Willowbrook Hospice

Quality Report

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Date of inspection visit: 11 and 19 December 2019
Date of publication: 11/02/2020

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Good ●

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

Willowbrook Hospice is operated by Willowbrook Hospice. The hospice accepts palliative adult patients aged 17 years and above from across the St Helens and Knowsley areas for complex symptom control and pain management, and end of life care. It has 12 inpatient beds across two wards, Oak Suite and Willow Suite.

The hospice offers 66 day therapy places and 20 medical outpatient clinic appointments per week in its dedicated wellbeing services unit, the Cedarwood Centre.

The hospice operates specialist palliative care telephone advice line 24 hours a day, seven days a week. A bereavement support service 'Willowbrook Connections' provides anticipatory bereavement support to patients and families.

We last inspected this hospice in August 2016 and the report was published in September 2016. We previously rated the hospice as good.

We carried out this short-announced inspection on 11 December 2019 and 19 December 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

Our rating of this hospice improved. We rated it as **outstanding** overall.

- The hospice truly respected and valued patients, families and carers as individuals who were empowered as active partners in their care, practically and emotionally, by an exceptional and distinctive service. Staff were highly motivated to treat their patients with compassion and kindness, respected their privacy and dignity, always took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The hospice's services were planned and tailored to meet the complex needs of individual people, and the local population, in partnership with the wider health economy. The hospice's services were delivered flexibly, by a responsive and passionate multidisciplinary team, providing choice and continuity of care for patients, their families and carers. The hospice planned and worked to improve awareness and access to palliative care for hard to reach communities. The service made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- The hospice had enough staff to care for patients and keep them safe. Most 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 mostly managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- 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

Summary of findings

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.

We found areas of outstanding practice:

- The hospice is involved in a working partnership with the Pain and Anaesthetic Service. We were given information about a patient who had benefited from this service, where the anaesthetic team from the acute hospital had attended the hospice to administer an anaesthetic to ease discomfort while dressings were changed, and a more appropriate mattress was put in place.
- The hospice had also recently linked with two other hospices in the locality to hold collaborative medicines management group meetings. The aim of this is to share learning and good practice within the group.
- The hospice had achieved the European certificate in holistic dementia care.

We found areas of practice that require improvement:

- Safeguarding vulnerable children level two training rates were low across nursing, medical and allied health professional staff groups.
- Basic life support training completion rates for healthcare assistants was low at 64%.
- The fluid used to dilute medicines for the syringe pumps was not always specified by the prescriber and the time frame for administration was not specified as part of the prescription.
- Documentation of who had recorded the increase in dosages of medicines in the syringe pump was unclear on the medication chart, although a contemporaneous record had been made in the electronic clinical notes.

Following this inspection, we told the hospice that it should make some improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Ann Ford

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	**Outstanding** ☆	The hospice supported palliative and end of life care services to people in the Knowsley and St Helens areas. The hospice has 12 inpatient beds for patients admitted for complex pain, symptom control, or end of life care. It has a dedicated wellbeing centre providing day hospice services and medical outpatient clinics. We rated the service as outstanding overall. This was because all the hospice's staff and multidisciplinary team were passionate to deliver individualised, safe care to patients living with complex symptoms and life-limiting conditions. Compassion was truly embedded in the hospice which supported people's emotional as well as physical needs. Staff were highly motivated to respond to patients' individual needs as well as those in the local area. The hospice was led by a strong effective executive leadership team, who had a strong vision and strategy for the service that promoted an inclusive culture and engagement with staff, patients, carers and the wider community.

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Outstanding ☆

Willowbrook Hospice

Services we looked at
Hospice services for adults

Summary of this inspection

Background to Willowbrook Hospice

Willowbrook Hospice is operated by Willowbrook Hospice. The hospice opened in 1997. The hospice has 12 inpatient beds and offers up to 66 day therapy places and 20 medical outpatient appointments per week. The hospice provides care to palliative adults with complex symptom control and pain management needs, and end of life care. It does not currently offer respite or community hospice services.

The hospice operates a specialist palliative care telephone advice line 24 hours a day, seven days a week. A bereavement support service 'Willowbrook Connections' provides anticipatory bereavement support to patients and families.

The hospice primarily serves the communities of St Helens, Knowsley and the surrounding areas. Out of area referrals are accepted from other areas such as the borough of Halton on a named patient basis only.

The hospice, which is a registered charity, is funded through grants and income generation through its trading and fundraising arms, and through NHS commissioned funding from St Helens and Knowsley clinical commissioning groups. Our inspection did not include review of the trading and fundraising functions.

The hospice has had a registered manager in post since June 2005.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,a specialist advisor with expertise in hospice nursing and governance, and two CQC medicines inspectors. The inspection team was overseen by Judith Connor, Head of Hospital Inspection.

Information about Willowbrook Hospice

The hospice has two inpatient wards, Oak Suite and Willow Suite, providing 12 inpatient beds. The hospice offers 66 day therapy places and 20 medical outpatient clinic appointments per week in its dedicated wellbeing services unit, the Cedarwood Centre. Bereavement support services and community wellbeing services were delivered from the hospice's The Living Well centre.

The hospice operates specialist palliative care telephone advice line 24 hours a day, seven days a week. A bereavement support service 'Willowbrook Connections' provides anticipatory bereavement support to patients and families.

The hospice is registered to provide the following regulated activities:

- Diagnostic and screening procedures.
- Treatment of disease, disorder or injury.
- Transport services, triage and medical advice provided remotely.

During the inspection, we visited all areas of the hospice. We spoke with 25 staff including registered nurses, health care assistants, medical staff, non-clinical operational staff, senior managers, and volunteers. During our inspection, we reviewed four electronic patient records, one individualised care and communication record for a person in the last days or hours of life, seven patient prescription charts, and five do not attempt cardiopulmonary resuscitation orders.

There were no special reviews or investigations of the hospice ongoing by the CQC at any time during the 12 months before this inspection. The hospice has been inspected four times. The most recent inspection took place in August 2016, and the report was published in September 2016.

Summary of this inspection

Activity (1 September 2018 to 31 August 2019)

- The hospice had 192 inpatient admissions.
- The hospice provided palliative care to 544 patients aged between 18 and 65.
- The hospice provided palliative care to 559 patients aged over 65.
- 135 patients in the care of the hospice or on their caseload died.

The hospice had granted practicing privileges to fifteen staff; these included:

- Three consultants.
- Three anaesthetist/consultants in pain management.
- Two GP registrars (GpR) and one specialist registrar (SpR).
- Three research nurses.
- Two pharmacists.
- One social worker

The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety:

- No never events.
- No serious incidents, or injuries.
- No incidences of service acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA), or Clostridium difficile (C. diff).
- One incidences of service acquired E-coli.
- Two Vancomycin-resistant Enterococcus (VRE).
- Four complaints – non-clinical.

Services provided at the hospital under service level agreement:

- Planned preventative maintenance of medical equipment.
- Enhanced nurse practitioner role in pain management and palliative care.
- Provision of pharmacy services.
- Provision of informatics services.
- Clinical waste.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Our rating of safe stayed the same. We rated it as **Good** because:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection and when transporting patients after death. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- 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.
- The hospice had enough 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, agency and locum staff a full induction.
- The hospice 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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.
- 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.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The hospice used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Summary of this inspection

However, we also found the following issues that the service provider needs to improve:

- The service provided mandatory training in key skills to all staff and made sure staff completed it. However, basic life support training completion rates for health care assistants were low at 64%.
- Safeguarding vulnerable children level two training rates were low across nursing, medical and allied health professional staff groups.
- The fluid used to dilute medicines for the syringe pumps was not always specified by the prescriber and the time frame for administration was not specified as part of the prescription.
- Documentation of who had recorded the increase in dosages of medicines in the syringe pump was unclear on the medication chart, although a contemporaneous record had been made in the electronic clinical notes.

Are services effective?

Good

Our rating of effective stayed the same. We rated it as **Good** because:

- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support to help them live well until they died.

Summary of this inspection

- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Are services caring?

Outstanding 

Our rating of caring improved. We rated it as **Outstanding** because:

- There was a strong, visible person-centred culture that was promoted by the hospice's leaders. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Staff always treated patients and relatives with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. Staff recognised and respected the totality of people's needs. They always took people's personal, cultural, social and religious needs into account, and found innovative ways to meet them. People's emotional and social needs were seen as being as important as their physical needs.
- Staff saw people, who were approaching end of life, and those close to them as active partners in their care. Staff were fully committed to working in partnership with patients, their carers and their families, and with ward staff to make this a reality for each person.
- Staff and volunteers throughout the hospice and its wider services were passionate about meeting patients' needs. This was part of the day to day provision of palliative and end of life care in the hospice such that outstanding care had become the expected standard.

Are services responsive?

Outstanding 

Our rating of responsive improved. We rated it as **Outstanding** because:

- The hospice's services were delivered flexibly, by a responsive and passionate multidisciplinary team, providing choice and continuity of care for patients, their families and carers.
- The hospice proactively planned its services and provided care in a way that took into account, and met, the preferences and needs of local people and the communities it served.
- The hospice worked with others in the wider system and local organisations to plan care that promoted equality, including for those with protected characteristics.

Summary of this inspection

- The hospice planned and worked to improve awareness and access to palliative care for hard to reach communities.
- The hospice put people's individual needs and preferences central to the delivery of its services. The service was inclusive and tailored its care to individual patient needs. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- Patients could access the specialist palliative care service in a way and at a time when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice. There were processes in place to ensure urgent admission and rapid discharge when needed.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, comprehensively investigated them and shared lessons learned with all staff and other agencies where applicable. The service consistently included patients and their carers and families in the investigation of their complaint and could demonstrate how improvements had been made.

Are services well-led?

Good 

Our rating of well-led stayed the same. We rated it as **Good** because:

- 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.
- 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.
- 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.
- 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.

