Willowbrook Hospice

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected this service on 16 and 17 August 2016 and we gave short notice to the registered provider prior to our visit. This was to ensure that key people were available during the inspection.

Willowbrook hospice offers care and support for adults with life-limiting illnesses in the St Helens and Knowsley area. The service is registered to care for up to 12 people on two in-patient wards. Willow Suite has seven beds, four of which are single rooms plus a three-bedded room. Oak Suite has five beds, three of which are single rooms, plus a double room. All rooms are en-suite, with the three-bedded room having a walk in bath. There is also a multi-sensory therapeutic bath for use by inpatients. The day therapy unit provides up to 60 day care places per week.

Willowbrook Hospice is a purpose built independent hospice opened since 1997. There is car parking available to the front of the building. There were 11 people staying at the hospice at the time of this visit.

The previous inspection was undertaken in January 2015 and the service met the regulations we assessed at that time.

There was a registered manager in place at this service, who has been registered for 15 years. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us that they received very good quality of care from all the staff. People told us staff were kind, patient, wonderful, superb and caring towards them and that staff supported them to meet their physical, social and emotional needs. People described the culture of the service as positive, calm and caring.

People told us they felt safe at the service with the staff team. Staff had been trained to recognise and report any signs of abuse. No safeguarding issues had arisen at the service since the last inspection.

The management and administration of medicines was safe and staff were competent and suitably trained in this area of care.

Care plans were person-centred and kept up to date. End of life care was given in compassionate, sensitive and appropriate ways that acknowledged people's rights and preferences. The service supported people and their families to enjoy the time they had together and enhance their feelings of well-being.

The staffing levels were good and sufficient staff were seen on the days the inspection took place. Staff were well trained and had access to a variety of training courses which enabled them to develop their skills and knowledge base. Good support was given to staff by senior management and regular meetings and

supervision sessions were undertaken.

Robust staff recruitment processes were in place which ensured that only staff who met the service's high specifications regarding experience and qualifications, character and caring abilities were employed. This included the recruitment of volunteers.

People told us the food was very good and that they had access to snacks and drinks whenever they wanted them. Care plans showed that people were encouraged to have a nutritious diet.

The service worked closely with other professionals and agencies to ensure people's holistic needs were fully met. There was clear evidence of close and effective partnership working between the service, people, their families and carers, and external professionals.

Regular checks were made regarding the safety of the building and equipment. Staff were given training in safe working practices and provided with any necessary personal protective equipment. The building was clean, hygienic and in a good state of repair. The gardens had been developed with a "Japanese" theme which people and visitors commented positively, saying it was a peaceful and calming place to be.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medication was kept safe and well managed.

Robust and safe recruitment practices were in place. Staff were trained and aware of how to protect people from abuse and harm. They knew how to report any concerns.

Risk assessments were centred around the individual and their specific needs. There was sufficient staff on duty to meet the needs of people safely.

Is the service effective?

Good

The service was effective.

The registered manager understood the principles of the Mental Capacity Act (MCA) 2005 and how to apply these. Staff had received training on the MCA 2005.

Staff were trained appropriately and they had a good knowledge of how to support each person's specific needs.

People told us the food was very good and that they could have food and drinks whenever they wished.

Is the service caring?

Good

The service was very caring.

Staff showed kindness and compassion and knew when and how to convey empathy to people when they faced difficult situations.

The service was very flexible and responded quickly to people's changing needs or wishes. Staff approach to people was caring and people described it as "Excellent".

End of life care was undertaken by staff that were very

experienced, motivated and well trained. People and relatives said the support given to them was "outstanding".

Is the service responsive?

Good

The service was responsive.

Staff delivered people's care in a person-centred way and encouraged them to make choices about their daily lives.

People and their families were fully involved in assessing their needs and planning how their care should be given.

People told us they didn't have any complaints about the service. A Complaints policy and procedure was in place for people to use if they wished to make a complaint.

Is the service well-led?

Good

The service was well led.

There was a clear management structure and lines of accountability in place. People and staff told us the service was very well managed.

