

# Woodlands Hospice Charitable Trust

# Woodlands Hospice

## Inspection report

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## Ratings

Overall rating for this service

Good ●

Is the service safe?

Requires Improvement ●

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

This announced inspection of Woodlands Hospice took place on 17 and 18 May 2016.

Woodlands Hospice is an independent charity situated in the grounds of University Hospital Aintree. Woodlands is based in North Liverpool and covers a population of 330,000 in North Liverpool, South Sefton and Kirkby in Knowsley. The hospice provides 15 overnight beds in a purpose built wing (in-patient unit). Woodlands has a multi professional team of staff who provide specialist palliative care to people who have a life threatening illness and for people who are in the terminal stage of their disease. Palliative care is the total care of people whose illness is not responsive to curative treatment.

Other services provided by the hospice include day therapy services (well-being and support centre), community therapy, outreach and outpatient services and a hospice at home service for South Sefton patients only. Hospice at home provides a sitting service, support for the district nurse team, accompanied transfer home from hospital or hospice and crisis intervention. This service is provided by the staff from Woodlands and is commissioned by South Sefton. Woodlands Hospice medical staff visit people in their own home to advise the community team on appropriate management if this is needed. This is to prevent a crisis or inappropriate hospital admission if the person's preferred place of care is home.

There was a registered manager in post. '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'. The senior management team included the Chief Executive (CE), consultant in palliative medicine/clinical lead, head of income generation and registered manager.

People were very complimentary regarding the standard of care, treatment and support offered to them. Their comments included, "First class", "An amazing place", "Fabulous support" and "The staff just do so much for you, I can't say any more."

Staff told us people were at the heart of the service and that everyone worked as a team to achieve this. We received positive feedback about the management of the hospice from staff, people at the hospice and their relatives. The management structure was clearly defined and robust governance processes and systems were in place across all departments. This included the completion of audits and information collated was reviewed, actions taken to improve practice and lessons learnt shared with the staff.

Emphasis was placed on driving forward improvement for end of life care internally and via established links with other hospices and organisations. Staff attended external training events and attended conferences, including conferences run by Hospice UK to support good practice and further develop standards for end of life care.

The safeguarding process to follow in accordance with local authority protocol had not always been followed to protect people from abuse.

People using the services of the hospice were protected against the risks associated with the use and management of medicines. Medicines were audited (checked) to ensure they were managed safely.

Risk assessments were in place to ensure people's health and safety. The risk assessments helped to help mitigate those risks and to protect them from unnecessary harm. There was a robust system in place to assess and monitor accidents and incidents.

People were supported by sufficient numbers of staff to provide care and support in accordance with individual need. There was a flexible approach to adjusting the levels of staff required.

Staff sought advice and support from health professionals to optimise people's health and provide continuity of care. Hospice staff included doctors, nurses, physiotherapists, occupations therapists, complimentary therapists, pastoral support worker, family support team and counsellor.

The provision of family support was seen as very important and the family support team helped to provide emotional support to families and friends in coping with the effects of terminal conditions and palliative care illnesses. Volunteers worked alongside hospice staff and links were forged with community based services to promote integrated working.

A high standard of cleanliness was maintained at the hospice. Systems and processes were in place to monitor standards of hygiene and control of infection.

The hospice provided suitable accommodation and equipment to meet people's individual needs.

Recruitment procedures were robust to ensure staff and volunteers were suitable to work with vulnerable people.

Systems were in place to maintain the safety of the hospice. This included fire prevention and health and safety checks of equipment and the building.

Staff told us they were supported through induction, on-going training, supervision and appraisal. Staff were trained in specialist communication skills to help build relationships with people and their families at difficult times. The formal training programme for staff included end of life qualifications as part of their professional development. Staff told us the training programme was very good.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to hospices. Staff were trained in the principles of the MCA and the DoLS and were knowledgeable in the main principles of the MCA that they applied in practice. They assessed people's mental capacity when necessary and when applicable they held meetings to make decisions on their behalf and in their best interest. This meant that people's rights were protected and respected. People's consent was documented in the care files we saw to evidence their inclusion around their care and treatment.

People's nutritional needs were monitored by the staff and their dietary requirements and preferences were taken into account. Emphasis was placed on 'what people liked to eat at home' and staff did their best to replicate this so that people really enjoyed their meals. A person told us "The meals are just like a hotel."

Staff carried out personal care activities in private. We found staff support was given in a respectful and caring manner. Staff took time to listen and to respond in a way that the person they engaged with understood.

People were involved in the planning and review of their care and staff provided care, treatment and support in accordance with people's needs, wishes and preferences. People told us their views were listened to on all accounts and their wishes were recorded in care documents for example, advance care plans (ACPs).

Comprehensive information about the service and its facilities was provided to people, relatives and visitors to enable them to make choices and to understand the ethos of the hospice. This included information on how to make a complaint and to provide feedback about the service provision. Feedback seen was very positive in all areas, comments included, 'never too busy to listen' and 'nothing is too much trouble'.

You can see what action we told the provider to take at the back of the full version of this report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement** ●

The service was not always safe.

The local authority's and the service's safeguarding process had not been followed on one occasion to protect people from abuse.

People were protected against the risks associated with the use and management of medicines.

Risk assessments were in place to ensure people's health and safety.

The required employment checks had been carried out when new staff and volunteers were recruited to ensure they were suitable to work with vulnerable people.

There were enough staff to support people and keep them safe.

The premises and equipment were maintained to a high standard.