Summary of this inspection

- 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. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- The service collected reliable data and analysed it. Staff could find most of 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.
- 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.
- 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.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospice services for adults	Good	Good	Outstanding	Outstanding	Good	Outstanding
Overall	Good	Good	Outstanding	Outstanding	Good	Outstanding

Outstanding ☆

Hospice services for adults

Safe	Good ●
Effective	Good ●
Caring	Outstanding ☆
Responsive	Outstanding ☆
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 staff completed it. However, basic life support training completion rates for health care assistants were low at 64%.**
- The mandatory training programme was comprehensive and met the needs of patients and staff and was included as part of a structured induction programme for new staff. The mandatory training programme included a range of modules covering subjects such as, but not limited to, fire safety, manual handling, information governance, infection prevention and control, conflict resolution, basic life support and safeguarding adults and children.
- Nursing staff received and kept up-to-date with their mandatory training. At the time of the inspection, the average completion rate for nursing staff was 86%; the hospice's target for mandatory training completion was 90%. The completion rates for the majority of modules were high (80% or above). Individual subject completion rates ranged from 100% for conflict resolution and fire safety to 49% for manual handling theory.
- Medical staff received and kept up-to-date with their mandatory training. At the time of the inspection, the average completion rate for medical staff was 86%. The completion rates for the majority of modules were high (80% or above). Individual subject completion rates ranging from 100% for conflict resolution and the control of substances hazardous to health to 50% for manual handling theory.
- Allied health professional staff received and kept up-to-date with their mandatory training. At the time of the inspection, the average completion rate for allied health professional staff was 89%. The completion rates for the majority of modules were high (80% or above). Individual subject completion rates ranging from 100% for duty of care and dementia awareness to health to 33% for manual handling theory (but with 100% rate for manual handling practical training).
- Basic life support training was included in the hospice's mandatory training programme. At the time of the inspection all doctors and allied health professionals had completed the training, while 92% of nursing staff had completed the training and 64% of health care assistant staff had completed the training.
- Managers and the practice development nurse monitored mandatory training and alerted staff when they needed to update their training. At the time of the inspection the hospice was reviewing its clinical dashboard to assist it in monitoring of clinical training compliance.
- Leaders told us the hospice was due to commence a review of mandatory training and job specific training in 2020, which would include the development of mental health first aiders.

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. However, safeguarding vulnerable children training completion rates were low.

- The service had a safeguarding lead, who managed any safeguarding alerts that needed to be made to the local authority. Staff knew how to contact the safeguarding lead and who to inform if they had concerns. A process was in place for obtaining advice or making urgent referrals to the local authority out of hours. The hospice's electronic reporting system flagged any known previous safeguarding issues.
- Staff knew how to identify adults at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.
- All staff and volunteers were expected to undergo safeguarding vulnerable adults and children level one training as part of their mandatory training. The safeguarding training included awareness of female genital mutilation and child sexual exploitation.
- Nursing staff received training specific for their role on how to recognise and report abuse. For safeguarding vulnerable adults level one training, 83% of nursing staff had completed this by the time of the inspection, while 80% had completed safeguarding vulnerable adults level two training. For safeguarding vulnerable children level one training, 98% of nursing staff had completed this training; 59% had completed safeguarding vulnerable children level two training.
- Medical staff received training specific for their role on how to recognise and report abuse. All nursing staff had completed safeguarding vulnerable adults training level one, and 83% had completed safeguarding vulnerable adults level two training. Training completion rates dropped for completion of safeguarding vulnerable children level one training with 50% of staff having completed this, and 67% had completed safeguarding vulnerable children level two training.
- Allied health professional staff received and kept up-to-date with their mandatory training. For safeguarding vulnerable adults, 67% of allied health professional staff had completed level one and level two training, while all allied health professional staff had completed safeguarding vulnerable children level one and level two training.
- Staff followed safe procedures for children visiting the hospice.
- Staff underwent disclosure and barring service (DBS) checks prior to commencement of employment in line with the hospice's disclosure and barring service policy and procedure. The policy did not require staff to undertake further DBS checks. We discussed this with the leadership team who acknowledged the potential risk of relying on staff disclosure of any subsequent disclosable convictions, particularly given the long-service of many members of staff.
- The hospice had undertaken a safeguarding audit in June 2019 to monitor safeguarding standards. The audit covered a range of standards including clarity of lines of accountability for safeguarding; safeguarding governance and quality assurance; safeguarding policies, procedures and systems; information sharing; recruitment practices, supervision and support; and, staff training and continuing professional development. The hospice was compliant with all standards assessed.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection and when transporting patients after death. They kept equipment and the premises visibly clean.**
- The hospice had an infection and prevention control lead nurse.
- All areas of the hospice we visited were visibly clean, including the sluice rooms.
- The hospice had suitable furnishings and equipment which were clean and well-maintained.
- The hospice participated in the Patient-Led Assessments of the Care Environment (PLACE) programme. The hospice performed well for cleanliness. For the period April 2018 to March 2019, the hospice achieved a cleanliness score of 99.64%, which was better than the England average of 98.47%.
- Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly by the hospice's dedicated housekeeping staff.
- Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff following the 'arms bare below the elbow' protocol.

- The hospice used an ultraviolet light box system to aid staff, patients and visitors in understanding how well they had washed their hands, and to improve hand-washing practice.
- Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Green 'I am clean' stickers were used throughout the hospice to identify equipment that had been cleaned and was ready for use.
- In the period, 1 September 2018 to 31 August 2019, the hospice reported three patients with infection; one patient had an E. coli infection, and two patients were identified with vancomycin-resistant enterococcus infections on admission. Leaders told us that root cause analysis of the E. coli infection was undertaken by a clinical nurse specialist from an NHS partner organisation; the investigation did not identify any specific learning or actions that the hospice needed to take.
- Patients with active infection were isolated and warning signs were used to inform staff and carers of the potential infection risk. Leaders confirmed that the rooms for each patient were decontaminated in line with the hospice's policy. The hospice had invested in decontamination equipment.
- Senior staff undertook a quality assurance clinical services walkabout every quarter. We reviewed the walkabout action plan which demonstrated progress towards completion of previously identified actions.
- Weekly tap flushing was undertaken for all taps in the hospice to prevent against the risk of the development of water-borne bacterial load, such as legionella. Water samples were tested every six months by a third party contractor.

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.**
- The design and layout of the hospice promoted accessibility in all areas with patient rooms facing out to the gardens which surrounded the hospice.
- Patient rooms were housed in two wards, Willow Suite and Oak Suite. Willow Suite had four single rooms and a three-bed room. Oak Suite three single rooms, and one double room.
- The Cedarwood Centre, which was used for day-hospice patients and out-patients, included a creative therapy studio, day room and outpatient clinic rooms.
- Emergency exits were clearly signposted and free from obstruction. We checked a random sample of fire extinguishers, which were located throughout the hospice; these had been tested appropriately.
- Staff carried out daily safety checks of specialist equipment. Electrical safety testing had been carried out on all portable electrical equipment. A planned programme of maintenance was in place to ensure all equipment was serviced and maintained appropriately. Back-up generators were available to maintain essential power in the event of a power failure.
- Contracts were in place for the maintenance of medical equipment. This included maintenance of standardised syringe drivers. Following a recent Medicines and Healthcare products Regulatory Agency safety alert, the hospice had removed affected syringe drivers from use. The hospice maintained sufficient stock of non-affected drivers to meet the needs of its patients. All syringe drivers were placed in a locked, tamper-proof box when in use.
- The hospice had enough suitable equipment to help them to safely care for patients. The hospice had access to specialist equipment, such as bariatric equipment.
- Weighing scales were used and patients' weights were recorded as part of their clinical management.
- An automated external defibrillator was held in the emergency equipment cupboard with daily quality checks carried out. Staff knew to contact the emergency services if a patient required resuscitation.
- Staff disposed of clinical waste safely. Clinical waste was appropriately segregated. Sharps boxes were appropriately constructed and part-closed when not in use. Contracts were in place for the disposal and removal of clinical and non-clinical waste.
- The hospice performed well for condition, appearance and maintenance in the Patient-Led Assessments of the Care Environment (PLACE) programme. The aim of the PLACE programme is to allow healthcare providers to undertake an assessment to a standard national format of a variety of non-clinical aspects of the care they provide. For the period April 2018 to March 2019, the hospice achieved a score for the environment of 98.95%, which was better than the England average of 94.33%.
- Patients could reach call bells and staff responded quickly when called.

- Senior staff undertook a quality assurance clinical services walkabout every quarter. This review the condition of the hospice building and estate and identified areas of repair, or improvement. Entries on the register were RAG-rated to highlight their priority level; for example, an issue with a door lock into the intravenous room, and an excess of oxygen cylinders on the ward were rated as red priorities requiring action within four weeks, while the clarity of car parking signage was rated as amber priority requiring action within two months. Completed actions were rated green.