Systems were in place to monitor the quality of the service provided.

Willowbrook Hospice

Detailed findings

Background to this inspection

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

We inspected the service on 16 and 17 August 2016. We gave short notice to the registered provider because we needed to be sure that key people would be available during our inspection visit. The inspection team consisted of an adult social care inspector and a pharmacist inspector.

Before the inspection the registered provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help inform our planning of the inspection. We reviewed all the information we held about the service. This included looking at any safeguarding referrals received, whether any complaints had been made and any other information from members of the public. We looked at notifications we had received. A notification is information about important events which the registered provider is required to tell us about by law.

We contacted the local authority safeguarding team and commissioners for their views on the service. They raised no concerns about this service.

On the days of our inspection we spoke with two people who used the service, two relatives, the chief executive, the registered manager, clinical pharmacist and nine staff members. Staff members included a consultant clinical lead, specialist doctors, nursing staff, health care assistants, day care and human resource managers, associate chaplain and cook.

We looked at a selection of records. This included two people's care and support records, three staff and one volunteer recruitment files, staff duty rotas, medication administration and storage, quality assurance audits, complaints and compliments information, policies and procedures and other records relating to the management of the service.

Good

Is the service safe?

Our findings

People told us that they felt safe at the service. They said "I feel very safe here", "I sleep well and I wouldn't be able to do that if I wasn't safe" and "Absolutely, without a doubt". Relatives said they felt that people were safe within the service and one relative commented "[name] is safe here, I wouldn't leave them here if I thought it wasn't safe".

Staff told us how they would keep people safe from harm and they knew about the different types of abuse that could occur. this included physical, neglect, emotional, financial and sexual abuse. Staff explained they had access to policies and procedure which related to safeguarding adults and children and that they had undertaken training in safeguarding adults and children. Training records and certificates kept on staff files confirmed this. The registered provider had a safeguarding file which contained the local authority's multi-agency safeguarding adult's policy, procedure and good practice guidance. A flow chart was available to staff showing how and who to contact if they suspected abuse. The registered manager had also resourced other guidance from the Royal Collage of Nursing; National Medical Council; NHS and CQC with regarding to raising concerns and reporting suspected abuse. Staff were aware of the term whistle blowing and one staff member explained it was to do with an incident such as safeguarding or bullying and it's where a staff member can report the incident without fear of recrimination.

People were protected from the risks associated with medicines because medicines were used safely. The registered manager (was the controlled drugs accountable officer) and there was a clinical pharmacist who visited the hospice. The controlled drugs accountable officer is the person who has a legal responsibility to ensure that controlled drugs (drugs liable to misuse) are properly managed. The consultant told us "I am impressed by the clinical governance structures here". The clinical pharmacist said "It is excellent here. I have no concerns about medicines. The doctors and nurses are very competent".

We looked at four people's medication administration records (MARs) and saw that nurses recorded the administration of medicines in the right way. We did notice however, that some prescriptions for anticipatory medicines (to be given if a person's health deteriorated) were not dated when they were recorded on the person's MAR. There was also insufficient detail about maximum doses on some MARs for 'when required' medicines. This increased the risk of an adverse incident or medicines error if nurses misunderstood the prescriber's instructions.

There were clear, detailed policies and procedures covering the different aspects of medicines management. Medicines were supplied by a local pharmacy. A pharmacy technician visited the hospice to give support with managing and ordering medicines. A clinical pharmacist visited daily Monday to Friday to provide a clinical service and reconcile patients' medicines. Medicines reconciliation is the process of ensuring people continued to receive the medicines (at the right doses) they were taking before admission, where appropriate.

Medicines were stored in a room locked by a key pad. As a small number of medicines in the room were not kept inside locked cupboards we have recommended the registered provider to risk assess the security of

medicines storage. Medicines were kept at the right temperatures. However, the medicines fridge was not monitored properly because minimum and maximum fridge temperatures were not recorded. Medical gas cylinders were handled safely. Unwanted medicines were disposed of promptly, in an appropriate way.

