CQC is the independent regulator of all health and social care in England. We are given powers by the government to register, monitor and inspect all health and care services.

Woodlands Hospice Charitable Trust

Woodlands Hospice

Inspection summary

CQC carried out an inspection of this care service on 17 May 2016 and 18 May 2016. This is a summary of what we found.

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

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.

You can ask your care service for the full report, or find it on our website at **www.cqc.org.uk** or by telephoning **03000 616161**