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.**
- Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Initial assessment for all patients on admission, and reviewed throughout, included review of discharge plans, whether the patient was to be resuscitated in the event of a cardiac arrest, if the patient was for escalation (or if there was a ceiling of care in place), anticoagulation status, and mental capacity status. A short nutritional assessment questionnaire supported staff in understanding patients' nutritional requirements.
- Staff completed risk assessments for each patient on admission and updated them when necessary and used recognised tools. Risk assessments for falls, pressure ulcers, nutritional needs and manual handling needs were completed on admission and 72-hourly afterwards.
- We reviewed four electronic inpatient records during our visit; all had comprehensive risk assessments recorded on admission, including the risk of falls, development of pressure ulcers, and the risk of developing venous thromboembolism (VTE - blood clots). Risk assessments and care plans were generated on the electronic patient record system according to, and tailored towards, individual patient needs. We saw evidence of risk assessments being reviewed during the patient's admission as appropriate to their needs.
- Staff knew about and dealt with any specific risk issues. Pressure relieving mattresses were available for patients at risk of developing pressure ulcers. Prophylactic medicines were prescribed by the doctors for patients at risk of developing clots.
- The hospice had a sepsis care bundle policy (supplemented by a flowchart), which detailed the actions to be taken by staff if a patient was thought, or confirmed to be, septic. This provided guidance for staff on how to manage the patient if they declined transfer to acute hospital. A quick reference 'Think Sepsis' poster was displayed throughout the hospice.
- Patients were regularly assessed for delirium using the Confusion Assessment Method (CAM) tool. A carers information leaflet on delirium was available and included descriptions of the symptoms of delirium and how it can be treated.
- The hospice had undertaken a six month retrospective audit of practice in the diagnosis and management of patients with delirium. As a result, the hospice developed a 'Think Delirium' step approach to the recognition and diagnosis of delirium to ensure an appropriate management plan. The approach, and the education provided to staff around it, showed demonstrable improvement in staff awareness of guidelines, confidence in recognition, diagnosis and management of delirium, and an improvement in care of patients as a result.
- Shift changes and handovers included all necessary key information to keep patients safe. Patient management plans were discussed at each shift handover using a detailed handover document; this ensured that all relevant clinical and non-clinical information was passed to the next shift and included review of any spiritual or pastoral care needs for each patient. The handover discussion was supported by the use of a 'live' acuities board in the inpatient ward office; this enabled staff to see relevant information 'at a glance' throughout the shift.
- Staff were aware of the actions to take in the event of an emergency. Emergency escalation plans and ceilings of care for each patient were discussed twice weekly at the consultant-led multidisciplinary meeting.
- Medical staff were available in the hospice to support any medical emergencies between 9am and 5pm Monday to Friday; out of hours doctors would return to

the hospice if required. Where transfer to hospital for further management was appropriate for the patient, this was arranged by nursing or medical staff via the emergency services.

Staffing

- **The hospice had enough 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, agency and locum staff a full induction.**
- The hospice had enough nursing staff and support staff to keep patients safe. Staffing levels were calculated, at least annually, in line with safer staffing level guidelines from the Royal College of Nursing. The last review was undertaken in July 2019, with a further review planned before the end of the 2019/20 financial year. Staffing levels were calculated to maintain a ratio of one registered nurse to four inpatients during the day, and one registered nurse to six inpatients at night.
- The hospice's managers accurately calculated, reviewed and adjusted the number and grade of nurses, healthcare assistants and allied health professionals needed for each shift in accordance with national guidance. The hospice operated with a minimum of one senior band six nurse on each shift. However, the inpatient service's manager and senior nurses had the discretion to use their professional judgement to increase staffing levels based on patient acuity.
- The clinical director told us the hospice would close inpatient beds temporarily to new admissions if, with the agreement of the multidisciplinary team, it was felt the hospice was unable to meet the staffing levels.
- The number of nurses, allied health professionals and healthcare assistants matched the planned numbers. The hospice employed 26 nursing and allied health professional staff and 13 healthcare assistant staff. The clinical staff were supported by a total of 261 volunteers across the organisation.
- The hospice had recruitment policies in place for staff and volunteers, and a trustee recruitment policy which aligned to the fit and proper persons regulation and the hospice's fit and proper persons requirement policy.
- The hospice had low numbers of vacancies. At the time of the inspection, the hospice had 2.9 whole time equivalent (WTE) staff nurse vacancies, with a further 1.9 WTE for maternity leave. The hospice has 1.0 WTE vacancies for healthcare assistant staff, and 1 WTE vacancy each for senior occupational therapy and senior physiotherapy staff.
- The hospice had low turnover numbers. Between September 2018 and August 2019, nine nursing and allied health professional staff left the hospice, while two staff joined. The main criteria quoted for staff leaving the service were for personal reasons or for career development.
- Between September 2018 and August 2019, the hospice reported sickness rates of eight per cent for nursing staff and three per cent for healthcare assistant staff.
- Managers limited their use of bank and agency staff. They used a specialist agency which provided palliative care trained staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.
- The hospice had low rates of bank and agency staff usage. Between September 2018 and August 2019, the hospice used agency staff for a total of 66 hours.
- The hospice's volunteers supported nursing, medical and administration staff to deliver services across the organisation. For the year ending March 2018, volunteers had provided 106,000 hours of their time.

Medical staffing

- **The hospice 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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.**
- The hospice had enough medical staff to keep patients safe; it employed seven medical staff. The medical staff matched the planned number on all shifts and provided 24 hours a day seven days a week medical cover.
- The hospice was led by a whole time equivalent consultant in palliative medicine, who was also the medical director. The hospice employed six (2.5 WTE) speciality grade doctors, working a variety of sessions across each week.
- Out of hours cover was provided by a first and senior level on-call rota. Four speciality grade doctors and a specialist trainee contributed to the first on call rota,

while the senior level on-call rota was covered by three consultants in palliative medicine and two experienced speciality grade doctors (with access to consultant advice if required).
- The service had one whole time equivalent GP registrar who was supernumerary and did not contribute to the on-call rota.
- There were no medical staff vacancies at the time of the inspection.
- Between September 2018 and August 2019, two medical staff had left the hospice. The main criteria quoted for medical staff leaving the service were for personal reasons or for career development.
- Sickness rates for medical staff were low. Between September 2018 and August 2019, the hospice reported a sickness rate of three per cent for medical staff.

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 records were stored securely. Patient notes were comprehensive, and all staff could access them easily.
- The hospice predominantly used an electronic patient records system, which was password protected. The individual end of life care and communication record for patients approaching the last days and hours of life was paper based.
- Although the hospice's patient records were not integrated into the local acute hospital's system, hospice staff had access to correspondence and investigations held on the electronic patient records systems for both the hospital or community teams. This meant patients would be flagged as an alert if they attended hospital as an acute admission.
- The hospital, community specialist palliative care teams with patient consent, provided with read-only access to the patient records. The hospice was in the process of obtaining access to GP shared care records for its patients.
- We reviewed four electronic patient records, one paper end of life care and communication record and five do not attempt cardiovascular resuscitation records during our visit.
- All the records we reviewed were comprehensive, clear and included relevant risk and clinical assessments including escalation and ceiling of care plans, known allergies, nutritional and pain assessments, medical and nursing clinical management plans and pathways, and were linked to the integrated palliative outcome scale (IPOS) phase of illness and advanced care planning. Communication with patients and their families were clearly documented throughout the records.
- At the time of the inspection, the hospice had engaged the electronic system database manager to review the hospice's use of the system, and to explore any data quality extraction benefits that could be derived from more effective use of the system. For example, although patient's preferred place of care and preferred place of death were recorded on all records we looked at, the system was unable to automatically extract this data for analysis and therefore required manual review of individual records to obtain this information.

Medicines

- **The service used systems and processes to safely prescribe, administer, record and store medicines.**
- The hospice's clinical director was the organisations controlled drugs accountable officer. The inpatient services manager was the service lead for safe handling of drugs. At the time of the inspection 28 staff were authorised to administer controlled drugs. The hospice had no non-medical prescribers and no patient group directions in place. Patient group directions allow some registered health professionals to administer specified medicines to a pre-defined group of patients, without the patient having to see a prescriber.
- Staff mostly followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff had access to appropriate guidelines to aid prescribing decisions and administration of medicines. The hospice had a 'prescribing of medication in anticipation' policy. Governance oversight was provided by the hospice's medicines management group.
- We observed nursing staff check compatibility of medicines in syringe pumps before administration. A syringe pump is a mechanism to allow medicines to be mixed together in a syringe and given under the skin.
- Prescriptions for syringe pumps were not always fully completed. The fluid used to dilute the medicines for the syringe pumps was not always specified by the prescriber and the time frame for administration was not specified as part of the prescription. However, the

syringe pumps in use were pre-programmed to deliver the medicines over 24 hours. Syringe pumps were monitored regularly by nursing staff once they had been started.

- We reviewed seven patient medication records; there were no gaps in administration of medicines. However, documentation of who had recorded the increase in dosages of medicines in the syringe pump was unclear on the medication chart, although a contemporaneous record had been made in the electronic clinical notes.
- Sixty-seven per cent of nursing staff, authorised to administer medicines using a syringe driver, were up to date with their syringe driver training. Leaders told us the relatively low figure was due to long term absence of six registered nurses. A plan was in place to address this with training scheduled in January 2020. The hospice expected all eligible staff to be up to date with syringe driver training by the end of the month.
- Following our visit, the hospice created an action plan to address the issues we found. This included the development of a new syringe driver dose changes supplementary sheet; to amend the hospice's prescribing policy, administration of medicine policy and syringe driver policy; and, a full communication strategy to communicate the changes once the policies had been updated and ratified.
- The hospice issued a 'Highlight 5' briefing to staff to remind them to sign or enter a variant code on the contemporaneous record to confirm any dose variations. It also produced a reminder card for staff to insert on their lanyard to re-enforce the briefing. The hospice also updated its medicines audit policy and audit capture tool to ensure all appropriate variations had been appropriately documented.
- The hospice had a service level agreement with a regional hospital trust to provide a clinical pharmacy and supply services. The hospice was able to access medicines outside of normal working hours.
- Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. Patients were reviewed regularly via twice weekly multidisciplinary meetings and daily handovers.
- A clinical pharmacist visited the hospice Monday to Friday to review patients' medicines. Patients were assessed for self-administration of medicines where appropriate. Patients and carers were given information leaflets so that they were informed when receiving medicines which were being used off-licence. The use of medicines outside their licence was widespread within palliative care. This is when a medicine is being used differently to how the company manufacturing the medicine intended.
- Staff stored and managed all medicines and prescribing documents in line with the provider's policy. Medicines including controlled drugs were stored securely. Staff carried out daily controlled drugs balance checks and disposed of unused controlled drugs according to legislation. Staff monitored refrigerators and store rooms where medicines were stored appropriately.
- The hospice had a process to audit the use of green FP10 prescriptions and these were stored securely.
- Staff followed current national practice to check patients had the correct medicines. Staff had access to each patient's summary care records to check what medicines the patient was taking before admission to the hospice. Pharmacists checked this was completed in a timely manner and communicated discrepancies and clinical issues with prescribers on their daily visit. However, pharmacists did not document any advice given within the patient record.
- Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. The hospice had conducted an audit in response to the Gosport report to review the use of sedating medicines and opioids at the end of life and benchmark against their own standards. The outcome of the audit confirmed that doses of opioids and sedating medication were within agreed clinical guidelines. This review of medicines had resulted in prescribing of lower dose ranges.
- The hospice had also undertaken an audit on the recognition, assessment and management of delirium which had resulted in a standardised tool being used to diagnose delirium and guidance about the right medicines used to treat the delirium being put in place.
- Patient medication charts had clear indications for 'when required' medicines. We also observed dosing ranges being utilised for medicines according to indication and severity of symptoms.