Controlled drugs were handled safely and nurses checked stocks each day. We checked a sample of four controlled drugs and found no discrepancies. The controlled drugs accountable officer participated in local intelligence network (LIN) meetings and reported incidents involving controlled drugs in the required way.

Staff were encouraged to report medicine errors, including those that did not affect people, so lessons could be learnt and practices made safer. No errors in the last twelve months had resulted in people being harmed. Medicine charts were audited every three months and the findings were considered by doctors, senior nurses and the clinical pharmacist at medicine management meetings. An audit of the use of antibiotics and procedures to prevent the spread of infection had recently been carried out. These audits helped to protect people's health.

People told us that there was enough staff around to support them as they required although at busy times, such as first thing in the morning, they may have to wait a while. However, they said that they understood and didn't mind. People confirmed that call bells were answered promptly. We reviewed the staff duty rotas and saw that there were three nurses on duty and three healthcare assistants during the day and two nurses and two healthcare assistants on during the night. The care team were supported by a wide range of ancillary staff. This included domestic and laundry staff, cooks, maintenance team, hospice chaplaincy, physiotherapist, occupational and complementary therapists, administrative team and social workers. The service was also supported by 160 volunteers who undertook a wide range of activities across the hospice service. The registered manager explained that staffing levels were dependent on the number of people in the 'in-patient beds' but confirmed that a minimum of two nurses were always on duty regardless of the numbers of people staying at the service.

People told us the service was very clean and well maintained. They said "The service is excellent here", "They have an excellent reputation", and "It's very clean here". We toured the service and found it was clean and well maintained. The gardens were well kept and had been developed in a Japanese theme. People spoke of the gardens with admiration and said it was a very "Peaceful environment" and the "Outside is fantastic". Throughout the service, fittings and equipment were regularly checked and serviced. There was a system in place to identify any repairs needed and action was taken to remedy these in a timely manner. We saw that safety checks were in place for the gas and electrical systems and that the fire alarm and nurse call systems were regularly checked and serviced. This meant that good systems were in place to ensure that the service was safe and adequately maintained.

We looked at the security of the building and noted that entry to the building between 9pm and 9am was via an intercom system and that a security guard was on duty during this time. Outside these hours the reception desk was manned by volunteers. CCTV was also used to provide added security overnight to monitor outside the building and the grounds.

We reviewed two care records which contained up-to-date risk assessments for areas such as pressure care, falls, nutrition, bedrails, manual handling and pain management. We saw that risk assessments were up to date and reviewed every three days during each person's stay.

Staff and volunteers told us about their recruitment experiences. They said that they had undertaken an interview and had supplied an application form and other information. They confirmed that the registered provider had undertaken two references and a Disclosure and Barring Service (DBS) check. A DBS is a check

employers undertake to ensure that the person is not barred from working with people who may be deemed vulnerable. One person explained that they had been appointed as a "bank" staff member which meant that they were called on to support the team when permanent staff were not available, for example covering sickness or annual leave. They said once a permanent post became available they applied for that and was successful.

Good

Is the service effective?

Our findings

People told us that they were supported in the way they wanted and that they had experienced the best possible health and quality of life from the staff at the service. People said that staff were very friendly and always made time to listen to their worries or concerns regarding the future. Relatives said the service was effective and that staff were very experienced in end of life care and had treated people with compassion and understanding.

People told us that the food was good and that although there was a menu available often they didn't want a full meal. One person explained that they didn't feel hungry and often felt nauseous. When they felt well, the staff would arrange for some food and the person had discussed the types of things they liked. They also said that the cook had discussed different foods with them and they had developed a range of foods that the person could request when they felt like eating. This often wasn't at 'regular' mealtimes but the person said this was accommodated well by the service. The cook explained that the person's choice was paramount and that they would try and accommodate any changes they could. There was a four week summer menu in place. The cook explained options were available for people who required or preferred a special diet such as gluten free, vegetarian, vegan and diabetic diets. Each person had a nutritional assessment and a record of meals taken was recorded. Daily records were kept of fridge and freezer temperatures and we saw that foods were stored at appropriate temperatures. We noted that a good stock of food was kept and once opened was covered and labelled appropriately. We saw the kitchen was clean, tidy and well maintained. The cook said that if equipment broke down then it was repaired in a timely manner.