### Is the service effective?

**Good** ●

The service was effective.

Staff sought advice and support from external health professionals when needed to help assure people's health and wellbeing.

Staff followed the principles of the Mental Capacity Act (2005) for people who lacked capacity to make their own decisions.

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

People's nutritional needs were monitored by the staff.

Staff told us they were supported through induction, regular on-going training, supervision and appraisal.

### Is the service caring?

Good ●

The service was caring.

Staff support was given in a respectful and caring manner.

People's dignity was observed to be promoted in a number of ways during the inspection

Staff demonstrated a good knowledge of people's individual care, their needs, choices and preferences.

People's end of life choices were discussed with them sensitively and at the appropriate time.

Families and carers received support from the staff during their family member's stay at the hospice and during their period of grief.

### Is the service responsive?

Good ●

The service was responsive.

Staff had a good understanding of people's care and treatment and how people wish to be supported.

The hospice provided comprehensive health care management and worked closely with community-based professionals to provide an integrated end of life care service.

A process was in place for managing complaints and complaints were logged and responded to.

Arrangements were in place to seek the opinions of people and their relatives, so they could share their views and provide feedback about the hospice.

### Is the service well-led?

Good ●

The service was well led.

The hospice had a registered manager in post.

We received very positive comments regarding the overall management of the hospice from staff, relatives and people who used the service.

There was a clear management structure and quality assurance systems and audits were in place to monitor performance and to

drive continuous improvement.

Staff were aware of the hospice's whistle blowing policy and said they would not hesitate to use it.

The service was actively involved in building local community links, took part in project work and close working with other hospices and organisations at regional and national level.

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# Woodlands 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.

The inspection took place on 17 & 18 May 2016 and was announced.

The inspection team consisted of an adult social care inspector, a specialist advisor (SPA) Pharmacist and an SPA with experience in end of life care and hospice services.

The provider submitted a Provider Information Return (PIR) prior to the inspection. A PIR 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. Before our inspection we reviewed the information we held about the service. We looked at notifications and other information the Care Quality Commission (CQC) had received about the service. We contacted the commissioners of the service to obtain their views.

During the inspection we spent time with five people on the in-patient unit. We spoke with the registered manager, manager of the in-patient unit, two doctors, a consultant in palliative care services, a senior registrar, five nurses (two ward sisters, three staff nurses), a health care assistant, a pastoral support worker, the manager of the well-being and support unit, a health care worker, the manager of the complementary therapists and a volunteer. We also spoke with three relatives during the visit and Vice Chairman of the Board of Trustees who was also an external health care professional.

We viewed a range of records including, care documents for five people who used the service, four staff personnel files, medicine records, records relating the running of the service and a number of the provider's policies and procedures.

# Is the service safe?

## Our findings

People who used the service told us they felt safe when receiving treatment, care and support from the staff; one person said, "I am in safe hands." People told us the numbers of staff on duty was satisfactory and calls for assistance were answered promptly in respect of physical care and therapy, pastoral and catering support. A person said, "It does not matter who it is, the help is there for me. Just great."

The service had systems to protect people from abuse. A safeguarding policy was in place along with local area safeguarding procedures for staff to follow. The staff training plan evidenced training in safeguarding adults and children which was given to all staff. We spoke with staff about safeguarding and steps they would take if they were concerned about somebody; the staff gave appropriate responses. A safeguarding lead was appointed to oversee safeguarding practices at the service.

When talking with the registered manager about safeguarding people from abuse we found in one instance the safeguarding process to follow in accordance with local authority's protocol and service's safeguarding policy had not been adhered to. An allegation of abuse had been reported internally and the alleged incident had been investigated under the service's complaints' procedure. This was a failure to report an alleged incident of abuse via the correct channels and had the potential to place a person at risk. The registered manager said they would take immediate action to provide staff with further training around reporting allegations of abuse.

This was a breach of Regulation 13(1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw how accidents and incidents were recorded and staff told us about the reporting system and actions taken to minimise the risk of re-occurrence, this included discussion about people's individual risks at the staff handovers. We saw a detailed report regarding a medicine incident and the actions taken to improve practice through more rigorous safety checks and an amendment to a medicine procedure. Risks to the service were recorded at service and organisational level and monitored through clinical governance. This included actions plans and feedback to staff as lessons learnt.

Risks to people's safety had been assessed with people's consent and as part of their plan of care. The risk assessments helped to help mitigate those risks and to protect people from unnecessary harm. The care files we looked at showed staff had completed risk assessments in areas such as, moving and handling, falls, skin integrity and nutrition. A falls working group monitored the incident of falls and people had access to a falls' alarm system should this be required to ensure their safety.

Environmental risk assessments were in place and the health and safety group last met in May 2016 as part of monitoring health and safety within the service. Minutes from this meeting were available.

We looked at the staffing arrangements for the service. The registered manager informed us they had sufficient numbers of staff to provide care and support to people and staffing numbers were adjusted using

a flow chart. The flow chart indicated the staffing levels and bands of staff to cover the early, late and night shift. These were adjusted to cover training, study leave, staff sickness and an increase in dependencies including 'one to one' support. The flow chart enabled the registered manager to identify staff shortages in advance or at the start of a shift so that cover could be arranged promptly. Staff told us the staffing numbers were good, consistent and monitored by management. A staff member said, "It is a lovely place to work we have loads of staff, in the morning we can have three nurses and three health care assistants, for fifteen patients, but you can't anticipate how the shift will go, we are blessed in the staffing compared to other places I have worked."