Incidents

- **The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

- The hospice had an accident, near miss and incidents reporting policy and operational procedure.
- The hospice had a serious untoward incident and recovery plan policy which set out a series of actions to be taken in the event of serious untoward incidents or never events. The policy's purpose was to minimise risks to staff, patients and the general public and to ensure prompt, efficient and effective management of such incidents, and was aligned to the requirements of the local NHS clinical commissioning group.
- Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the hospice's policy.
- In the year 2018/19, the hospice reported no never events or serious untoward incidents.
- One serious incident occurred during our visit. We saw evidence that this was appropriately investigated and managed, including the application of the duty of candour.
- Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The hospice had a being open policy which incorporated the duty of candour.
- Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff received feedback from investigation of incidents during staff meetings.
- The service had systems to ensure staff knew about medicines and other nationally issued safety alerts and incidents, so patients received their medicines safely. Staff were encouraged to report incidents and near misses. There were processes for investigating and learning from errors when they occurred.
- We saw evidence that patients or relatives were informed, if necessary, about any errors occurring with medicines. Incidents were discussed at the medicines' management group; themes were analysed, and learning disseminated in various monthly update briefings including the 'Highlight 5' and 'drug of the month' briefings. We saw evidence that staff had acted on safety alerts where appropriate.

Safety Thermometer (or equivalent)

- **The hospice used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.**
- Staff used the safety thermometer data to further improve services. The hospice undertook a comparative study of patient accidents between the periods 2017/18 and 2018/19. This enabled leaders to understand when, how, and the degree of harm for patient accidents, and whether or not these were preventable in order to devise strategies for improvement.
- In the financial year 2018/19, the hospice reported 49 patient slips, trips or falls; 28 of these resulted in no harm and the remaining resulted in low harm. The hospice had invested in falls prevention equipment, including pressure mats and alarms. The number of falls had reduced from 56 in the previous reporting period.
- In the same period, 44 pressure ulcers were recorded; 34 of these were pressure ulcers that were present on admission to the hospice. The total number of pressure ulcers had reduced from 102 in the previous reporting period.
- For healthcare associated infections, the hospice recorded five infections in 2018/19 which was lower than the previous reporting period, where six infections were recorded.

Are hospice services for adults effective?
(for example, treatment is effective)

Good

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

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.**
- Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The clinical director managed a central database of policies and procedures for the hospice that

enabled tracking of policy review dates. A process was in place for policies to be updated with any new or amended guidance. The database provided staff with up-to-date links to policy documents.

- We reviewed a range of policy documents held by the hospice. These all clearly recorded references for guidance that had been relied on in the development of each document. This included guidance from a range of organisations including the National Institute for Health and Care Excellence, the Royal Colleges, Hospice UK, the Merseyside and Cheshire Palliative Care Network, and other professional bodies such as the European Resuscitation Council, the UK Renal Association.
- Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Awareness of the requirements of the acts was included in mandatory clinical core skills training on consent.
- Patients had an individualised plan of care which, if the patient was at end of life, was supported by the individualised care and communication record for a person in the last days or hours of life. This was in line with the National Institute of Health and Care Excellence quality standard QS13, end of life care for adults, and national guideline NG31 care of dying adults in the last days of life.
- At handover meetings, staff routinely referred to the psychological, emotional and spiritual needs of patients, their relatives and carers. The hospice used a detailed, pre-formatted handover sheet to ensure a consistent approach to handover for all patients. All members of staff at the handover were able to contribute to the discussion, including healthcare assistants and spiritual care staff.
- The hospice undertook a comprehensive range of audits throughout the year. The audits covered a range of areas relating to patient experience, communication, risk management, quality effectiveness, clinical effectiveness, learning effectiveness, and resource effectiveness.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.**
- Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. This was supported by the hospice's nutritional care policy which guided clinical and catering teams in meeting each patient's individual needs.
- The hospice promoted a 'food first' approach, which aimed to avoid the use of artificial supplements as a first choice. Patients were able to select their preferred meal and drink options from a menu, which also included snacks.
- Each ward had a self-catering kitchen area for patients and their relatives to make drinks and refreshments. The on-site restaurant provided a range of meal options during the daytime, while vending machines and microwaves were available for patients and relatives to obtain food out of hours.
- Staff fully and accurately completed patients' fluid and nutrition charts where needed.
- The hospice promoted a 'sip system' using hydrant bottles to aid patients in maintaining their hydration. Hydrant bottles are designed for people that find drinking from cups or mugs difficult. The large plastic bottles include large easy to grip handles, that can also be used to hang the bottle off a suitable ledge, and a tube to enable people to sip from the bottle.
- Staff used the palliative life-state and nutritional tool to monitor patients at risk of malnutrition, and to assess symptoms that can affect nutritional status of palliative patients. Nutritional assessment was undertaken at admission and every subsequent 72 hours and used to inform the development of an individual nutritional care plan for the patient, if required. Referrals were made to dietitians, speech and language therapists, or occupational therapists as required.
- Any relevant nutritional risk assessments were shared with the catering team. Red trays were used to identify patients that required additional support when eating or drinking; use of red trays was highlighted on the staff 'at a glance' board.
- Specialist support, from staff such as dietitians and speech and language therapists, was available for patients who needed it. Patients requiring total parenteral nutrition were supported in the hospice through a specialist third party provider.

- The hospice performed well for food in the Patient-Led Assessments of the Care Environment (PLACE) programme. For the period April 2018 to March 2019, the hospice achieved a score of 93.34%, which was better than the England average of 90.17%.
- Clinical staff undertook basic food hygiene, dysphagia (swallowing difficulties) and fluids and nutrition online training as part of their clinical core skills training. Dysphagia training was provided in response to a national patient safety alert in 2018 on the safer modification of food and drink.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**
- Staff assessed patients' pain using a recognised tool, the Abbey Pain Scale, and gave pain relief in line with individual needs and best practice.
- Patients received pain relief soon after requesting it. A patient we spoke with confirmed there were informed about their medicines and staff responded quickly when they needed pain relief.
- Staff prescribed, administered and recorded pain relief accurately, including anticipatory medicines for patients who were in the last days and hours of life.
- The pain and anaesthetic team supported patients and were able to provide anaesthetic interventions to patients with complex cancer pain.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**
- Current limitations in the hospice's patient record system meant that it was not possible to automatically report on metrics such as the patient's preferred place of care or preferred place of death. However, the hospice undertook a manual audit of the records for patients who had been discharged from, or who had died in, the hospice between 24 September 2019 and 16 December 2019. In all 47 patient records (100%), a preferred place of care and preferred place of death was recorded.
- Of the 30 patients who died in the hospice, one patient's wishes for preferred place of death were unknown as they lacked capacity at the time, and six patients had expressed a wish to die at home. This equated to 83% of patients dying in their preferred place. For the remaining patients, their needs were too complex or their decline too rapid to achieve their wishes of dying at home.
- During the same period a further 17 patients were discharged from the hospice to home. Six of these patients had expressed a preference to die at home; and two of these were facilitated as rapid discharges. The remaining 11 patients were discharged for on-going care at home. Therefore, of the 12 patients admitted to the hospice during the period who had stated a preferred place of death as at home, this was achieved on 50% of occasions.
- The multidisciplinary team pre-emptively discussed outlying patients who were known to the local palliative care services to ensure that admission for symptom control or end of life care progressed smoothly.
- Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.
- The hospice had a dedicated rehabilitation assessment suite to assess, treat and improve patients' abilities to undertake day to day tasks.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**
- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.
- Managers recruited, trained and supported volunteers to support patients in the service. The hospice had a volunteer co-ordinator, who managed the day to day co-ordination and training of volunteers. Volunteers were provided with a structured full-day induction programme, which ran quarterly, and a separate day for completing relevant mandatory training.
- The hospice's practice development nurse supported the learning and development needs of staff. All new staff a full induction tailored to their role before they started work. A full competency programme, overseen by the practice development nurse, ensured that staff were competent in their roles to deliver care and treatment to patients.

- The hospice had a local induction programme for new bank or agency staff. This programme ensured that staff completed relevant mandatory training modules and were made aware of local processes and procedures. Staff were given time to complete the programme prior to the start of their first shift and were supernumerary during the induction period.
- A calendar of education meetings was in place for January to December 2019. A range of internal and external classes were delivered covering clinical, therapeutic and regulatory subjects. For example, although not limited to, human rights in end of life; pharmacology of hypoactive delirium; exploring preferences for place of death with terminally ill patients; supporting the homeless; radiotherapy education; stress awareness; and, meditation.
- Managers supported staff to develop through yearly, constructive appraisals of their work. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with told us the hospice were supportive of additional skills training.
- Staff had the competence, skills and training, in conjunction with the local hospital, to support paracentesis (the perforation of the body with a hollow needle to remove fluid or gas) and pleural drain insertion carried out by the respiratory team.
- A process was in place to regularly check nursing staff registrations. The hospice supported nursing staff through the revalidation process.
- Managers supported medical staff to develop through regular, constructive clinical supervision of their work. The hospice had a clinical supervision programme which included a revalidation tool to support medical staff in revalidation through the local NHS acute trust.
- In the year 1 April 2018 to 31 March 2019, all specialty grade doctors had received an appraisal. At the time of the inspection all medical, nursing, allied health professional and health care assistant staff had received an appraisal.
- Consultant staff received appraisals in their substantive NHS position; however, a two-way process was in place for sharing relevant and appropriate performance information between the hospice and NHS organisations.
- Managers made sure staff attended team meetings or had access to full notes when they could not attend.
- The hospice had developed an educational toolkit for staff covering the 24 hour telephone advice line. The toolkit aimed to develop a consistent approach in providing advice on the helpline and included a structured call handling flowchart, an audio compact disc for listening to actual calls, a reflective practice proforma, learning transcripts and useful tips.