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

We checked whether the service was working within the principles of the MCA 2005, and whether any conditions or authorisations to deprive a person of their liberty were being met. The registered manager was aware of the principles of the Act and how to determine people's capacity. The registered provider had up to date policies and procedures in regard to the MCA 2005 and DoLS, Best Interests and Lasting Power of Attorney (LPA). LPA is where someone is appointed by the Court of Protection to make decisions on the person's behalf within specific areas of their life. Care records showed that people's mental capacity was considered. One staff member explained that decisions are based on the person and what is in their best interests. They went onto explain that a person's capacity to make a decision must be explored first. Staff had received training in the MCA 2005, and were aware of their roles and responsibilities in regard to this. No person was being deprived of their liberty at the time of this inspection visit.

New staff were inducted into their role when they first started to work at the service. Staff and volunteers told us about the induction process and said that it was good. An induction check list which was used was signed and dated when sections had been completed. The initial part of the induction included general information about the running of the service, a tour of the building and meeting people who used the service and staff. This was followed by corporate information and sessions on moving and handling and communication. Staff said they shadowed an experienced staff member initially and following the induction period staff said that they felt 'well qualified' for their role. Staff explained they had access to handbooks which were role specific and we saw induction evaluation forms on staff's recruitment files. These confirmed that staff had been given sufficient information for them to perform their duties. Staff confirmed they had access to supervision sessions and an annual appraisal where they could discuss their work and training needs. They also confirmed they were encouraged to attend staff meetings. On staff member explained that they were allocated a senior staff member as 'mentor' and that they found this very useful.

Staff told us about the value of handover and admissions meetings that occurred each day. We observed the handover meeting and saw that staff on duty were involved in these. The lead nurse led the meeting and used an aide-memoire that had been devised for the meetings. This was called "Dream" and was used as a prompt for important palliative care issues that may need to be considered. "Dream" stood for Discharge planning and discussions; Resuscitation status; Escalation of care decisions; Anti-coagulation and advanced care planning; and Mental Capacity Act (MCA). The lead nurse went through the details of each person who was staying at the service. This included their diagnosis, how the person was feeling that morning, any needs or wishes they had for the day, any referrals that were needed to internal or external agencies and any issues that may have arisen that needed action. This was a very detailed session and afterwards we spoke with staff who said this occurred each day and that they were well informed about people's needs and wishes. This meant that staff had detailed information about the people who were staying at the hospice, those who were due to be discharged and new admissions.

We saw there were good networks between the service and other professionals. Staff told us that people were only discharged when they were ready. Staff ensured they were going to 'the place where they wanted to be' and with the appropriate equipment already in place. Also that family support was available where appropriate. The staff said that this approach took the 'stresses out of the move for the person. The registered provider used an educational toolkit to enable staff to provide expert support through a 24 hour specialist palliative care telephone advice line. This was aimed at healthcare professionals who cared for people with palliative and end of life care needs. This meant that GPs, district nurses, community pharmacists and others caring for people in their own homes had access to specialist advice.

Good

Is the service caring?

Our findings

People and their relatives said that the staff were very caring and had a compassionate and understanding attitude which they appreciated. Comments included "All the staff are very friendly and approachable", "They [the staff] are superb", "The staff are spot on", "Staff are perfect and excellent" and "Staff are wonderful".

People told us about how the staff treated them with dignity and respect. We saw that in multi-occupancy rooms that privacy curtains were used whenever people were being supported with personal tasks. People told us that the curtains were always used when necessary. People said they were able to make choices about how they were supported. They explained that they were involved in the care planning process and that they were always consulted before any support was offered. One person told us that they "Always ask me if it's alright if they help me" and another person said "Staff know from the beginning of my stay my preferences and they always respect these". Staff told us that people were always involved in the care planning process and sometimes family members supported people as well with this.