On the first day of our inspection 14 people were receiving in-patient care on the unit. The unit manager was on duty with four nurses, three health care workers and ancillary staff which included kitchen and domestic staff. There were also medical staff and other staff in supporting roles such as, volunteers, family support team, therapy and staff providing spiritual and religious support. The staff team helped to ensure people's physical, emotional and social needs were met.

Staff told us there was an 'on call' system for 'out of hours cover. This system ensured the registered manager or manager of the well-being and support centre (day service) was available.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We looked at four staff files and asked the registered manager for copies of appropriate applications, references and necessary checks that had been carried out. We saw these checks had been made so that staff employed were 'fit' to work with vulnerable people. The hospice was supported by a large number of volunteers who undertook multiple roles, for example reception, catering, helping with the day service. Volunteers were recruited via the same procedures.

We looked at the management of medicines at the service. Medicines were administered by the nursing staff once they had completed the service's medicine courses. Medicine training included administering controlled medicines, syringe driver training, commonly used drugs in palliative care, drug calculations, unlicensed medicines and injectable medicines. A competency assessment tool was used to check nurses' medicine competencies to ensure they had the skills and knowledge to administer medicines safely.

Stock medication was stored in a locked clinical room in locked cupboards or fridges. Fridge temperatures and the room temperature were recorded daily to ensure medicines were kept at the correct temperature so they worked effectively. The nurses administered medicines from three medicine trolleys which were stored safely in the clinical room. Nurses wore tabards to advise people they were administering medicines to reduce the risk of being disturbed when undertaking this clinical practice. People's medicines were recorded on prescription cards and a check of two people's prescription cards showed their controlled medicine had been administered as prescribed. Controlled medicines are drugs liable to misuse and require stricter legal controls.

Staff had access to a range of medicine policies and procedures for the safe management of medicines including controlled medicines and self-administration.

Pharmacy support was contracted from a local acute service and a senior pharmacist provided cover for the service two hours each day. The service also benefited from a weekly visit by a pharmacist technician to provide a 'top up' service and staff had access to an 'on call' pharmacist 'out of hours' service.

The pharmacist was a palliative care specialist and advised us of their input into the weekly multi-disciplinary meetings regarding the management of people's medicines. The pharmacist advised us of how

medicine reconciliation took place within 24 hours of a person being admitted (except on weekends) to assure the safe management of medicines. This is to make sure that medicines prescribed on admission are in accordance with those prescribed before admission; this is in line with the government's national guidelines for the safe management of medicines.

People on the unit received a combination of stock medication and their own medicines from home. The pharmacist met with people to discuss their medicines during their stay at the service. When speaking to a person on the unit they told us they were happy with the support around their medicines and management of pain through the administration of PRN 'as required' analgesia.

Medicine alerts and any factors affecting the safe management of medicines, for example, a medicine errors, were discussed within a medicine management group and a designated person was made responsible for cascading alerts and actioning points from the meetings. The medicine management group met monthly and attendees included pharmacists, nursing representation from the unit and wellbeing and support unit, medical director and senior managers. Minutes were seen of recent meetings held.

Some people's medicines were required to be administered via a syringe driver. 'A syringe driver is a small, portable pump that can be used to give you a continuous dose of a painkiller and other medicines through a syringe.' We saw a syringe driver chart for undertaking four hourly safety checks in respect of, for example, the rate, site of infusion and also content of the syringe driver to ensure people's welfare and safety. These safety checks were also recorded in people's care evaluation record. This we saw when reviewing one person's medicines given via this route.

An accountable officer was appointed to govern the management of controlled medicines; this is a required under the regulations governing the management of controlled drugs. The accountable officer attended Local Intelligence Network (LIN) meetings to discuss the management of controlled medicines, controlled drug training for staff and any matters arising. We were shown minutes of a LIN meeting held in March 2016. The accountable officer undertook random monthly controlled drug balance checks. Twice weekly checks for all controlled drugs were also carried out, along with a quarterly check by the pharmacist as part of auditing the safe management of controlled medicines. The pharmacist discussed with us a potential medicine error and how this was being reported and the investigation that will take place. It was evident that an open and transparent culture existed in reporting all medicine incidents.

Other medicine audits completed by the service included a monthly audit of medicines administered and a self-administration audit twice a year. The pharmacist's audit programme included a fridge audit, non-controlled drug stock review and quality of prescribing audit. A tool was also used for auditing controlled drugs from a recognised national organisation.

During conversation with medical staff we discussed discharge arrangements. Patients/carers are informed of any changes to medicines on discharge, for example, stopping/starting of new medicines and secondly a letter is sent to the person's GP informing them of what the service has done in terms of medicines (stopping/starting) with a rationale.

There was a comprehensive cleaning schedule for the service though areas cleaned on the in-patient unit were not recorded on a day to day basis. We raised this with the registered manager who took appropriate action to rectify this. We found all areas to be clean and staff had access to gloves, aprons and hand gel to reduce the risk of cross infection. Infection prevention and control policies and procedures were available and staff received infection control training. Infection control was closely monitored by an infection control lead and the hospice was well presented and clean in all areas seen. We were shown an environmental audit

which assessed dirty utilities such as, bathrooms, sluice, urinals and bedpans, flooring and shelves; a 97% pass was achieved.