Multidisciplinary working

- **Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**
- The multidisciplinary team included the consultant in palliative care supported by speciality grade doctors; specialist palliative care nurses; occupational, complimentary and creative therapists, the hospice social worker; and, the spiritual care team.
- Staff held weekly multidisciplinary meetings to discuss patients and improve their care. We observed a multidisciplinary meeting which took a clear, structured and systematic approach that supported all member of the team to contribute. As well as reviewing all current patients, pre-emptive discussion of known outlying patients was included.
- Staff worked across health care disciplines and with other agencies when required to care for patients. With patient consent, relevant information and consultation records was shared with appropriate professionals in the community or acute trust; for example, patients' GPs, hospital consultants, or the hospital specialist palliative care team. This ensured that all professionals responsible for a patient's care had all their relevant clinical information should the patient be admitted to hospital. When discharging a patient, the hospice provided a discharge letter or outpatient letter to the original referring clinician.

Consent and Mental Capacity Act

- **Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, and Mental

Capacity Act 2005 and they knew who to contact for advice. Awareness of the requirements of the acts was included in the clinical core skills mandatory training for staff.

- Staff gained consent from patients for their care and treatment in line with legislation, guidance, and the hospice's consent to care and treatment policy. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. For patients in the last days or hours of life, assessment of capacity was undertaken and recorded in the patient's individual end of life care and communication record.
- The hospice's consent policy set out the two-stage functional test for capacity in line with the requirements of the Mental Capacity Act. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.
- The hospice recognised that the guidance surrounding the deprivation of liberty standards was updated in May 2019. The hospice safeguarding lead was in the process of being trained on the new guidance and it was expected the training would be cascaded to all the relevant service leads once this had been completed.
- We reviewed five unified do not attempt cardiopulmonary resuscitation (uDNACPR) forms. The forms we viewed were completed appropriately and in line with guidance.
- The hospice had undertaken an audit of forms. The audit identified that 97% of the 30 patients in the audit sample had a uDNACPR order in their records, which indicated a discussion with the patient or their family. Twenty-four of these patients had the uDNACPR in place on arrival at the hospice. The audit identified a number of completion omissions (by hospitals or GPs) on forms that had been accompanied patients on their arrival at the hospice. Although none of the missing information was key clinical information, the audit recommended sharing the findings with the resuscitation lead at the local NHS acute hospital.
- The hospice was in the process of identifying, training and developing mental health first aider roles.

Are hospice services for adults caring?

Outstanding ☆

Our rating of caring improved. We rated it as **outstanding.**

Compassionate care

- **There was a strong, visible person-centred culture that was promoted by the hospice's leaders. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Staff always treated patients and relatives with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**
- During the inspection, it was clear that a culture of compassion, privacy, dignity and delivering individual needs and wants to palliative and end of life care patients was endemic, truly embedded and ingrained in the hospice.
- People's emotional and social needs were seen as being as important as their physical needs. All inpatient respondents to the 2018 patient survey said that the care team 'always' treated them as a whole person; and, all respondents from the wellbeing unit said the care team 'always' or 'most of the time' treated them as a whole person.
- Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.
- Consideration of people's privacy, dignity and needs was consistently embedded in the hospice in everything that staff did. The hospice participated in the Patient-Led Assessments of the Care Environment (PLACE) programme. For the period April 2018 to March 2019, the hospice achieved a privacy, dignity and wellbeing score of 97.44%, which was significantly better than the England average of 84.16%.
- Patients said staff treated them well and with kindness. All inpatient respondents to the 2018 patient survey said

that staff 'always' treated them with respect and dignity; and, all respondents from the wellbeing unit said staff 'always' or 'most of the time' treated them with respect and dignity.

- Staff followed policy to keep patient care and treatment confidential.
- Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients' spiritual needs were discussed in handover meetings, which were attended by representatives from the hospice's multifaith chaplaincy.
- Compassion by service staff extended beyond helping patients or families and carers, including to staff and to the wider users of the hospice's services. All the staff we spoke with provided examples of occasions when they had truly gone 'above and beyond' for patients and their relatives.
- One example included the facilitation by the hospice of a 200 mile transport of a severely ill patient to a hospice closer to the patient's family to meet the patient's advanced care plan request; this meant the patient was able to spend time with their family before they died.
- Another example shared with us detailed how the hospice's complementary therapist and family support therapist worked with a patient's young children to help them understand their parent's condition, get involved in their parent's pain-relief massage treatment, which helped the children to feel more included in their parent's care and less isolated.
- A third example shared was of a patient admitted urgently to the hospice at the weekend. Within 24 hours of admission the patient's condition was deteriorating so rapidly it was expected they would have only hours to live. On hearing the patient and partner's wishes to be married, hospice staff contacted the out of hours registrars and chaplaincy team, decorated a room in the hospice and set up a function buffet. The wedding was undertaken within a few hours. The patient died the following day in the presence of their family.
- We heard examples of staff really taking the time to get to understand what was important to patients, carers and families. In the 2018 patient survey, all inpatient respondents said staff always considered the things that were important to them in planning their care. This was reflected in the records we reviewed which all clearly recorded patient's views on what mattered to them.

Emotional support

- **Staff provided emotional support to patients, families and carers to minimise their distress. Staff recognised and respected the totality of people's needs. They always took people's personal, cultural, social and religious needs into account, and found innovative ways to meet them. People's emotional and social needs were seen as being as important as their physical needs.**
- Staff gave patients and those close to them help, emotional support and advice when they needed it. The hospice had a strong focus on wellbeing and provided a range of complementary and creative therapy programmes to support people's emotional needs.
- Staff showed us a number of examples where creative therapy had helped patients. A patient of the long-term day hospice had written inspirational poetry. Another inpatient, who was approaching the end of their life had increased anxiety and agitation; the patient was supported to learn to paint and sketch, which reduced their anxiety in the last weeks and days of their life.
- The hospice's multifaith spiritual care team attended handover meetings and visited all patients as needed or requested. Patients, their families and carers could access the multifaith quiet room.
- Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. All wellbeing unit and inpatient unit respondents in the 2018 patient survey said they felt safe in their place of care.
- Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. A dedicated social worker, based at the hospice, supported patients and carers with access to social care and advice on claiming relevant benefit payments. The social worker was key in arranging packages of care to allow patients to return home or to transition to nursing homes or care homes. This included making the arrangements for any rapid discharges to a patient's preferred place of death.
- The creative therapy team had developed a 'Celebration of Life' project, which aimed to help patients explore creative ways to reflect on their life and to celebrate what they had achieved. The project supported patients to undertake this reflection through a range of activities

such as poetry, drawing and painting, letter writing, the development of family trees, creation of memory boxes, photography, creative writing and recording video diaries.
- The hospice had accommodated remembrance memorial services for patients, and a wake for a long-standing staff member who had died. Remembrance books were held in the multifaith quiet room.
- The Wellbeing Suite accommodated a range of wellbeing groups for day hospice patients and inpatients, including breathlessness support groups and being active workshops.
- The hospice had developed a range of compact discs with recordings designed for relaxation for patients to listen to at home to reduce anxiety.
- Although the hospice did not provide care for children, its Living Well centre had hosted drop-in sessions, delivered by a child bereavement organisation, for families and professionals to find out about the support and training available when a child dies or when a child grieves.

Understanding and involvement of patients and those close to them

- **Staff saw people, who were approaching end of life, and those close to them are active partners in their care. Staff were fully committed to working in partnership with patients, their carers and their families, and with ward staff to make this a reality for each person.**
- Staff and volunteers throughout the hospice and its wider services were passionate about meeting patients' needs. This was part of the day to day provision of palliative and end of life care in the hospice such that outstanding care had become the expected standard.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. Staff made sure patients and those close to them understood their care and treatment. In the 2018 patient survey, all respondents in the wellbeing unit and the inpatient unit said they 'always' or 'most of the time' had been able to talk with members of their care team as openly as they would wish, and all respondents said they had the opportunity to ask questions.
- Staff talked with patients, families and carers in a way they could understand. Staff ensured that people's communication needs were understood. People's individual preferences and needs were consistently reflected in how care was delivered. They showed determination and creativity to overcome obstacles to delivering care.
- One comment recorded as part of the patient survey said "I couldn't have been treated better if I had gone private. I love the way the doctors spend the time to discuss everything with you and explain things fully. They treat the full person and not just what is wrong with you. Everyone seems fully aware of what has been said and they're all on board. Even kitchen staff are encouraging and caring."
- Staff supported patients to make advanced decisions about their care. Advanced care planning was embedded in the service, and it was clear that all areas of the hospice had influence in this; for example, the creative therapy team played a part in helping patients to understand and express what was important to them.
- Staff supported patients to make informed decisions about their care. We saw evidence in the records we reviewed of discussions between end of life care staff and patients, and their families, including discussions around do not attempt cardiopulmonary resuscitation decisions, and decisions about patients' preferred places of care.
- The hospice's Wellbeing Service aimed to support patients living independently through optimising their function and wellbeing. It delivered a range of education sessions for patients on self-management. This included, but was not limited to, education sessions on understanding pain management, anxiety management, energy conservation, body image, reminiscence through music, and Tai-Chi.
- Staff recognised that people need to have access to, and links with, their advocacy and support networks and they supported people to do this. The bereavement team supported families before and after the death of their loved ones, and in conjunction with the hospice social worker helped families access support services for advice, including financial advice.
- The hospice had accommodated up to 40 relatives of a young patient to enable the extended family to stay with the patient during the last days and hours of their life in accordance with their faith.
- Patients and their families gave continually positive feedback about the service and their treatment and staff supported them to do this.