All the people we spoke with commented on the caring, compassionate and empathic nature of the staff team. One person told us that "Staff treat you as if you are the most important one" and they said that this made them feel welcomed and valued as a person. People said that staff would do anything for them and that this was "Greatly appreciated." One relative commented "Nothing is too much trouble for any of the staff, they can't do enough for us". They went onto say "I can only say they [staff] are angels – all of them". Another relative said the way staff speak to people is excellent and the empathy they have was superb. We saw that staff spent time with people and seemed to be aware of when someone wanted to talk to them. We saw that pets were welcome at the hospice and information regarding this was included in the patient and visitor guide. Staff told us that a number of dogs visited the service as part of the pets as therapy scheme.

We spoke to the associate chaplain and they explained that spiritual care is about the essence of who the person is, what adds meaning to them, and what brings them peace. They said that staff were compassionate with people and that spiritual care was very person-centred. They went onto say that a person's preferred spiritual leader was always welcome at the hospice and that people's faith was honoured.

Relatives told us about how they were also well supported by the staff during the stay of the person. They went onto say that they could visit at any time during the day and night and two people told us that they had been staying overnight with their loved ones. One person said that the staff were superb and that the banter between them was good and welcoming. Family members explained that they could bring in food for themselves and their relatives and that they had a fridge and microwave available for their use. Family members commented that all the staff were caring and that nothing was too much trouble.

We saw that all care plan documentation reflected end of life care. However, when a person was nearing their final days a specific care plan for end of life care and communication record was initiated. This included a care plan and risk assessment and sections for the doctor, health care professionals, nurses and

health care assistants to complete. We spoke to the consultant about this record and they explained that this was used during a person's last few days of care. It enabled the doctors to prescribe medications in anticipation of the person's needs and this meant that medication was available as people needed it. Also all information about the person's care and needs at this time were recorded in one document, which meant that staff were able to easily see what others had written.

People told us about how staff helped them with pain control. One person said that they were at the hospice to help control their pain. They said that staff were helping them to get the medication right so that they would not be in pain. Staff explained that pain control was very important and that staff were trained and knowledgeable in recognising signs of people being in pain. They said this was imperative as people should not be in pain.

One nurse told us about the 6C's programme that is used throughout the hospice. This covered care, compassion, competence, communication, courage and commitment. They went onto explain that this was being incorporated into all areas of the service and that it was about how staff presented themselves and their approach towards people, relatives, visitors and other staff members. We saw a noticeboard on the corridor which showed information about the programme and examples of how staff could show each of the 6C's within their day to day work.

A wide range of compliments had been received at the service from people who used the service, relatives and friends and some of these had been compiled into a "Thank you" board in the foyer. Comments included "Thank you for all your care and kindness", "Thank you for all the wonderful care I have received", "I would like to convey my sincere and heartfelt thanks and special care and support during my stay" and "Thank you so much for everything you did to facilitate [name's] final wish to return home. We can never thank you enough."

We received a range of compliments about the service from CQC's "Tell us about your care" surveys. Comments were from people who use the service and their relatives. These included "[Name] has terminal cancer and is in the last few days of their life, they have received outstanding care, and so have we, nothing is too much trouble", "The service is beautiful and relaxing and the services provided are excellent", "The staff are perfect and excellent", Exceptional care and holistic therapy and support when needed. Staff are wonderful and all deserve a medal" and "Willowbrook hospice is excellent".

A wide range of information was available to people who used the service and prospective people who may wish to use the service. These included a patient and visitor guide which was seen in each bedroom. This contained information about the wellbeing and in-patient services provided, complimentary therapies, pastoral and spiritual care and compliments and complaints procedure.

A range of leaflets were available in the foyer on a wide range of topics included advocacy, catering, visitors, smoking, breathless group, relaxation support, outreach services, in-patient services, day therapy, aftercare, mouth care, benefits help, complimentary therapies, compliments and complaints, standards of services and end of life charter. This meant that people had access to a wide range of information about the services provided and how to access external services if required.

