St. Luke's Hospice (Harrow & Brent) Ltd

St Luke's Hospice Kenton Grange Hospice Harrow & Brent

Inspection report

Kenton Grange
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Summary of findings

Overall summary

Our rating of this location went down. We rated it as inadequate because:

- The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. They did not always keep equipment and the premises visibly clean.
- The service provided mandatory training in key skills to all staff but did not make sure everyone completed it.
- The design, maintenance and use of facilities, premises and equipment did not always keep people safe.
- The service used systems and processes to safely prescribe and record medications, but they did not always safely administer and store medicines.
- Staff did not always keep detailed records of patients' care and treatment. Records were not always clear or up to date.
- Staff did not assess or monitor patients regularly to see if they were in pain and therefore may not always give pain relief in a timely way.
- Leaders did not always operate effective governance processes throughout the service and with partner organisations.
- Leaders and teams did not always identify and escalate relevant risks and issues or identify actions to reduce their impact.

However:

- The service had enough staff to care for patients and keep them safe.
- Staff provided good care and treatment and gave patients enough to eat and drink.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Inadequate 	Our rating of this location went down. We rated it as inadequate because: • The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. They did not always keep equipment and the premises visibly clean. • The service provided mandatory training in key skills to all staff but did not make sure everyone completed it. • The design, maintenance and use of facilities, premises and equipment did not always keep people safe. • The service used systems and processes to safely prescribe and record medications, but they did not always safely administer and store medicines. • Staff did not always keep detailed records of patients' care and treatment. Records were not always clear or up to date. • Staff did not assess or monitor patients regularly to see if they were in pain and therefore may not always give pain relief in a timely way. • Leaders did not always operate effective governance processes throughout the service and with partner organisations. • Leaders and teams did not always identify and escalate relevant risks and issues or identify actions to reduce their impact. However: • The service had enough staff to care for patients and keep them safe. • Staff provided good care and treatment and gave patients enough to eat and drink.

Summary of findings

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Summary of this inspection

Background to St Luke's Hospice Kenton Grange Hospice Harrow & Brent

St Luke's Hospice Kenton Grange Hospice Harrow & Brent is a registered charity providing specialist palliative and clinical support for people over the age of 18 years with life limiting illnesses irrespective of diagnosis. The service provides a 12-bed in-patient unit, a day service, outpatients' service and care in people's own homes provided by community teams. The hospice also provides support for families, friends and carers of people using its services. At the time of our inspection, there were approximately 555 people using or known to the service. Although the in-patient unit had capacity for 12 patients, only six beds were in use at the time of the inspection.

The service is registered for diagnostic and screening procedures, and treatment of disease, disorder or injury and has a registered manager in place to oversee this. We last inspected St Luke's Hospice in 2016. The hospice was rated good in all five domains, with no compliance actions or enforcement issued.

At this inspection, we found significant issues of concern and have placed the service in special measures.

As a result of this inspection, we used our enforcement powers to serve a Warning Notice to the provider under section 29 of the Health and Social Care Act 2008. This was served for failing to comply with Regulation 12: Safe Care and Treatment, and Regulation 17: Good Governance. As a result, the provider must demonstrate to CQC compliance with the concerns identified in the warning notice by set dates. A future inspection will be held to check compliance.

Professor Ted Baker, Chief Inspector of Hospitals said: I am placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

How we carried out this inspection

We carried out an unannounced inspection of the service from the 6 to the 10 October 2021.

During this inspection, we observed care and treatment at the inpatient unit, looked at six sets of patient notes, spoke with four patients and their families on the inpatient unit, two volunteers and 10 members of staff. Due to the COVID19 pandemic, we did not visit patients in the community, however, we undertook telephone interviews with four patients who were receiving community care, and spoke with three community nurse specialists. We spoke with staff at the Woodgrange Centre (day centre) and observed a virtual gardening session run by the volunteers.

Summary of this inspection

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The service provided by this service was hospice care for adults.

You can find information about how we carry out our inspections on our website:

https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Following the site visit, we issued two warning notices to the provider, setting out clearly, areas in which it needed to improve.