Outstanding ☆

Hospice services for adults

Are hospice services for adults responsive to people's needs?
(for example, to feedback?)

Outstanding ☆

Our rating of responsive improved. We rated it as **outstanding.**

Service delivery to meet the needs of local people

- **The hospice, and its multidisciplinary team, proactively planned its services and provided care in a way that took into account and, quickly and responsively, met the preferences and needs of local people and the communities it served. The hospice, and its team, worked with others in the wider system and local organisations to plan individualised and highly responsive care that promoted equality, including for those with protected characteristics.**
- Managers planned and organised services, so they met the changing needs of the local population.
- Facilities and premises were appropriate for the services being delivered. The 12-bedded in patient unit accepted planned admissions between 9am and 5pm, Monday to Friday. However, the hospice had processes in place to support urgent admissions at any time, including out of hours, according to patient need.
- Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The inpatient unit was divided into two wards. Willow Suite had seven beds, of which four were single rooms with en-suite facilities and one three-bedded bay with a walk-in bath. Oak Suite had five beds, three of which were single en-suite rooms and the remaining was a double room. Staff told us that the multi-bedded rooms were single-sex only when in use.
- Each en-suite room was equipped with a radio, CD player, television and wi-fi access. Self-catering facilities were available for the use of patients and their families in both wards. A multisensory therapeutic bathroom was available for the use of in-patients.
- The service had suitable facilities to meet the needs of patients' families. Quiet rooms were available in the hospice for families which included facilities to stay overnight. Television, DVD players, books and children's books were available in the quiet rooms. Shower facilities were available for families within the Cedarwood Centre.
- Staff were trained to support patients with intravenous antibiotics and fluids, blood and iron transfusions, and with tracheostomies.
- The service had systems to help care for patients, including those with complex needs, who required additional support or specialist intervention. The joint hospice and hospital pain and anaesthetic team supported the management of complex pain within the hospice.
- The hospice had also developed, jointly with the local NHS acute hospital, a pain and anaesthetic team. Piloted over 12 months from November 2018, the aim was to provide seamless care for patients requiring anaesthetic interventions for complex cancer pain. The success of the pilot had resulted in approval by both organisations for a further 12 month extension of the team.
- Staff told us of a number of examples where the pain and anaesthetic team's intervention had benefitted patients. One patient, who had been admitted for management of pain, could not be moved without suffering excruciating pain. The pain and anaesthetics team intervened and enabled the patient to be moved onto a mattress more suited to their needs. Through the intervention the patient's pain improved substantially to the point they were comfortable enough to spend time with their family and making handprints prior to their death.
- The hospice worked with other agencies to meet the needs of its patients and those in the wider health economy; these included primary, social and secondary care services. The hospice's medical director chaired, and attended, the Cheshire and Merseyside clinical network's palliative and end of life care delivery and oversight group.
- Staff provided an example of a patient where staff had undertaken multiple inter-agency meetings with occupational health, district nurses, GPs, physiotherapy, dietitian and social service staff to find suitable accommodation for the patient to be discharged into their family's care. Staff maintained communication throughout with the patient's medical team in a distant geographical area who were monitoring the patient's progress.

- The hospice's trading company supported travelling communities with furniture and equipment to enable its patients from the travelling community to return home.
- The hospice had a dedicated, and well-equipped, occupational and physiotherapy gym.
- The outpatient service was delivered from the purpose built outpatient suite. Four outpatient clinics were delivered each week by three consultants and one specialist registrar. The outpatient service was led by a band seven manager supported by a senior staff nurse, and a healthcare assistant. A team of volunteers provided administration support, including transporting patients to and from the service.
- Managers ensured that patients who did not attend outpatient appointments were contacted. The hospice had a process in place to contact any patient that did not attend for an appointment. This included the ability to check if patients had been admitted to hospital, or to request a welfare visit by the police if appropriate.
- Day therapy services were available Monday to Friday for patients living in the community. These included a four week breathlessness management programme; complimentary therapy; creative therapy; and day therapy for up to ten patients per day.
- Staff in the hospice took a proactive approach to understand the needs and preferences of different groups of people and to deliver care in a way that met those needs, which was accessible and promoted equality. This included people with protected characteristics under the Equality Act, people who may be approaching the end of their life, and people who were in vulnerable circumstances or who had complex needs.
- This was demonstrated by the work being undertaken by the hospice to increase engagement in palliative and end of life care with the homeless community, through its work with a local homeless charity, and with the lesbian, gay, bisexual, transgender, intersex and questioning (LGBTIQ) community. The hospice had proactively worked in the St Helens Pride event in August 2019 to improve visibility of the hospice and its services to people in the lesbian, gay, bisexual, transgender, intersex and questioning community that were living with life limiting illnesses.
- The hospice's strategy of involving and reaching out also included work with the local homeless community and a local charity organisation to understand and seek ways to improve access to palliative care services. The hospice's end of life care nurse advisor and charge nurse attended the Liverpool homelessness conference with the aim of developing support in The Living Well centre for the homeless community.
- The hospice had recently, since April 2018, developed a bereavement support service. Called 'Willowbrook Connections', the service was based in the hospice's The Living Well centre. The service provided proactive anticipatory and post bereavement support to patients and families known to the specialist palliative care across St Helens and Knowsley to help them support their relatives and to understand and prepare for their relatives' deaths.
- An end of life care nurse adviser worked alongside the hospice and clinical commission groups' integrated quality team. The adviser delivered training in advanced care planning and supported primary care teams in the community.
- The hospice had a dedicated viewing room, and an adjoining relatives' room. This meant that families and carers could spend time with their deceased relative prior to the body being collected by the undertaker. A separate door from the viewing room enabled the undertaker to move the patient out of the hospice discretely.

Meeting people's individual needs

- **The hospice, and its multidisciplinary team, put people's individual needs and preferences central to the delivery of its services. The service was inclusive and responsive in its tailored care to meet the individual and complex needs of its patients. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**
- Care plans and risk assessments for patients were person-centred and consistently tailored to each individual patient's needs. Each person's care plan was devised in discussions with the patient about what was important to them. The care plans were regularly reviewed and updated, and referrals were made to members of the multidisciplinary team according to each patient's needs.
- The hospice used a tailored individualised care and communication record to document each patient's care at the end of life. This included any advanced care plans, or advanced decisions to refuse treatment that

had been put in place by the patient. These were in line with the National Institute of Health and Care Excellence Quality Standard QS 15 Statement 9: Patients experience care that is tailored to their needs and personal preferences, considering their circumstances, their ability to access services and their coexisting conditions.

- Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The hospice's dementia policy supported the use of the 'This is me' passport for patients living with dementia. The hospice had dementia friendly signs throughout to assist patients to orientate themselves within the unit and the areas they needed to use.
- The hospice had a dementia care lead, who delivered training to staff to embed the service's dementia strategy and worked closely with the Admiral nurses (Admiral Nurses provide specialist dementia support that families need). The hospice had achieved the European certificate in holistic dementia care; we were told the hospice was one of only seven hospices that had achieved the certificate.
- The hospice performed well for in the Patient-Led Assessments of the Care Environment (PLACE) programme assessments for people living with dementia or disability. For the period April 2018 to March 2019, the hospice achieved a score of 95.97% for dementia, which was significantly better than the England average of 78.89%. For disability, the hospice scored 91.78%, which was better than the England average of 84.19%.
- Two of the hospice's doctors were qualified to administer western medical acupuncture. Acupuncture was provided, following assessment, to both inpatients and outpatients in bespoke treatment plans to manage pain, anxiety and breathlessness.
- We were shown three examples where acupuncture had proved to be beneficial to patients. One example included an elderly patient where, having had two previous unsuccessful anaesthetic nerve blocks, was still experiencing significant pain in their back and legs. The patient was sensitive to medicines and was not keen to have further pharmacological treatment. The patient was given acupuncture on the knee which resolved their pain to an acceptable level and improved their quality of life.
- Another outpatient, suffering from chronic neck and head, was offered acupuncture. Following two successful treatments, the patient no longer needed the additional pain relief medicine they had been taking.
- The hospice's facilities were designed to meet the needs of the full range of people who used its services. The building was designed to be accessible with all its operational services and inpatient rooms located on the ground floor. There were separate entrances to the day hospice, Cedarwood Centre, which maintained privacy for the patients in the inpatient areas.
- The facilities within the Cedarwood Centre were used flexibly to meet the needs of day hospice patients as well as relatives of inpatients who stayed overnight. The Cedarwood Centre had a range of rooms supporting the creative and complementary therapy services, a multimedia suite, a multisensory relaxation room, and a dedicated dining area for day hospice patients. Accessible toilets were available throughout the building, one of which included a shower facility for use of relatives who stayed overnight.
- A multi-sensory therapeutic bathroom was available for use by inpatients 24-hours a day. The room, which had multisensory adjustable mood lighting, included a hydrotherapy bath with USB connectors to enable patients to play their own music while relaxing in the bath.
- Landscaped gardens surrounded the hospice building and were maintained to a high standard. These included a raised vegetable garden, which supplied the hospice's kitchen. Patients were encouraged by the therapy teams to participate in the planting and maintaining of the gardens as part of their care. A private, internal garden enabled patients to maintain their privacy while still enjoying the benefits of the garden. A children's play area in the gardens was developed following engagement with patients and their families.
- The hospice supported open visiting for relatives and carers seven days a week; however, mealtimes and rest times for patients were protected. Patients were given a choice of food and drink to meet their cultural and religious preferences.
- The hospice undertook a carer's assessment on each patient's admission to identify any support needs for their carers and how these could be met through the existing hospice therapy and spiritual care teams, or through social care support.