Guides were also available which had been written by people who had previously used the service. These included information about their experiences at the hospice and were available for all people who used the service and relatives to read. Within these guides we saw that following people's death families were given time to spend with people after they had passed away. Staff explained that there was a separate room that was used once people had died and that family members to stay there for as long as they wished. People

told us that these guides helped them to have information about what to expect at the service.

Good

Is the service responsive?

Our findings

People and their relatives told us that the staff and the service was very responsive to their needs and that people received the care they needed and were listened to by the staff. Comments included "Staff are very friendly", "Nothing is too much trouble and needs or concerns are discussed with such a positive approach" and "Staff seem to anticipate my needs".

People told us that they were fully involved in the care planning processes and relatives also confirmed this. Comments included "I have told staff what I want and they know this from the beginning", "I was involved in my care plan and it is noted that I want [name] here when I die" and "[Name] is fully involved in their care plan and everything goes through them". We saw that care plans were person-centred and reflected a holistic approach to care and support of people who used the service.

We looked at two care plans that were stored electronically and saw that good details were kept about people's care and support needs. This included their wishes and preferences on how they wished to be supported and what they wanted. We spoke with staff about the health needs and support people required and they had an in-depth knowledge about people's health needs and what support people required. For example they spoke about each person's diagnosis, how the person felt and about the individual's needs, wishes and desires. All these were recorded in the person's care plan. Daily records which were maintained for each person included the support people had received with personal care and mobility and information from other staff who may have visited the person, for example, doctors, chaplaincy, complimentary therapist and healthcare assistants. This meant that staff had access to information about people's care and wellbeing on a daily basis.

Most people we spoke with didn't undertake recreational activities during the day, but they were aware of what was on offer and this included complimentary therapies, painting and crafts. Complimentary therapies included hand and foot massages, Reiki, aromatherapy, reflexology and relaxation and visualisation. Other activities available included painting and crafts. The holistic therapy lead had developed ways in which people could express their needs, hopes and wishes. These included the use of creative writing to help meet the spiritual support needs of people. Creative therapy whereby people told their story and used photographs to leave messages as gifts to their loved ones. Mosaic art which was used to show what people thought about the hospice through the use of mosaic designs. Also a celebration of life which offered creative opportunities to explore how life threatening illnesses can impact on the physical, emotional or spiritual well-being of a person. One person told us about the activities they had undertaken during their stay. They had received some complimentary therapies and had made memory boxes and written cards to pass onto their children after their death. The person went onto say that it was important to them to leave something for each child. Another person said that "[Name] had benefitted greatly from the massage and relaxations techniques". One person said how much they had enjoyed the sensory bath which had lights to change the colour of the water, a Jacuzzi facility and option to play music of their choice. Their family member said "The highlight of [name's] visit was the sensory bath, it certainly made their day". Staff explained that it was often used to help people who were anxious or in pain to get some relief and that comments they had received about it had been very positive.

The spiritual care team supported people if they wished. We spoke with the associate chaplain who explained that they were there to provide spiritual care to people, relatives and the staff team. They said they tried to lessen people's worries and concerns with dignity. They said the team helped people prepare for death and helped to make it a peace-filled time for the person and their family.

People and relatives said they did not have any concerns about the service but that they would speak to the registered manager or nurse in charge if they had any issues. A complaints policy was available which detailed how a complaint would be dealt with, timescales when this would be completed and action that could be taken if the person was not happy with the outcome. A compliment and complaints leaflet was available in the foyer and a copy of the complaints procedure was seen in the hallway. This included how to make a complaint and included timescales for when a complaint would be dealt with. Since the last inspection the registered provider had received two complaints which had been resolved to the complainant's satisfaction. We saw that appropriate records had been kept.

Good

Is the service well-led?

Our findings

A registered manager was in post that had been registered with the Care Quality Commission (CQC) for 15 years. The registered manager had worked for the hospice for 19 years in various roles and had a vast experience of caring for people within a hospice setting. The registered manager had the support of the registered provider, doctors, nurses, care workers, other professionals and volunteers.

