

We looked around Sefton Ward which consisted of five single bedrooms, a two-bed bay and two bays each containing four beds. These rooms were located on either side of a corridor which people could enter and leave from both ends. The nurses' station was positioned opposite one of the bays. The bay had a large window opposite the nurses' station which meant people could be observed. Bays had a large entrance space that did not have doors so that anyone walking past could easily see in. We considered that this may compromise people's privacy. A member of staff explained that having the window meant they could see how people were and considered that some people felt reassured being able to see staff.

During our visit the ward appeared very busy with staff and visitors present throughout the day. A member of staff told us that the ward had been particularly busy that day due to an event that was taking place and said it was usually much more relaxed. A member of staff said that people staying in the bays could not sleep-in late as the general hustle and bustle of the ward would disturb them. We discussed this with the manager who told us that a study was planned to look at possible reconfiguration of the ward areas.

Each bay or single bedroom had a shower room with toilet and wash basin. In addition, a hydrotherapy bath was available for people to use. Externally there were lovely gardens and sitting areas that people could use. The single bedrooms had access to the gardens via patio doors. There was no lounge or dining room on the Sefton Ward, however outside of the ward there was a lounge area people could use and a quiet multi-faith room. There was a bedroom available for visitors to use.

Good

Is the service caring?

Our findings

During the morning ward round we observed a positive rapport between people using the hospice, their families, and the consultant, with the consultant being known by their first name. This encouraged mutual involvement and decision making. A family member told us ''I'm not scared to ask, they're marvellous even the cleaners know us. They are not only here for [the person] but us as well.''

People told us that they were satisfied with the care and support they had received at the hospice. One person said "I would give it ten out of ten." Another person explained "It's not like a hospital, it's less regimental, your anxiety goes here." And a third person described the hospice as "fabulous, brilliant staff". With reference to the wider services the hospice offered, a relative told us ''You only have to ring out-patients with a problem and they get you an appointment as soon as possible. Three hospitals have been involved in my [relative's] care but none have been as clean and helpful as the hospice. They don't keep anything from you and don't build up hopes."

The family of a person who used the hospice had written 'We as a family cannot praise the Marie Curie enough. Our family member was given both the medical care and the emotional support he needed at a very difficult time. He was treated with dignity, patience and professionalism and caring at all times by all the staff and we as his family were informed of everything going on with empathy and sensitivity.'

The manager told us that Marie Curie had a national policy of 24 hour visiting for people staying their hospices. We spoke with a member of staff who explained that in the past there had been quiet time in an afternoon when visitors had only been allowed in exceptional circumstances. The member of staff said that people staying at the hospice had welcomed this quiet time. During the inspection we saw that there were a number of visitors throughout the day. This meant that for people staying in the bays there were always visitors in their room which could be disturbing for them. None of the people we spoke with expressed concern about this and one person told us "You become friends with others in a similar situation. It's a peaceful oasis."

We discussed with staff how they maintained respect and dignity. They identified that sometimes communication with people may not appear respectful from the outside, for example names and words used in conversation, but for the individual this was appropriate.

The hospice had a patient family services team who provided practical, psychological, spiritual and emotional support to everyone staying at the hospice and their family and friends. The team consisted of social workers, chaplains and a children and young person's counsellor. We spoke to a member of the team who explained that everyone was offered this service when they came to stay at the hospice. A bereavement befriending service was available to all family members and psychological support was available via a visiting clinical psychologist.

A notice-board on the ward showed that staff roles could be identified by the uniform they wore. It displayed photographs of senior staff and information about their roles. There were no photographs of the more junior

members of staff. Having information about more junior staff members may be helpful to people staying at the hospice and their visitors.

A number of leaflets were available for people to read and take away. These included information about the hospice service and about tax, pensions, terminal illness and pain. This information was also available for people to look at on the internet. There were also details of an event called 'It takes a community' which was an open day the hospice had organised as part of 'Dying Matters Awareness Week'. The manager told us that a translation and interpretation service was available to support people whose first language was not English, and picture boards could be used for people with speech problems.

A lounge was available for people to use and this had been equipped with toys and seating for children. In addition, a number of private rooms and a multi-faith room were available within the building for people to use. Drinks machines were available for visitors.