Action the service MUST take is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- Ensure that all equipment used by the service provider for providing care or treatment to a patient is safe for such use and is used in a safe way. This includes equipment used in emergency situations and syringe pumps. Regulation 12(2)(e)
- Use equipment and control measures to protect patients, themselves and others from infection. They must keep equipment and the premises visibly clean. Regulation 12(2)(h)
- Safely administer and store medicines. This includes regularly checking storage temperatures and removing expired medicines from use. Regulation 12(2)(g)
- Assess or monitor patients regularly to see if they are in pain. Regulation 12 (2)(a)(b)
- Keep detailed records of patients' care and treatment and ensure that these are individualised and specific to each patient's needs. Regulation 17(2)(c)

Action the service SHOULD take to improve:

- Check that all staff receive and are up to date with their mandatory training.
- Check that all staff have regular appraisals including those who are employed by honorary contracts.
- Check that clinical risks are included in the service risk register.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospice services for adults	Inadequate	Requires Improvement	Good	Good	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Good	Good	Inadequate	Inadequate

Inadequate

Hospice services for adults

Safe	Inadequate
Effective	Requires Improvement
Caring	Good
Responsive	Good
Well-led	Inadequate

Are Hospice services for adults safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills to all staff but did not make sure everyone completed it.

Staff did not always receive and keep up-to-date with their mandatory training. Whilst 76% of all staff were up to date with mandatory training, the remaining staff's mandatory training had lapsed which had the potential to affect patient care. The lowest compliance was infection prevention and control with 57% of staff being up to date, and medical gases training which had a compliance rate of 66%. This was because staff were not able to attend face to face training during the COVID-19 pandemic. Staff had completed electronic learning while waiting for face to face training and staff were booked for face to face training. Managers monitored mandatory training and alerted staff when they needed to update their training. Staff said they received email alerts, so they knew when to renew their training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff and volunteers received training specific for their role on how to recognise and report abuse. Training records showed all staff were trained to level 2 in safeguarding adults and children. The service had a safeguarding lead who was trained to Level 3 alongside senior managers. Staff kept up to date with their safeguarding training. There was a system to alert managers and staff when they needed to update or refresh their training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. They could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff said they felt confident to raise issues with the senior management team. They knew when they should make referrals to the local authority. Any community safeguarding concerns were also raised at the daily community multi- disciplinary team meeting.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. They did not always keep equipment and the premises visibly clean.

The inpatient unit was not visibly clean and tidy. Cleaning records were not always up-to-date and did not demonstrate that all areas were cleaned regularly.

There were gaps in the weekly cleaning checklists for the previous six months. Weekly checklists included the blood sugar measuring machine, oxygen concentrators, drug trolley, drug room, resuscitation box, hoists, store rooms and commodes. Cleaning schedules for the previous six months showed that no month had fully completed checklists in place. This meant there was a risk that dirty equipment could be used when delivering care to patients.

Equipment including the portable suction and resuscitation trolley, were visibly dusty and dirty. Managers told us that 'I am clean' stickers should be used to indicate equipment such as hoists were clean and ready for use. I am clean stickers were used on some commodes but were not found to be used on any other equipment including hoists, meaning there was no assurance that the equipment had been cleaned. Storage areas were cluttered, and equipment used for moving and handling patients was stored in a patient shower area, creating a potential trips, slips and falls hazard.

Hand hygiene audits were not regularly or consistently undertaken. For the previous 12 months prior to the inspection, five audits were undertaken. The audits ranged from observing three staff in an audit, to six staff in another, meaning there was not a consistent amount of staff being observed. Only one audit achieved 100% compliance with hand hygiene practices, which included activities undertaken in order to prevent the spread of infection, including washing hands before patient contact and being bare below the elbows.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

Staff did not regularly carry out safety checks of specialist equipment. The portable suction machine should be checked daily to ensure it is safe for use in an emergency. Records showed it was checked on the 5, 14 and 15 August 2021, and the 14 and 21 July 2021. The last documented check prior to those dates was April 2020. This meant there was a risk that the equipment may not work in an emergency, and dirty equipment could be used when delivering care to patients.

The top of the resuscitation trolley was cluttered. The resuscitation trolley should be checked weekly. The resuscitation checks log showed that for the previous six months, (April 2021 to September 2021) the resuscitation trolley was not checked on six occasions: one week in August 2021, two weeks in July 2021, one week in June 2021, and two weeks in April 2021. This meant that emergency equipment such as the suction machine and resuscitation trolley were not being checked in accordance with the Resuscitation Council UK, Quality Standards: Acute Care Equipment and Drug Lists. This states that a reliable system of equipment checks, and replacement must be in place to ensure that equipment and drugs are always available for use in a cardiac arrest. The frequency of checks we observed was not consistent or reliable and therefore, there was a risk that the equipment may not work in an emergency situation, or would be dirty and therefore unsuitable to use, when required. The resuscitation trolley was stored behind a desk in an office area meaning that it could be difficult to access in an emergency situation.