- Family support and support from the spiritual care team was also consistently undertaken and monitored. Between April 2019 and November 2019, the hospice provided support to 419 new relatives or carers. This was provided through 1117 face to face contacts, and 832 telephone contacts.
- Managers made sure staff, and patients, relatives and carers could get help from interpreters or signers when needed, although it was recognised that the hospice was located in an area that did not have a significant ethnic community. A telephone interpretation service was available as required. Two staff members translated directly for an inpatient whose first language was Cantonese.
- The hospice had a range information leaflets available for patients and their relatives and could access translated versions if required.

Access and flow

- **Patients could access the specialist palliative care service in a way and at a time when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice. There were processes in place to ensure urgent admission and rapid discharge when needed.**
- Referrals for people with advanced incurable disease of any cause were accepted from any health professional working with the person and their carers. Patients could be referred to the hospice by their GP, local district nurse team, and direct from hospital. As the hospice cared for patients with more complex physical, psychological, spiritual and social needs, it did not accept self-referrals or provide respite care. The hospice had processes in place to accept urgent admissions.
- Managers monitored waiting times and made sure patients could consistently access services when needed and received treatment within agreed timeframes. Referrals for all inpatient unit admissions were reviewed daily, triaged and prioritised by a senior doctor. Patients were admitted according to greatest need and availability of beds.
- Daily admission meetings were in place to ensure timely review and action of referrals received to prevent delayed admissions. Referrals for the therapy services were triaged by the day therapy staff.
- The hospice monitored bed occupancy rates as part of their data submission to the clinical commissioning groups. In quarter one, April to June 2019, the average bed occupancy rate was 78%; in quarter two, July to September 2019, the occupancy rate was 93%.
- Managers and staff consistently worked to make sure that they started discharge planning as early as possible. We saw evidence in the records that discharge planning commenced on admission.
- The hospice monitored the number of delayed discharges. Between July and November 2019, there were two delayed discharges, which equated to an additional 37 bed days, for Knowsley clinical commissioning group patients. In the same period, there were ten delayed discharges, which equated to an additional 143 bed days, for St Helens clinical commissioning group patients. The hospice social worker consistently liaised with the local authorities and local care homes to ensure that any barriers to the discharge of patients were removed as soon as practicable.
- The hospice facilitated rapid discharges of patients who wished to die at home within six hours. A rapid discharge checklist was in place to ensure all relevant needs were considered and documented. The hospice's social worker had links to relative services to provide equipment at a patient's home at short notice. The hospice had access to an out of hours pharmacy service which provided medicines required for home use.
- Referrals to the medical outpatient service were reviewed and triaged against the referral criteria by a consultant or doctor. Patients were offered appointments according to need, with an initial assessment followed by review as appropriate. Patients were discharged from the service once the episode of care was completed.
- Between 1 September 2018 and 31 August 2019, 53 patients waited up to two weeks from referral for their initial outpatient appointment; 37 patients waited between two and three weeks; 27 patients waited between three and four weeks; and, 19 patients waited five weeks or longer. An audit of outpatient referrals showed that for patients who had not been seen previously by a specialist doctor 85% were seen within the standard of two weeks.

Learning from complaints and concerns

- **It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, comprehensively investigated them and shared lessons learned with all staff and other agencies where applicable. The service consistently included patients and their carers and families in the investigation of their complaint and could demonstrate how improvements had been made.**
- Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Information about how to complain was also included in the patient information guides and leaflets.
- Patients and visitors were encouraged to raise any concerns directly with staff when they arose, and it was the hospice's policy to address informal concerns before they escalated to formal complaints. Comments cards and suggestion cards and boxes were displayed throughout the hospice. This enabled patients, visitors and staff to submit comments informally if they did not wish to speak directly with staff members or the management team.
- Staff understood the policy on complaints and knew how to handle them. Complaints were acknowledged within two working days of receipt and responded to within 15 working days.
- The hospice executive management team investigated and responded to complaints and identified themes. The policy set out the two stage local complaints process followed by the third independent review stage by a convenor (one of the hospice trustee's).
- Staff knew how to acknowledge complaints and patients received feedback after the investigation into their complaint.
- Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints was shared in staff meetings and in handover meetings, as relevant, and with other agencies if appropriate.
- Between September 2018 and August 2019, the hospice received only four complaints across the whole organisation, all of which were acknowledged and responded to within the timescales set out in the complaints policy. None of the formal complaints relating to clinical care. However, as a result of one of the complaints the hospice had invested in customer care training for staff and volunteers in its trading company. Following another complaint, the café had increased the time that hot food was available.
- In the same period, the hospice received 412 compliments. We reviewed a range of compliments during our visit which demonstrated the commitment and compassion of staff across all departments of the hospice.

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.**
- The hospice's executive management team (EMT) reported directly to the hospice's trustees. The EMT team consisted of a triumvirate of the clinical director, the medical director, and the corporate director. Two of the three executives had been with the hospice for a significant number of years, and the third executive had joined with significant executive director experience from other organisations.
- The triumvirate EMT leadership model had been in place since April 2019, having moved from a chief executive-led model. Although the EMT model was still embedding, our group interview with the chair of trustees and two current trustees indicated there was an effective and respected working relationship with between the trustee board and the EMT.
- This positive relationship was, similarly, reflected by operational staff. Staff we spoke with confirmed that the EMT and senior managers were visible, approachable and had an 'open door' policy. The EMT offices were located between the inpatient and outpatient units, rather than in the upstairs administration office area, which promoted availability and access for staff.

- The EMT, and the trustees, understood the quality and sustainability challenges facing the hospice including, although not limited to, sustainability of financial streams. Trustees maintained their understanding of quality and safety of care through attendance at governance sub-committees.
- Revenue generating streams, through the hospice fundraising and trading arms, were continually reviewed to ensure sustainability, cost effectiveness, and best use of the existing resources. The leaders were looking at developing further services and revenue generating uses of its community spaces in The Living Well centre; however, they had also taken the necessary decision to close one of their loss-making shops and redistributed staff to other areas.

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**
- The hospice's three-year vision and strategy of "the best care, delivered with compassion for our community" was supported by a mission to "care, educate, engage", and was underpinned by the values of "every contact counts".
- The strategy for 2019/2022 was developed in conjunction with input from patients, staff and volunteers in face to face consultations and forums undertaken by the medical director. Staff we spoke with were aware of the strategy and had been able to contribute to it.
- The strategy included six strategic priorities; patient and carer experience; patient and carer outcomes; staff and volunteers; education and training; partnerships and community; and, supporting our care. Each strategic outcome was supported by 'we will' statements on how the hospice intended to achieve the outcomes. Two main goals to achieving the strategy were set. These were to "maintain and improve the quality of care provided by us and by others", and to "engage with our community and strengthen and develop partnerships that allow us to extend our reach beyond the hospice walls".
- We reviewed the hospice's workplan that had been developed for each of the 'we will' statements across all six strategic priorities. Each statement had an objective, which was subdivided into initiatives (actions) to be taken and the lead individual responsible for each initiative. Each initiative was linked to a key performance question, and measures for achievement with planned completion dates. Although a number of actions remained ongoing, we saw evidence during and after our visit of actions that had been completed; such as, though not limited to, the development of the 'at a glance' dashboard; pain and anaesthetic team assessment report; and, progress towards the achievement of the Navajo Charter Mark.
- The strategy was visibly embedded across the hospice in documentation, leaflets, and in wall art. For example, an 'every contact counts tree' in the corridor between the inpatient wards and outpatient centre, displayed quotes from patients and staff. One note read, "Not just a place for the dying, but a place to help the living get the best from their lives with sympathy, understanding and companionship". Another note read, "Forget your preconceptions, hospice is a happy place, it's relaxing, it's good food, it's fun and laughter and learning together".
- The hospice was in the process of undertaking a staff consultation to review its core standards of behaviour and to embed these into its vision and values.

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.**
- We spoke with a range of staff during our visit, including senior and managerial staff, doctors, nurses, healthcare assistants, therapist, domestic, catering, and estates staff and volunteers. Without exception, staff we talked with were proud to work for the hospice. More than one staff member told us the hospice was like 'a family'.

- Staff and volunteers at all levels in the hospice, were committed and focussed on improving the experiences and care for all patients who used the service. This included recognising, acknowledging and apologising when things went wrong. Staff we asked were aware of the hospice's being open policy and the being open principles of the duty of candour.
- The duty of candour confers on the organisation a duty that, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- The hospice's being open policy provided a framework for managers and staff to meet the requirements of the regulatory duty of candour. Operational staff were aware of the need to be 'open and honest', and senior managers were aware of the regulatory requirements of the duty.
- The hospice had a freedom to speak up guardian.
- The hospice's equality and diversity (workforce) policy, for employees, was aligned to the requirements of the Equality Act. The hospice's privacy and dignity policy, for patients, incorporated equality and diversity elements.

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.**
- Governance within the hospice was overseen by the board of trustees and executive management team through the quality and integrated governance framework. The framework, and supporting policy, provided the structure for managing and reporting on a range of auditable metrics to the board and to the clinical commissioning groups.
- Board-led sub-group committees, all of which were attended by a trustee, included the quarterly clinical governance committee, the quarterly corporate governance committee and the quarterly risk management committee. We reviewed the minutes of the clinical assurance committee which included review of all clinical risks, incidents, and clinical alerts.
- Audits undertaken at the hospice included the dignity audit, patient led assessments of the care environment (PLACE), patient satisfaction, nutritional audits, dementia audits, and audit of the individualised plans of care for patients approaching the end of life. We identified some areas that could be improved during our inspection. These had not been identified by previous audits; however, the management team were responsive and put actions in place to address these.
- The hospice had been reviewed by the Knowsley clinical commissioning group in May 2018. The review was positive, identifying only four recommendations. The St Helens clinical commissioning group also undertook a review of the hospice in August 2019; there were no recommendations made by the clinical commissioning group to the hospice.
- The hospice had a system for ensuring their wide range of policies and procedures were reviewed and updated regularly. The system ensured that staff had access to the most up to date policies available.
- The hospice had a system for the granting of practicing privileges to clinical staff working at the hospice. The practicing privileges policy was supported by checks to ensure, where relevant, staff had a responsible officer in their respective designated body; to ensure that professional qualifications had been checked and the date of revalidation was known, and to confirm that indemnity insurance was in place as appropriate. We saw evidence that all the checks had been undertaken.
- As the hospice's controlled drugs accountable officer, the clinical director attended the Cheshire and Merseyside controlled drugs local intelligence network meetings twice a year. The clinical director completed a quarterly occurrence report, which was discussed in the hospice's medicines management and clinical assurance meetings, and an annual report for the board of trustees.