A schedule of planned maintenance and service contracts were in place and overseen by the service and/or by Aintree Hospital NHS Foundation Trust. This included regular checks and service contracts for Legionella and water treatment, piped oxygen supply, fire system including emergency lighting and fire alarms, gas and electric service, emergency lighting and portable appliance testing. An 'out of hours' service was available. Other service contracts included servicing for moving and handling equipment (hoists and slings) and disposal of clinical waste. A risk assessment for the building and grounds was in place and night workers carried out various security checks of the building to ensure people's safety.

The service's fire risk assessment was last reviewed in 2015. Any required actions had been signed off once completed. Senior staff were appointed the role of fire marshals to help oversee fire safety and to cascade a model of fire training for the staff.

## Is the service effective?

### Our findings

People on the in-patient unit spoke positively about their care and treatment from all staff and volunteers. They told us the staff were highly trained to meet their needs. People told us they saw the medical and nursing staff each day and that they had the information they needed about their care and treatment. People told us there was a team approach by the hospice staff so they got the right level of support from each department when they needed it and wished to receive it. A person said, "I see the doctor each day, there is always time to ask questions and everything is explained. All the staff are great, so much support from everyone for me and my family. This support is day and night."

We asked people on the in-patient unit to tell us what they thought about the food. We received very positive feedback regarding the quality, presentation and variety of meals served. Comments included, "I am impressed there's so much to choose from and I can have something small when I want it", "The food is just brilliant, always so much to choose from, any time day of day, you could not have better" and "I have had homemade chicken soup, today I am having cod and if I wanted one I could have a ham balm cake".

The hospice offered an in-patient service for people who required assessment and symptom control, rehabilitation following treatment and the provision of end of life care. The hospice's 'multi-professional team provided specialist palliative care to patients living with a life threatening illness and those patients in the terminal phase of their disease. The team aim to provide holistic evidence based care for patients and their families to improve quality of life and ensure a dignified death. Referrals to the unit were from the community via GP's, district nurses, Macmillan Nurses, from the day hospice and clinics and wards at the University Hospital Aintree at the request of medical staff or specialist palliative care nurses. Referrals to the hospice also came from Clatterbridge Cancer Centre.

In response to diverse needs and people's choices, the registered manager told us that training around behaviours that may challenge was seen as a priority. This was to ensure the delivery of specialist palliative and end of life care for people with a dementia or cognitive impairment. We saw that staff received training in communication skills up to advanced level to promote effective communication and interpersonal skills.

During our inspection we observed staff seeking people's consent before supporting them and also checking whether they wished to receive visitors. A staff member said, "We would always check with a patient before proceeding with any intervention."

We saw that people received care from a multi-disciplinary staff which included palliative care nurses, medical staff, therapy staff, pastoral staff and a family support team. Medical and nursing cover was provided 24 hours a day on the in-patient unit with on call medical cover for 'out of hours'. The team were trained to meet people's needs and staff interviewed were knowledgeable regarding people's plan of care and medical treatment.

Staff promoted the importance of good nutrition and hydration. The PIR provided information about the service's nutritional group. This group meet every other month to identify nutritional risks and support and

provide a coordinated approach to nutritional care. The registered manager informed us that that the group had worked closely with a recognised organisation around the development of their own nutritional audit tool and guidelines to help monitor people's nutritional needs. We saw that people had a nutritional assessment and plan of care which outlined the dietary support they needed and wished to receive.

We spoke with a chef who told us how people's dietary requirements, allergies and preferences. This information was accessible for the catering staff. A 3/2/1 chart recorded how much of the meal people had eaten, the score of three meaning the person had eaten all of their meal. The chef told us this was a useful tool for monitoring how much people had eaten and also if they had enjoyed their meal. The nurses prepared a list each day of people's dietary needs and requirements for the kitchen staff; the chef told us the catering staff had all the information they needed to prepare meals in accordance with individual need and preference. All diets were fortified with the use of full cream milk; 'smoothies' were prepared daily and people were offered a good choice of fresh fruit and vegetables.

A menu recorded a choice of hot and cold meals with a cooked breakfast and/or choice of cereals and toast in the mornings. The chef told us the key question when people arrived on the in-patient unit was to ask 'what they would eat at home' and to try and replicate this, so that meals served were to people's liking and preference. The chef told us they met people on the unit each to advise them of the menu choices. The choice during the inspection was not the same as recorded on the menu. We brought this to the registered manager's attention to ensure people were provided with an up to date menu if changes were made. On the day of our inspection people were served a choice of two hot meals at lunch and tea time. People were also offered, salad or omelettes, for example. A person requested an omelette mid-morning and this was immediately prepared for them. All meals were attractively served and attention paid to portion sizes.

People had access to snack menus if they wanted something light during the day and night. People could choose to have their meal by their bedside, in the lounge area or in the hospice's café. The café was open to people on the in-patient unit, visitors and staff.

Staff had access to a training programme which included courses such as moving and handling, health and safety, dementia, bereavement, dignity/ respect, person centred care, safeguarding adults and children, infection control, communication, incident reporting, personalised care plans, Mental Capacity Act 2005 (MCA), malnutrition, handling complaints and advance care planning (ACP). Volunteers also received training in accordance with their duties. Staff discussions took place around challenging events and nurses were being supported with their nursing revalidation with the Nursing Midwifery Council (NMC).

The training plan showed some staff required a moving and handling update and dates for cascading this training were being arranged. Staff told us they received a good standard of support and training with protected time arranged for staff to attend courses. A staff member said, "We get offered training on a regular basis, attend supervision meetings and annual appraisals." Staff had individual supervision with their line managers; dates for these meetings were recorded along with annual appraisals.