We looked at comments that family members had made on the internet. These included: 'My Mum was in care here for only six days, but, because of the exceptional pain management, those last days of her life were spent pain free. ALL the staff there are kind, compassionate, caring and extremely professional and I cannot commend them enough. The hospice itself is bright and homely and outside are many colourful flowers, shrubs and bushes which brighten the place even before you go in.' and 'My husband only spent three weeks at the hospice and without the kindness and compassion shown to both of us we would have found his final weeks so much harder. The care he received was excellent and the time taken by both the nurses and doctors to listen to my concerns was worth their weight in gold, and has helped me through the months after.'

On the first day of our inspection, the hospice was celebrating International Nurses Day. Nurses working at the hospice had been invited to add their comments about working there. Their comments included: 'I work at Marie Curie because caring for people at the end of their lives, and making it a more dignified experience is the last nice thing you can do for someone.'; 'I enjoy working for such a well-known charity with a good reputation for caring for patients and families. Marie Curie gives you the opportunity to care for people at such a significant time which is a great privilege to be able to share with them, and help the experience be the very best it can be in such circumstances.'

'Fundamentals of Palliative Care' training was provided for new staff. The hospice had signed up to the 'Liverpool Dying Well Community Charter', which provides a visible commitment by individuals, communities and organisations to work together towards the principles which should apply for all as they are affected by dying and death. Complementary therapies were available to promote comfort and relaxation. End of life care plan documentation was in place and there was an 'advance decision to refuse treatment' policy. These decisions were documented in people's clinical notes. The manager told us that whenever possible the hospice staff supported people's last wishes, for example visits by family pets, weddings, support with will writing and funeral planning. The hospice could facilitate rapid discharge for people who wished to return home to die. Care after death policies and procedures were in place.

Good

Is the service responsive?

Our findings

People staying at the hospice confirmed that they were involved in discussions about their care. One person explained "The social worker visited, we talked about my plan of care and agreed it." Another person said "You are more involved here in discussions and management. They are very keen to get you involved to get the best for you – not the best for them." People told us that staff had involved them in their plan of care and listened and acted upon their opinions. One person said "They discuss options, discuss medication, if you ask a question you get a full answer." Another person told us, "I did do a plan with them."

The consultant ward round we observed included a senior nurse, social worker, physiotherapist and junior doctors. The ward round was flexible giving protected time for individual professionals to discuss concerns with people when appropriate. There was evidence on the consultant ward round of person centred care with conversation and discussion focused on the individual. One person, whose condition had deteriorated, was given the option of staying in the hospice or returning home. Plans of care and treatment, or the discontinuation of treatment if it was not effective, was discussed with people, and their relatives if appropriate.

The manager told us that an electronic care planning system was going to be introduced but currently a paper-based system was in use. Each person had two sets of notes which were multi- disciplinary notes, kept in a trolley at the nurses station, and nursing care plans that were kept at the person's beside. We looked at the nursing care plans and found that these were not always up to date. For example, one person had been admitted to the hospice with breathing problems. The person's 'breathing' care plan had been discontinued as the problem had stabilised, however on the day of our inspection they were receiving oxygen therapy. Psychological and spiritual problems did not appear to be followed through in the nursing care plans, however these issues were acknowledged in the multi-disciplinary notes through visits made by the chaplain team. We also noticed that in some records, people were referred to as 'the patient' rather than using their name, which did not support a person centred approach.

An experienced nurse had been employed by the hospice to review the nursing care plans. She was enthusiastic and passionate about capturing person centred care and understanding how the illness impacted on the individual. Training had been delivered to the majority of nursing staff, however it was appreciated that further work was required. An audit of the new care plans was being undertaken on the day of the inspection.

Occupational therapy and physiotherapy assessments were available for people staying at the hospice and ensured that people had suitable equipment both in the hospice and after discharge. Everyone who stayed at the hospice was offered the services of a social worker. The social workers provided support to people to plan their discharge, including liaising with other health professionals regarding funding, and the care and equipment the person may need at home. People were invited to attend the day service provided by the hospice and to have out-patients appointments to discuss their continuing support needs. Social and therapeutic activities took place in the day centre every day. People were offered access to the Marie Curie helper service to provide befriending support in the community following discharge.

The manager told us that a weekly meeting was held with representatives from the hospice, community, acute and tertiary trusts palliative care teams. Complex discharges were managed by a case manager who liaised with family, care agencies, district nurses and care homes as required. Discharge documentation was sent home with people and sent to district nurses and care agencies. Joint home visits were available from the senior medical team with GPs and community specialist nurses. The hospice provided a 24 hour advice line for healthcare professionals across Liverpool.