People and relatives told us what they thought about the service. They all said that the service provided was exceptional and that staff were friendly, approachable and competent. People also said that it was a tranquil place to be and that the atmosphere was a calming and peaceful one. Comments included "It's a fantastic service", "The way staff speak to you is with empathy and understanding", "Nothing is too much trouble" and "It doesn't feel like a hospice here, more like a hotel".

People and relatives told us that they were consulted at every stage of their stay and treatment at the hospice. They said that they were always asked what they wanted to do and when support was needed staff confirmed with people how this would be undertaken. The end of life quality assessment tool was used to record patient and carers responses to questionnaires that had been completed. These showed that people and their families were satisfied with how they were communicated with and that they were sufficiently informed. We noted that carers and families of people approaching the end of life felt well supported.

The registered manager told us about the 15 steps challenge that they had adopted at the hospice. It had been devised by the NHS Institute for Innovation and Improvement to help staff, patients and others to identify improvements that enhanced the patient experience and environment. This looked at quality from a patient's perspective. The action plan was produced from information gathered from people who used the service and included positives such as "Staff and volunteers smiled and were very friendly" and "Great access to gardens" and noted where action was required. The registered manager confirmed that some work had been completed and that other areas were on-going.

Staff told us that they enjoyed working at the hospice and that it was a pleasant environment to work in. They told us that the management supported them in various ways, these included "The wellness for you" and "Releasing time to care: The productive ward" programmes and with the revalidation for nursing staff. The "Wellness for you" programme included a programme of weekly in-house workshops. These included self-confidence; developing a good sleep routine; how to be happy; little things matter; self-massage; self-reliance; and mindfulness techniques. The groups were informal and aimed at engaging staff and promoting their well-being. The "Releasing time to care: The productive ward" programme was aimed at the nursing team. The aim of the programme was to review working practices and minimise inefficient systems. One staff member explained that this had helped to increase the time they had to spend with people and therefore increasing positive patient experience. They went onto say that it also helped to improve communication between staff and helped to improve staff satisfaction in their work. The registered manager had developed a revalidation programme which the nursing staff could undertake and then use to verify that they had undertaken sufficient training and professional development to enable them to revalidate their PIN numbers. Nursing staff told us that this was a good way for them to show that they had undertaken

suitable and sufficient personal development.

A wide range of quality assurance audit systems were in place which were completed by the registered manager and senior staff. Audits were carried out to enable the registered provider to identify and monitor the service provided. The audits included medication, infection control, accidents and incidents, health and safety and the environment. All the audits were up to date, with summaries and action plans produced where required. These were actioned as needed and signed and dated when completed. All action plans were reviewed at the following audit.

Monthly management of risks such as medicines incidents, pressure ulcers, accidents and falls, incidents, clinical indications, complaints, compliments and suggestions were recorded and action taken where appropriate. These were recorded in the risk register and central risk metrics log. These were also discussed at the quality and integrated governance meetings. This meant that there was a range of audit systems in place to identify, monitor and improve the service provided.

The registered provider commissioned an external company to carry out a staff survey in 2015. Staff said that if a relative or friend needed treatment they would be happy to use this hospice. They also commented that they enjoyed their work, felt they made a difference and liked their working environment. This meant that staff had the opportunity to say what they thought of the hospice, the management, their role and the environment.

Willowbrook hospice is governed by a board of trustees who employ staff across the organisation to support and provide specialist palliative care to people in need. A number of reports were produced which were shared with the board of trustees. These included monthly management reports, annual provider review and the quality account. These reports helped to ensure that the board of trustees were kept up to date with the progress of the service.

The registered manager and her team have developed an end of life community forum in the Knowsley and St Helen's areas which helped to establish positive working relationships between providers. This was to provide a networking opportunity for nursing staff from nursing homes to meet for support. The aim was to provide support with end of life care issues and improve the delivery of end of life care in nursing homes. The registered manager explained this had provided an opportunity for improvement in the person's care pathway with shared learning between nursing homes and specialist palliative care services.