New staff received a full induction and were supported by more experienced staff as they became familiar with the service and the provision of hospice care. New staff worked alongside different hospice staff to create an awareness of the various staff roles.

The PIR recorded the introduction of the Care Certificate which the registered manager told us was now being implemented for new health care workers. This is 'an identified set of standards that health and social care workers adhere to in their daily working life'. The Care Certificate requires staff to complete a programme of training, be observed by a senior colleague and be assessed as competent within twelve

weeks of starting. We saw records of induction to support our discussions with the registered manager.

94% of staff had achieved a formal qualification in care, such as an NVQ (National Vocational Qualification) or equivalent. Formal training in palliative and end of life care was on-going for clinical staff up to degree/masters level. There was evidence of hospice staff working in partnership with other organisations to learn and implement best practice in end of life care.

At this inspection we looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) [MCA]. 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.

The registered manager told us how consent to receive care and treatment at the hospice was established before admission. They told us that if a person was not able to consent to their admission or subsequent care and treatment then a best interest meeting would be held. We saw examples of this in respect of advance care planning in respect of people's wishes for end of life care. We also saw examples of DNACPR (do not attempt cardio pulmonary resuscitation) decisions which had been made and we could see the person involved had been consulted and agreed the decision.

Staff were able to talk about aspects of the workings of the MCA and discuss other examples of its use and how someone is deprived of their liberty. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager informed us that at the time of the inspection no applications had been submitted to the 'Supervisory Body'. Previous applications had been to help protect people who were not able to make decisions about their care and treatment for themselves. We found the registered manager and staff had been trained and prepared in understanding the requirements of the MCA in general and (where relevant) in the specific requirements of the DoLS.

Staff had access to a mental capacity act policy and procedure. Staff discussed with us how they held best interest meetings with people and their family members or carers in case the person could no longer make decisions about their care. For example, if they suffered a sudden stroke, were unconscious and unable to make their wishes known.

We looked all around the premises which were spacious, comfortable, well lit and airy. The in-patient unit was spacious and provided comfortable en-suite rooms overlooking well maintained patio areas. There was suitable equipment and facilities to meet the need of people who were receiving end of life care and care after death. People had the use of a call bell for assistance, fully adjustable beds, pressure relieving equipment and an adjustable therapy bath to ensure their comfort. There were two lounges and a quiet reflection room. The hospice's facilities ensured sensitive and respectful arrangements were in place for funeral directors to attend and for relatives to spend time with their loved one following death.

## Is the service caring?

### Our findings

People on the in-patient unit were very complimentary regarding the caring, polite and kind nature of the staff. People used words such as 'fabulous', 'amazing' 'earth angels' and 'wonderful' when describing the care and support they received from the staff team. A person told us, "Everyone is just so kind I cannot praise the ward enough." Another person told us how the staff had spent so much time getting to know them and their family and listening to what they wanted to have in place to help them return home. The person described the care as 'first class'. A person told us how much they appreciated the spiritual support and the comfort this provided. A relative said, "Just such lovely staff, nothing is ever too much trouble."

People's families told us they could visit at any time and were always made to feel welcome by the staff. A relative said, "Nothing is too much trouble for any of the staff, you can come any time." Families were supported to stay overnight in relatives' rooms with a 'put you up bed' and separate shower facility. The registered manager said they were looking to provide tea and coffee making facilities in this room for use overnight; there was however a coffee machine in the lounge and vending machine which sold drinks and snacks in the main reception area that could be accessed at any time. The provision of comfort packs were available for relatives if they needed to stay over. For people who had no family or friends to represent them contact details for a local advocacy service and other support groups were available.

The hospice had a philosophy of care, 'At the heart of Woodlands is the individual who is seen as a unique person deserving of respect and dignity. Our aim is to support each person and family unit helping them to make informed choices and decisions affecting their lives'. A staff member said, "All of the staff want patients to receive the best care, I have never worked anywhere where it is consistently like that." Staff were motivated in their roles and told us how they were committed to providing people with informed choices and respecting people's decisions about their care and treatment. Staff said that the hospice was about 'living' and improving the quality of life for people. Our discussions with people and relatives confirmed this view in respect of the care and supporting people to receive care in their preferred place.

An external health care professional said the hospice ensured people received holistic care (caring for the whole person) and support was provided throughout for families and carers.

We observed positive interactions between the staff and people on the in-patient unit. We saw this when administering medication and offering aspects of personal care to ensure people's comfort and wellbeing. Support was given in a patient, respectful and caring manner; people were not rushed and staff took time to explain what they were going to do and waited for consent before proceeding. Staff took time to listen and to respond in a way that the person they engaged with understood. A staff member told us about the importance of taking time so that people felt comfortable with the procedure being undertaken. Staff demonstrated a genuine interest and concern regarding people's welfare and spent time with people to provide companionship when they were alone.

The layout of the in-patient unit provided people with privacy and people had their door closed to their room if they so wished. Staff knocked before entering and waited to be advised they could enter. People's

rooms had numbers and plaques on the adjacent wall with the names of flowers to identify the room, rather than people's names.

The service had a dignity champion appointed and a dignity charter which highlighted 10 key points around promoting standards of dignity and of people's rights to equality and diversity. The hospice's dignity group reported on February 2016 as being the dignity month and dignity cards for staff had been introduced as part of the focus. This was as a result from feedback from the Woodlands Hospice patient, friends and family forum. The cards detailed what people thought could be considered as degrading and how to 'treat me with dignity and respect'. These were seen as a useful tool in promoting people's rights to dignity and respect and were provided for the staff.