People staying at the hospice told us that if they had any concerns or complaints they would feel comfortable raising them with a member of staff. A complaints leaflet gave information and phone numbers and email addresses people could contact if they wished to make a complaint. The Marie Curie national complaints policy stated that complaints would be acknowledged within two days and would receive a response within 20 working days.

A complaints monthly log was maintained and we were able to look at records of complaints that had been made over the last year and how they had been addressed. One complaint had referred to the loudness of the nurse call system, and there were plans in place for improvement of the system. Another complaint had been about a delay in medication administration, and this had led to a change of policy. Another complaint had resulted in the implementation of a 'Senior Doctor of the Day' system.

Good

Is the service well-led?

Our findings

The hospice had a registered manager who had been in post for ten years. The manager was open and honest with us and had a good overview of the service provided and areas where improvements could be made. She told us that there was a senior manager on call seven days a week to provide support and advice.

Staff we spoke with all said it was a lovely place to work with good teamwork. A healthcare assistant told us she loved her job. She considered that the nurses and doctors respected the role of the healthcare assistant and asked for their advice. A new nurse said "I feel very supported by experience staff. They will also listen and share from my professional experiences."

Nurses who were participating in the International Nurses Day event had written 'I am so proud to be a nurse and so privileged to work at the hospice and wear a Marie Curie uniform. Working with a team of such inspirational people every day who give so much of themselves for the patient and their families in our care enables me to work hard and stay humble.'; 'I have been a part of the Marie Curie team for a number of years now and feel supported and encouraged by my colleagues. It is a privilege to work in palliative care and to be able to do something positive for patients and their families, no matter how small it may seem.'; 'I like working at Marie Curie because of all the lovely staff, who have made me feel so welcome since I started, and feel very privileged to look after all our lovely patients.' and 'I feel so honoured to be part of such an amazing team. It's a privilege to be part of the journey that our patients have to go through.'

We saw evidence that staff had opportunities for reflective practice process following incidents.
The manager told us that 'Schwartz Rounds' had been introduced during 2015. These were a forum for clinical and non-clinical staff from all backgrounds and levels of the organisation to come together and explore the impact that their job has on their feelings and emotions.

Forms located at the front desk offered people the opportunity to comment on their care. This was in the form of a survey asking people to rate their experience and provided a space for additional comments. The form also provided people with the option of requesting a response to their survey form. Attached to this form were the results of the survey carried out the previous month. This showed that two questionnaires had been returned with 100% satisfaction in most areas. The leaflet also advised people that from April to June 2016, the hospice would be working on improvements to how people were admitted, the environment, and obtaining feedback from people using the service.

All feedback was logged and any adverse scores were reported immediately to the manager for review and action. Feedback results were reviewed monthly at the hospice management group meeting and were posted on the quality noticeboard. Monthly 'You Said, We Did' posters showed how the organisation had responded to people's comments.

A meals survey was available at every bedside, and menu cards contained a feedback section so that the catering staff would be aware as soon as possible of any comments and could take appropriate action.

We saw that an audit schedule for the year was in place. This comprised 12 different medication audits carried out over nine months of the year; annual audit of do not resuscitate decisions; annual audit of end of life care documentation; annual infection control audit; quarterly catering standards audit; annual audit of nursing documentation; and annual 'delirium at end of life' audit. The staff responsible for each these was identified.

Six monthly internal compliance visits were undertaken by the Marie Curie national quality assurance team and the Marie Curie lead infection prevention control nurse also carried out audits. An annual quality account was produced for Commissioners. All incidents and complaints were reviewed weekly by senior managers and clinicians and action taken as required. Trends were reviewed at the Governance and the Environment and Risk meetings. We saw that learning from incidents was used in staff training and procedures updated accordingly.

The hospice was a member of the Merseyside and Cheshire Strategic Clinical Network, the Liverpool Specialist Palliative Care Services Group, and the Liverpool Clinical Commissioning Group end of life steering group.

We saw that the management team was continually improving the service including plans for reconfiguration of the ward areas to promote privacy and dignity; provision of a café for visitors; improvement to ventilation in the kitchen; redecoration of wards; upgrading the nurse call system; and upgrading the mortuary area.