Staff disposed of clinical waste safely. There were appropriate waste bins in each area which were clearly labelled with what could be disposed of in them. The bins in each room were regularly emptied. Sharps bins were clearly labelled with dates of assembly, as well as disposal.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff undertook regular visual observations and told us that if patients were unwell, they would increase the frequency of these observations and call a doctor to review if they still had concerns. There were guidelines for staff on when to escalate their concerns to ensure that specialist review took place consistently when needed.

Staff completed risk assessments for each patient on admission in line with nationally recognised tools. Inpatient unit records included skin integrity and malnutrition assessments, as well as falls prevention.

Shift changes and handovers between staff, included all necessary key information to keep patients safe. Staff in both the inpatient unit and the community, met every morning and discussed each patient in detail, including their psychological needs. All staff had access to electronic patient records which were able to be accessed from both the inpatient unit and the community services.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. The number of nurses and healthcare assistants matched the planned numbers. Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants in accordance with national guidance. Managers could adjust staffing levels daily according to the needs of patients. The service had low vacancy rates, and low staff turnover rates.

The service had low rates of agency nurses. When necessary, the service used regular agency staff who were familiar with the service. Agency staff received a full induction and received regular updates from the service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. The medical staff matched the planned number. The hospice directly employed one of their consultants and had honorary contracts in place for the other medical staff including consultants, specialty doctors, a junior doctor and trainee doctors.

The service always had a consultant on call during evenings and weekends. There were no doctors onsite after 5pm on weekdays but a medical on call rota meant nursing staff could access specialist advice seven days a week.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear or up to date. Records were stored securely and easily available to all staff providing care.

Nursing care evaluations were kept on the electronic system. These did not always reflect the care needs or care delivered to the patients. The last three nursing entries for six patients were checked during our inspection. No patient had pain mentioned in all three evaluations, meaning we could not be assured that staff were consistently assessing or addressing patients pain needs.

Care plans were not consistently completed and were not individualised to meet the needs of patients. Staff printed generic care plans that did not allow for the patients care needs to be tailored to meet their specific needs. Not all patients had care plans for their needs, such as pain care plans for patients who were receiving regular pain relief, meaning staff did not have the documented guidance as to steps they need to take to alleviate individual patient's pain.

Nursing staff did not regularly document syringe pump checks. A syringe pump is a piece of equipment that uses a syringe to administer a continuous supply of medication such as pain relief, medication used to control breathlessness, anti-sickness or sedation. Managers told us syringe pumps should be checked, and this was to be documented every four hours, to ensure the pumps were administering the medicines correctly. We saw gaps of up to nine hours between checks, meaning there was no assurance that patients were receiving the correct dose of their medication during this time.

Patient medical notes were comprehensive, and all staff could access them easily. The hospice used a mix of paper and electronic records. Most patient notes were kept on an electronic system that could be accessed from both the inpatient and the community settings. This included the patients resuscitation status. Care plans, risk assessments and medication charts were completed on paper.

Records were stored securely. We observed that all computers were locked when not in use. This meant patient records were kept secure and confidential. Patient written records were stored in the office in the inpatient unit, accessible only by staff.

Medicines

The service used systems and processes to safely prescribe and record medications, but they did not always safely administer and store medicines.

On the inpatient unit we observed there were eleven expired medicines in the clean utility room, as well as one expired medicine in the fridge that was intended for use in emergency situations. This meant there was a risk that patients could be administered medicines that were potentially less effective, and therefore may not have the desired effect that they had been administered for.

Inadequate

Hospice services for adults

We observed gaps in checking of the clean utility room temperature, and fridge temperature in the medication preparation room. The medicines fridge temperature was not checked for two days in September, 12 days in August 2021, and six days in July 2021. This meant that medicines might not be stored at the recommended temperatures, which could affect their stability and effectiveness.

Staff followed systems and processes when safely prescribing medicines. Medicines records were complete and contained details on dose, when patients received them, review dates, and any reasons for omissions. Staff stored and managed prescribing documents such as FP10 prescriptions in line with the provider's policy.