The Woodlands Hospice information pack included the dignity charter which was given to people on admission. This information pack also contained detailed information about the service provision, including catering, family and pastoral support, visiting times, recognising the ward team, infection control, parking, discharge, transport, complaints, consent to care and treatment and 'your information and how it is used'. Information about the hospice could also be found on their website.

The service took account of people's cultural, religious, spiritual, emotional and physical needs and these were met by the hospice team. People and their family members could access a range of support services across the hospice and community setting to provide the care and support they needed and wished to receive. This included pastoral support, bereavement and counselling support, occupational therapy and physiotherapy service, hairdresser, social therapy (including complimentary therapies), day hospice and access to a family support team.

We saw that the staff valued practice that acknowledged and promoted diversity and equality; information was recorded within care documents and also through staff training to support this practice.

Staff told us how they supported families at the time of death and after; this included families or carers being able to stay with their loved one as they wished. The staff had access to a bereavement folder and leaflets were given to the family explaining what they needed to do next such as registering the death and arranging the funeral. This also contained information relating to emotions that may occur following the death of a loved one. After a period of time the hospice sent a card to the family or carer offering 'follow up' support such as attendance at a bereavement group or individual counselling. Staff told us they supported people to attend 'follow up' sessions though this was left up to the individual to make that choice either then or at a later time.

The family support team had four members of staff and a volunteer team who were trained in understanding the support people may need at different times of their stay and on discharge home. This included after care following the death of a relative for an indefinite period of time; the provision of bespoke support for younger widows and widowers was being actioned as a priority for this year; staff felt this was an area that could be developed further, as they appreciated there was less support 'out there' for this particular age group.

Social support included people bringing pets in from home and christenings and weddings ceremonies held at the hospice. A staff member told us how a family member had requested some help to organise a birthday party for their relative. Staff told us how they achieved this in accordance with the family member's wishes.

People said they were consulted about their care and treatment and their views were listened to, respected

and acted upon. This was reflected in the care documents we looked at and people at the appropriate time had an advance care plan (ACP) in place to support their needs and wishes regarding end of life care. This was based on Cheshire & Merseyside Palliative and End of Life Care Network. 'This framework was developed to support a consistent approach to Advance Care Planning (ACP) for adult patients across the health localities in Cheshire & Merseyside'. The service followed the Priorities for Care of the Dying Person and were signed up for Liverpool Dying Well Community Charter.

## Is the service responsive?

### Our findings

People on the in-patient unit told the staff responded promptly to their requests for support. Comments included, "The staff are here straightaway" and "The help is amazing and I never have to wait." A person told us about how their pain was being managed and the checks undertaken by the staff to ensure their medicines were effective. Another person said, "The doctors are very good and explain things to you, they tell me what I need to know and are honest."

People were admitted to the in-patient unit at the hospice from their own home, hospital, clinic appointment or a care home, for example. The in-patient unit also provided an 'out of hours' service to provide advice and support for hospital and community based staff. The hospice ran a day hospice called the well-being and support centre which enabled people to receive the support they needed without having to stay overnight. Referrals were made for this service by GPs and other health professionals and the service was offered Monday to Friday. The day hospice had a dedicated staff and a range of facilities and equipment to support people's care needs. Staff told us people were encouraged to take part in social interests and the service gave people an opportunity to meet people in a similar position. The day hospice offered two multi professional assessments days and following assessment a plan of care was drawn up to support the person with their individual needs. People attended the day hospice for individual appointments or group appointments to access services such as, anxiety management, physiotherapy, medical review, aromatherapy, reflexology, reiki, lymphoedema management and counselling.

The hospice at home service was run by two clinical co-ordinators, an administrator and Woodlands hospice 'at home' health care assistants; a consultant provided medical support and the staff team worked closely with community based professionals, such as GP and district nurses. The hospice at home service had three elements of care: staff carried out a sitting service to support people and their families in their own home: crisis intervention – 'where, at the request of a GP or community specialist team, a consultant in palliative medicine will visit the patient at home and advise on the most appropriate care in order to prevent unnecessary hospital admission and enable the patient to stay at home': escorted discharge home from Hospice or Hospital - 'where a Woodlands Hospice at Home Health Care Assistant will accompany the patient home and ensure that everything is in place before the next care agency or District Nurse visit'.

The hospice at home service gave people and their families reassurance that they were fully supported in their own home with access to professional advice twenty four hours a day.

People received care and treatment from a multi health professional team. The hospice had their own palliative care consultant who led a palliative care team at the hospice worked closely with the local acute hospital to assess people for admission, care and treatment and plan discharge. Multi-disciplinary team meetings to discuss patient care took place on a weekly basis or more frequently if required. These meetings included in-patient staff and also community based professionals. Staff told us they received feedback from these meetings so that changes could be made to a person's care and treatment. This helped to ensure the right care was provided. The hospice had a chronic pain team who offered specialist treatments for pain control at the hospice or at the Walton Neurological Centre. Discharge planning took into account people's

choices around end of life care and nurses told us they worked closely with the district nurse team and GPs to ensure a smooth transition of service on discharge.

People's consent was obtained for their care and to share relevant information about this with other health care professionals. We saw that people were involved in decisions about their care and treatment; staff told us they would not proceed without people's full understanding and consent. People's future care wishes were recorded in their care plans. This included where and how people wished to receive their end of life care and support.