Managing risks, 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. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**
- The executive management team and the trustees were able to describe the service's main risks, and these

matched the risks identified on the hospice's risk register. We saw that a dynamic risk summary document, from December 2018 to November 2019, tracked each risk and recorded the risk score each month, demonstrating monthly review of each open risk.

- Risks were monitored through the quarterly risk management monitoring group, which reported to the hospice's quarterly quality and integrated governance committee. The hospice had plans to form a partnership with an external risk management monitoring company.
- In November 2019 the hospice had 12 open risks on the corporate risk register, one risk related to human resource matters, three related to income steering matters, one related to information governance, three related to the trading company, and the remainder related to estates.
- All corporate risks had control gaps and measures to reduce the risk identified. Of the open corporate risks, with control measures applied, one remained a red risk (take action within three months), four remained an amber risk (take action within three to six months), six remained yellow risks (take action within six to twelve months) and one remained a green risk (reduce risk if reasonably practical).
- The clinical risk register included four risks. Two of the risks were seasonal reactivated risks (management of a potential flu pandemic, management of a norovirus outbreak). The remaining two risks related to statistical reporting, and impact on beds of staffing levels. All clinical risks had control gaps and measures to reduce the risk identified. Three of the risks remained an amber risk and one remained a yellow risk.
- The hospice maintained a live risk management summary log for all incidents, accidents, near misses, Caldicott (data protection incident), and complaints. Each entry detailed the type of incident, the area (within the hospice, The Living Well, or the trading company), the date of the incident, summary, actions and follow-ups and the outcome. The outcome indicated if the incident was preventable, unpreventable, required a board level discussion or if it had been added to the hospice's risk register.
- Between April 2019 and November 2019 there were 25 entries on the summary log, none of which related to patient clinical incidents. All entries had been reviewed with follow-up actions detailed.
- The hospice had a central alerting system (CAS) liaison officer to ensure that any CAS alerts issued by Medicines and Healthcare products Regulatory Agency were identified and disseminated to the appropriate members of staff.

Managing information

- **The service collected reliable data and analysed it. Staff could find most of 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.**
- The hospice collected a range of performance data against metrics defined by the local clinical commissioning groups. This data was reported on a monthly basis and included incidents such as significant events, never events, serious untoward incidents, duty of candour incidents, medicines incidents; slips, trips and falls; pressure ulcers; healthcare associated infections; complaints, compliments; Caldicott notifications; and, central alert system alerts.
- At the time of our visit, the hospice had commissioned an external review of their electronic patient management system. The aim of the review was to determine how the hospice could use the system more effectively to support patients, their carers and families, and in supporting the hospice to more easily collate reportable data.
- Information governance was included as part of mandatory training for staff. Staff understood the need to maintain patient confidentiality and understood their responsibilities under the General Data Protection Regulations. For example, during handover meetings, we observed staff ensuring that patient's confidential information on the 'at a glance' whiteboard in the staff office could not be seen whilst being updated.

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.**
- The hospice was in the process of reviewing its services with a view to applying for/achieving the Navajo Charter

Mark. This was an equality mark supported by lesbian, gay, bisexual, transgender, intersex and questioning (LGBTIQ) community networks across Merseyside and Cheshire that signified good practice, commitment to and knowledge of the specific needs, issues and barriers facing LGBTIQ people in Merseyside. There were five main elements to the charter mark, including practices and policies, training, staff recruitment and engagement, monitoring and engagement with LGBTIQ service users and staff.

- The hospice had obtained major grant funding to develop Willowbrook Connections, a programme for meeting the needs of families and carers of patients known to the specialist palliative care services in St Helen and Knowsley. The programme ran in three phases between May 2018 and October 2019. The first phase aimed to improve pre-bereavement access to services through a volunteer befriending scheme. The second phase aimed to develop services for children, young people and families and to increase the volunteer workforce for this. The third phase aimed to develop a 'Man Shed' as a community project.
- The hospice undertook an annual patient survey for patients attending day hospice, outpatients and those accessing the inpatient unit. The 2018 survey had a 56% response rate for the inpatient unit and a 67% response rate for the wellbeing unit. Respondents from both units were very positive in their feedback on the survey.
- Results of the latest 2019 experience of care survey were not available at the time of writing. However, staff told us of actions that had been taken following previous surveys, such as obtaining a grant to upgrade wi-fi access in the hospice.
- A range of informal feedback systems were in place for patients and their carers. These included 'VOICEs Trees' in the day hospice and inpatient unit for patients to add feedback comments and suggestions. The hospice had also developed a rapid feedback counter/post-box system. This enabled patients to provide instant feedback by placing a small counter in feedback box. In November 2019, 96 patients indicated their experience was outstanding, exceptional or very good; a further 23 patients indicated their experience was good, happy or positive; while no patients indicated that the hospice 'could do better'.
- The hospice regularly engaged with its staff and volunteers. A very recent consultation event was held to gather staff and volunteers' views for the development of a hospice charter. The event which focused on 'every contact counts', achievements in the past year, and what the hospice could do in the coming year resulted in four charter statements: make a positive impact with every contact; Willowbrook expects mutual respect and understanding with a duty of care for all; be the person you would like to meet; and be mindful of others and show respect.
- Quarterly staff focus group meetings were attended by staff representatives in all areas. Monthly news briefings provided staff with relevant information about the hospice and good news stories.
- A volunteers' focus group was scheduled quarterly to engage volunteers and to share relevant information. The hospice also delivered three 'thank you' events for volunteers, along with a volunteer and staff evening and follow-up coffee morning where long service was recognised.
- The hospice recognised the need to ensure staff wellbeing. It had developed a wellbeing strategy 'Wellness for You' which was supported by a range of workshops to provide staff with supportive tools and strategies for self-care. Feedback from one staff member on the workshops said, "the sessions and peer support have helped me personally through a really difficult/life changing time in my life and helped me to keep a sense of wellbeing and gratitude."
- The hospice had engaged with local schools in its 'Enterprise 250' programme to promoted awareness of the hospice, to help children understand business skills in growing a hospice provided investment of £250, and to raise funds for the hospice from the profits. A similar programme 'The Willowbrook Corporate Challenge 2020' engaged local businesses across the Knowsley and St Helen's areas in growing an investment of £50 and raise funds through the profits.
- At the time of our inspection, local school children had been invited to visit the day hospice to sing and to join patients in a spiritual service.

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.**
- The hospice had implemented a Stop! Think! Prescribe! strategy to promote cost-effective prescribing of

medicines. While maintaining a best effect drug approach, the strategy encouraged prescribers to consider prescribing brand prescribing. The strategy had realised a 70% cost saving per month, just on laxatives alone.

- The hospice was holding a consultation exercise with patients and carers about their experiences on the care environment. The consultation aimed to inform the hospice's refurbishment campaign.
- The hospice was a finalist in the British Medical Journal's palliative care team of the year 2018 for its agitation and delirium project. The hospice was also highly commended in the Health Service Journal's patient safety awards for the same project.
- Staff achieved the holistic therapist award 2018.
- The hospice was actively involved in a number of improvements and research opportunities, and staff had developed a close relationship with the research development and innovation office at the local NHS Trust.
- At the time of our visit, the hospice was actively recruiting in two national portfolio adopted studies being undertaken by a regional university and the local NHS Trust. The first study, "investigation of biological changes in urine in patients with advanced lung cancer: a pilot study" was aimed at developing prediction models for when people with lung cancer are in the last weeks and daysof life.
- The second study, "ketone changes at the end of life" measured serum ketone levels in urine for inpatients. The hospice was the first to recruit patients into the study.
- One of the hospice doctors, following the publication of results of a national audit on blood transfusion practice in hospices, created the management of anaemia in patients in the palliative care setting guideline for the hospice to reflect some of the findings of the national audit.
- Doctors and nurses from the hospice contributed to the substance misuse in palliative care audit and guideline; the development of the NICE accredited regional guideline for management of constipation and the NICE accredited symptom control medication guideline; and, attended the regional cough audit group and the anticonvulsants audit group.

Outstanding practice and areas for improvement

Outstanding practice

- The hospice was involved in a working partnership with the Pain and Anaesthetic Service. We were given information about a patient who had benefited from this service, where the anaesthetic team from the acute hospital had attended the hospice to administer an anaesthetic to ease discomfort while dressings were changed, and a more appropriate mattress was put in place.
- The hospice had also recently linked with two other hospices in the locality to hold collaborative medicines management group meetings. The aim of this is to share learning and good practice within the group.
- The hospice had achieved the European certificate in holistic dementia care.

Areas for improvement

Action the provider SHOULD take to improve

- The hospice should continue to ensure that prescription charts are fully completed and include diluent substances and timeframes for syringe pumps where appropriate.
- The hospice should continue to ensure that dosage amendments made on a prescription chart are signed by the staff member making the change.
- The hospice should consider how it can increase safeguarding vulnerable children level two training rates.
- The hospice should consider how it can increase basic life support training compliance rates for healthcare assistant staff.
- The hospice should consider if it would be beneficial to introduce a system to periodically repeat disclosure and barring service checks for staff.