Incidents

The service managed patient safety incidents well. Staff recognised and could describe how to report incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

The service did not report any serious incidents for the 12 months prior to our inspection, however, staff knew what incidents to report and could describe the process for reporting incidents. All staff we spoke with were clear about their duty to report incidents and knew how to do so using the reporting system.

Staff understood the duty of candour. They could give examples of when they were open and transparent and gave patients and families a full explanation if and when things went wrong. The service had no never events.

Managers described the process used to investigate incidents thoroughly, including the involvement of patients and their families in these investigations. The service had a clear process for reporting and investigating incidents. When necessary, incident review meetings would be held to examine all actions following an incident.

Are Hospice services for adults effective?

Requires Improvement

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver care according to best practice and national guidance. At handover meetings at both the inpatient and the community services, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Staff ensured that patient's medical plan of care included symptom control, social and spiritual support, and psychological needs. Evidence of discussions with patients and relatives, were recorded in the electronic notes and discussed in handover meetings. Anticipatory medicines for distress, agitation, seizures and pain were prescribed and given in line with National Institute of Health and Care Excellence (NICE) guidelines.

Staff protected the rights of patients subject to the Mental Health Act and followed its Code of Practice. All staff had received training in the Mental Health Act and staff described the process to follow to us, if they had concerns about a patient's meant health.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. Patients told us they were happy with the food and drink they received, and we saw that they had water provided within reach. Staff offered drinks to patients throughout the day and we saw that regular mouth care was attended for patents with poor oral intake. Visiting families were offered drinks by staff.

Staff used a screening tool to monitor patients at risk of malnutrition. This was appropriately completed in the care records of patients we looked at. Staff completed patients' fluid and nutrition charts where needed.

Specialist support from staff such as dietitians, could be arranged for patients who needed it through the local hospital trust.

The hospice provided a full menu for breakfast, lunch and tea, including hot and cold food options, and staff told us that they could provide hot and cold snacks to patients outside regular mealtimes. Patients were able to request meals that met their religious and other beliefs, such as halal and vegetarian.

Pain relief

Staff did not assess or monitor patients regularly to see if they were in pain and therefore may not always give pain relief in a timely way.

Staff did not use a nationally recognised pain assessment tool to regularly assess and monitor patients' pain. This meant that staff may not know that a patient had pain. Staff told us that patients would tell them if they had pain. Pain assessment tools allow staff to use verbal and non-verbal ways to determine if a patient has pain. Not using a recognised pain assessment tool meant that staff may not know if patients who are unable to speak to staff, or who are non-English speaking, were in pain.

Patients' pain was not always assessed on admission to the inpatient unit. A pain assessment tool used on admission to the unit had not been completed for four out of the six records checked. This meant that staff may not know if a patient was in pain; did not have a baseline assessment to know what pain relief should be prescribed; and if administered pain relief had been effective in alleviating pain.

We observed that not all patients had a care plan specific to assessing and controlling their pain. A generic pain care plan was used for each patient, and this did not include individual pain management needs. Six out of the six records checked did not have completed pain management care plans. Failure to complete individualised pain care plans for those having pain could result in their pain being treated generically, and treatment not being tailored to each person and their needs.

We observed that patients pain was discussed as part of the agenda of the daily community team meeting and included any changes that had needed to be made to the patients' plan of care, or prescription, and it's effectiveness, to ensure that their pain needs had been met.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

All patients cared for by the service had the opportunity to develop an Advance Care Plan. Advance care plans allow patients and their families to make decisions about the care they would like in the future, including their preferred place of death. During 2020-2021, 100% of patients died in their preferred place of death.

Managers and staff carried out a programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. The hospice shared a clinical effectiveness and audit programme for 2021/2022. In the previous year, due to COVID-19, it had not been possible to complete all planned audits.

Competent staff

The service mostly made sure staff were competent for their roles. Managers appraised hospice staff's work performance and held supervision meetings with them to provide support and development, however they did not always check the appraisals of staff employed on honorary contracts.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. In addition to an induction, all members of staff were expected to complete a competency pack, that was tailored to their role.