The nursing staff ensured that people's needs were assessed and that care and support was planned to support the well-being of people in accordance with their needs and preferences. The assessments took into account different aspects of care such as, personal care, mobility, medical conditions, nutrition, wound care, medicines, pain management, social needs and support for family members.

People had a plan of care to identify the care. The majority of documents were held in paper format and care plans were mainly generic with pre-populated information. We looked in detail at the care being provided for five people and gained permission from them to see their care documents. A nursing care plan provides direction on the type of care an individual may need following the original assessment. Care planning is important to ensure people get the professional care they need when they are at the hospice. Care plans cover areas such as, as pain control, nausea, vomiting, skin integrity, constipation, assistance with personal care, psychological support, spiritual care and individualised care at the end of life. End of life care relates to the care provided for a patient anywhere within the last year of life, up to and including death. We saw examples of individual care plans for care at the end of life which included pain and symptom management, for example control of nausea and vomiting, and agitation at the end of life.

Staff told us how they ensured people and their family members had the opportunity to decide on the advanced care plans (ACP) they wanted to include in their care, such as the Preferred Priorities for Care at the end of life and decisions about cardio pulmonary resuscitation otherwise known as CPR forms. These were completed in advance with the person and/or family/carer and medical staff. These advanced care plans were sometimes completed in the community by the GP and because they belong to the person they could be taken with them in to the hospice or hospital. This ensures that the person's wishes are adhered to where possible. ACPs in Woodlands Hospice was completed by the medical team in partnership with the person and their family and carers.

With the generic care plans staff had added further information to make them more tailored to the individual. This however was not consistent in all the care plans we saw. For example, we saw a pain management care plan lacked detail regarding pain symptoms and what worked for the person to reduce the pain. We saw the nurses' daily evaluations recorded a detailed over view of the care given for this person and how the person was responding. We discussed with the registered manager ways of recording these details in the plan of care for staff to follow. The registered manager told us work was underway to improve the care documentation and provide further staff training around care planning as this had been highlighted through the service's care audits.

There were care plans for care after death which ensured families received the documentation they needed following the death of a loved one, such as what to do after the death of their relative and the emotions they might feel at this time.

A complaints procedure and a leaflet on how to raise concerns, complaints or comments was available should people wish to raise an issue or make a suggestion. Details of how to raise a complaint outside of the

organisations included, using the NHS Complaints Procedure or contacting the Ombudsman.

We looked at the complaint log and this recorded that from April 2015 to March 2016 the hospice had received 14 verbal complaints (12 related to patient care) and six written complaints (three related to patient care). We looked at two complaint records and these showed the investigation and actions taken. In respect of one of these complaints we identified this should have been logged as a safeguarding concern; the registered manager told us they were looking to provide further training around what constitutes a complaint or needs to be considered as a safeguarding concern so that the correct procedures were followed.

## Is the service well-led?

### Our findings

The hospice had a registered manager in post and a Board of Trustees who offered a wealth of knowledge and expertise from a clinical and business perspective. The senior management team included the Chief Executive (CE), consultant in palliative medicine/clinical lead, head of income generation and registered manager. Senior management were supported by a quality and improvement manager, well-being and support manager, ward manager, head of family support and head of therapy services. The management structure was clearly defined and recognised by staff. Trustees carried out formal visits to the hospice to meet with staff and people using the services of the hospice, as part of assuring the service provision. People said, "The hospice in every department is so good", "I can't praise everyone enough", and "It is marvellous here."

Feedback about the registered manager was very positive and staff told us the registered manager and in-patient unit manager were visible and very approachable. Staff told us they were offered support through learning and their day to day practice. A staff member said, "The management here are very good and very supportive". Staff told us they understood the concept of whistleblowing and would feel supported if they needed to raise a concern. They confirmed an open culture existed within the hospice.

Staff advised us they attended ward meetings and these covered subject matters such as, safeguarding people from abuse, care practices, staff training, family support and bereavement. We saw minutes of meetings held. A framework was in place to offer a more formal route for staff support, such as counselling sessions and spiritual support; it was recognised that caring for people in a hospice setting could be emotionally challenging. A member of the pastoral team told us, "In some circumstances I hold ad hoc debriefing sessions with the staff and we discuss a particularly complex situation that they have had difficulty coming to terms with." Staff told us how much they appreciated this level of support and the debrief sessions held.

All staff we spoke with were very clear about the hospice's approach to caring and supporting people in their last few days of life. The registered manager told us that the staff training programme took into account the Five Priorities for Care for the dying person - recognise, communicate, involve, support, plan and do. These priorities put people and their families at the centre of decisions about their treatment and care. We were able to confirm this during our inspection by looking at records and talking with people, relatives and staff. It was evident that people were at the heart of the service.

At this inspection we looked at quality assurance systems, including audits (checks) to monitor performance and to drive continuous improvement. The registered manager was able to show us the hospice had a structured approach to audits and information collated was discussed at committee meetings and working groups. This was to gauge the performance of the hospice against regulatory standards, to target areas of improvement and to celebrate areas of good practice. We saw that auditing procedures included subjects such as, infection control, tissue viability, the environment, medicines, controlled drugs, use of syringe drivers, care planning, ACPs, staffing, safeguarding, complaints and staff training. Clinical audits fed into a clinical audit plan and a risk register recorded organisation risks and required actions.