Managers supported staff to develop through constructive appraisals of their work. The hospice had recently introduced a quarterly appraisal programme to allow more regular discussions and development of staff. All staff we spoke with told us they had a recent appraisal and that they found it useful. Managers told us that they did not conduct the appraisals of the medical staff on honorary contracts, and that these were completed by their main employer. However, managers did not check that these appraisals had been completed or the content of the appraisals, meaning they may not be aware of any concerns or areas of development for staff who were employed on honorary contracts. Managers checked medical staff's registration with the General Medical Council (GMC) yearly to ensure they had current registration and that no concerns had been raised with their practice.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

Inadequate

Hospice services for adults

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective weekly multidisciplinary meetings to discuss patients and improve their care. In addition to this, the hospice held daily handover meetings for both the inpatient unit and the community services, which were attended by doctors, nursing staff, health care assistants, therapy and administration staff, working together to share information. Nursing staff and doctors reported good working relationships and felt well supported and part of a team. Community and inpatient unit staff reported good working relationships between the two areas and could seek support from each other when needed.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff worked well as a team within the hospice and with outside agencies. There were clear lines of accountability and all staff we spoke with knew what and who they were responsible for.

Seven-day services

Key services were available seven days a week to support timely patient care.

A 24-hour advice and support line specialising in hospice care was provided to all users of the service. Patients using community services and their families told us they were aware of the support line and had no difficulty is accessing it when needed.

Staff could call for support from other disciplines such as chaplaincy and mental health services, 24 hours a day and seven days a week. Staff told us they found access to support easy and always available.

Health promotion

Staff gave patients practical support and advice to lead healthier lives, and for patients at the end of their lives, to live well before they died.

The service had relevant information promoting healthy lifestyles and support. Day hospice services were being delivered remotely due to the COVID-19 pandemic. Physiotherapist's offered virtual assessment consultations to patients, and they ran virtual exercise classes. Complementary therapists offered support to inpatient unit patients and offered outpatient appointments at the hospice to community patients / carers. The social work team supported the patients on the inpatient unit, and in the community over the phone and via home visiting. Virtual Art therapy was offered alongside wider therapeutic services, including a virtual gardening service, which was observed during the inspection. Participants stated, "I have a reason to get up and get ready", and "this has given me something to look forward to and take my mind off things for a while'.

Staff assessed each patient's health when admitted and provided support for individual needs to live a healthier lifestyle. Staff referred patients to stop smoking services and leaflets covering topics such as smoking cessation were on display in communal areas.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Inadequate

Hospice services for adults

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. Patients entering the hospice did not routinely receive an assessment of their capacity, but where there were concerns, this was conducted, usually by a doctor, and clearly documented in their notes.

Most clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff whose training was out of date, were booked for courses in November 2021. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff contacted the local authority's Deprivation of Liberty Safeguards Team for advice and support where needed. Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Do not attempt cardiopulmonary resuscitation (DNACPR) decisions , were discussed with the patient concerned and, where consent was given, their family. The service had adopted the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) at the service. This is a national patient held document, which was completed following an advance care planning conversation between a patient and a healthcare professional. Patients' records contained the ReSPECT document with evidence of discussion with the patient and their family as well as recent reviews, to ensure they remained current and valid. When mental capacity assessments revealed that patients were unable to give consent to care and treatment, staff made decisions in their best interest, considering their wishes, culture and traditions. We reviewed four DNACPR and ReSPECT documents, which contained clear evidence that patients and their family had been fully involved in the decision.

Staff had access to up-to-date, accurate and comprehensive information on patients' medical care and treatment. All staff had access to an electronic records system that they could all update.

The hospice had a centralised electronic medical notes system which could be accessed by both the inpatient and the community staff. This meant that staff could seamlessly continue with a patient's medical plan of care, if they were transferred from the community to the inpatient unit and vice versa.

Are Hospice services for adults caring?

Good

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

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff being friendly and kind to all patients. Staff ensured they interacted with patients in a way that made them feel that they were being cared for as a person.

Patients both on the inpatient unit and the community, said staff treated them well and with kindness, and that 'they were angels'. Patients we spoke to said staff in every part of their pathway were kind and considerate and very caring and supportive towards them, their families and carers.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they related to care needs. Staff were able to seek support if they were unsure of the cultural needs of any patient. Staff were aware of patients' cultural and religious needs when caring for them on the inpatient unit, in the community, and after death.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. Staff were positive and attentive to the needs of patients at the hospice. We observed staff providing kind, thoughtful, supportive and empathetic care. Relatives also commented on how supportive the staff were. Staff provided patients with reassurance, which enabled them to relax and settle well into the hospice and accept the care and support provided.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The service emphasised that family or a caregiver's emotional needs were equally important to that of a patient. The service put both patients and their family at the centre of their care and made sure people received the support they needed. Staff promoted support for patients as well as the needs of family or caregivers.