The hospice had a clinical governance committee and a clinical effectiveness group for overseeing areas such as policy reviews, the risk register, systems and process for auditing, patient and family experience, medicines DoLS, tissue viability and staff development/ training. We were shown minutes from a clinical governance meeting for nutritional steering held in April 2016 which looked at compliance with the well-being and support centre's nutritional policy as this had been identified as not reflected of practice. Progress and actions to date were recorded including a re-audit of this policy to ensure it was fit for purpose.

The clinical effectiveness group recorded a key priority for 2016-2017 for patient safety in respect of cognitive impairment (a decline in people's mental ability such as, memory or thinking). The registered manager told us staff were signing up as a 'dementia friend' to create a greater awareness and understanding of care and support which is sensitive to the needs of people with dementia and their families. The minutes from their meeting in April 2016 identified an area of good practice. This was the introduction of a more robust syringe driver checklist which had been implemented following a medicine incident. Staff told us this was an effective tool for monitoring the delivery of medicines via this route and they appreciated its implementation.

Other key initiatives for assuring medicines were administered safely was the use of an aide memoire placed outside people's rooms to remind staff to give medication if the person had not been present at the time of the medicine round.

Nutritional support and catering arrangements on the well-being and support centre were audited by a trustee in October 2015 to ensure people received adequate nutrition and hydration. The report demonstrated effective nutritional support and staff knowledge around the importance of nutrition and hydration. It was acknowledged that the provision of food 'out of hours' for people and their families needed to be reviewed and the registered manager confirmed this was being actioned.

We saw minutes of a meeting from November 2015 held by the clinical effectiveness group. A recommendation around implementing three medicine trolleys had been actioned as this had been seen as good practice for the safe administration of medicines. A recommendation for further ACP training for staff was underway to help implement and monitor the implementation of ACPs. A number of nurses had recently been appointed a role as an advance care planning advocate. This was to support staff awareness and learning around clarifying and recording people's wishes, thoughts and needs for end of life care.

Other working groups looked at areas including dignity, patient documentation, tissue viability, falls, infection control and outcome measures to assess the quality of end of life care through different approaches. It was recognised by the group that further work was needed around 'palliative care outcome measures' and attendees were scheduled to undertake a course for trainers this month, as part of assuring the hospice continued to achieve the outcomes intended.

The falls group had reported on a falls audit which showed people had a falls risk assessment completed in six hours of admission to help monitor people's safety. The infection control group reported on environmental issues/concerns as part of monitoring infection control standards the infection control lead attended infection control meetings at the local trust and also Hospice UK infection control groups. This was to implement and promote and best practice infection control procedures. From December 2015- January 2016 the tissue viability group reported on education and training for nursing staff on the grading of pressure sores in line with the community for reporting and monitoring wound care.

The service was proactive in ensuring that patients, family members, staff and volunteers were actively

involved in the development of the service. These included questionnaires, face to face discussions, patient, family and friends forum meetings, staff meetings, social media sites. Three members of the patient, family and friends forum had volunteered to carry out a 'Patient Led Assessment of the Care Environment' (PLACE) assessment. This was carried out during our inspection and although there was no formal analysis as yet the initial feedback was very positive. Feedback from the PLACE assessment last year had resulted in improving the signage within the hospice to help identify different areas.

The hospice's newsletter provided information, such as forthcoming events, for people who used the service and for staff. The February 2016 newsletter celebrated the hospice's success in being open for 20 years and an overview of how the service has developed since its opening and move to Woodlands in 2009. The service was actively involved in building local community links, took part in project work and close working with other hospices and organisations at regional and national level. This was to promote excellent standards for end of life care.

Staff told us about the hospice's achievements within the region and nationally. The well-being and support centre had a creative group which was supported by staff, volunteers and people who used the service. The bereavement group created a piece of art work which depicted the Liverpool Skyline and is going to be exhibited in June/July 2016 in the Liverpool Museum. The well-being and support centre had also presented posters at conferences; these were displayed in the boardroom and included a poster related to nutrition. The well-being and support centre took part in "Big Conversation" as part of the Dying Matters Awareness Week which had been well attended by professionals. The well-being and support centre had also taken part in a radio interview during Dying Matters Awareness week. This was held to enable people to get together to talk about 'dying, death and bereavement'.

Family members told us the family support team provided so much support and advice. The family support officer told us that as part of developing the service they were looking to introduce a virtual library where books could be read through a computer or hand held device. Cards on how to contact the family support team were available on the in-patient unit and day hospice.

The registered manager told us how 'patient stories' were to be used as another means of obtaining feedback about the hospice. This was in its infancy stage though one story had been received. Patient and family satisfaction surveys from 2014/2015 reported very favourably regarding the service provision. The surveys had been developed with the support of the patient and friends and family forum. Comments included, 'never too busy to listen', 'everyone was polite and friendly', 'very warm welcome' and 'very good for care'. The results from the surveys 2015/2016 were not available as yet.

The hospice had links with other hospices and organisations for end of life care. Staff attended external training events and attended conferences, including conferences run by Hospice UK to support good practice and further develop standards. They also had links with Sefton Carers Forum which provides an on line facility for sharing views and experiences.

All records relevant to the running of the service that we saw were well organised and reviewed regularly.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 13 HSCA RA Regulations 2014
Treatment of disease, disorder or injury	Safeguarding service users from abuse and improper treatment  The safeguarding process to follow in accordance with local authority's protocol had not always been followed to protect people from abuse.