Staff took time to speak with relatives of patients that had died. Relatives appreciated still being involved with the hospice after the death of their loved ones. Staff spoke with them for as long as they wanted and asked them about their emotional wellbeing. Staff arranged for religious leaders to attend the hospice to provide emotional support. The service had links with religious leaders from many different faiths and kept a list of their contact details.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

There was a culture throughout the service that promoted a patient-centred approach. Staff made sure they involved patients and those close to them as much as possible, in the decisions made about their care. Staff always consulted patients and family or caregivers.

Patient feedback we reviewed consistently supported that staff consulted with patients, family and caregivers. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Inadequate

Hospice services for adults

Patients and family caregivers told us they always had opportunities to express their views in their daily conversations with staff and knew who to contact if required. Staff supported patients to make advanced decisions about their care. All patient records we reviewed showed staff discussed with patients and family or caregivers, their views, preferences and wishes about their future care. For example, staff discussed a patient's goals, different treatments, refusal of treatment and appointment of someone to act on their behalf. Where appropriate, staff discussed a patient's preferred place of death and clearly documented this within their records.

Patients, family or caregivers, both on the inpatient unit and in the community, gave positive feedback about the way staff consistently supported and involved them, and their family or caregivers, to understand their condition and to make informed decisions about their care. Family members told us the wellbeing services were extended to them and that they enjoyed the relaxing massages offered to them. One family member told us that the hospice had looked after them just as well as they had their loved one.

Are Hospice services for adults responsive?

Good

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It worked with others in the wider system and local organisations to plan care.

Leaders planned and organised services so they met the changing needs of the local population. They tailored services to meet the needs of individual people and delivered the services in a way to ensure flexibility, choice and continuity of care. The hospice worked closely with the local trust's palliative care team and accepted referrals from GPs, the hospice care team, local hospitals and other health and social care providers.

The service operated an urgent access pathway and rapid discharge pathways, which were responsive to patient's needs and risks. The hospice at home team provided care on the same day. The inpatient unit environment was well designed, welcoming and well maintained. Facilities and premises were designed with the needs of patients and families. The service had systems to help care for patients in need of additional support or specialist intervention. Staff had access to mental health support 24 hours a day, 7 days a week, for patients with mental health problems, learning disabilities and dementia.

The community team provided specialist palliative nursing care and support to people in their own homes. The hospice at home team provided short term domiciliary care to support people in their own homes. The hospice provided an holistic approach to care and supported people with their family support team, physiotherapist and occupational therapy team, chaplain, psychologist, counselling team and dedicated social worker.

The community team delivered "shared care" with the district nurses, supporting patients with syringe drivers, until their symptoms were settled and patients were handed back to the district nursing team. Hospice consultants and doctors worked in all the services provided and visited people in the inpatient unit and specialist out-patient clinics and provided advice and support for those in the community.

Inadequate

Hospice services for adults

Meeting people's individual needs

The service was inclusive and mostly took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Medical staff used admission documentation that involved a full holistic assessment of a patient's individual needs; however, care plans were not individualised to meet each person's individual care needs.

The environment was designed to meet the diverse needs of patients. People using wheelchairs could easily access all areas of the hospice. All patient services were on the ground floor, with step free access at all entrances, the terrace area and garden. Patients were encouraged to bring in items from home to personalise the suites and help reduce their anxiety.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to communication aids to help patients become partners in their care and treatment. Patients told us that staff took time to explain their care and treatment. The service could access information and leaflets in other languages and different formats such as large prints, to meet the needs of the community they served. Patients and their family had access to interpreters and signers if needed.

Staff described how to support patients with mental health needs, and where to seek advice and support when required.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

The service had processes to manage admission to the service. The service had an admissions and referrals team who monitored and forwarded referrals and admissions to the appropriate service. Referrals came through from the local hospital, GPs or nurse specialists.

Referrals to the service were managed well. The community team worked to keep people at home if that was where they wanted to be. A referral to the inpatient unit did not therefore always result in admission. People's preferences were respected and met where possible.

Patients had fast track admissions 24 hours a day and 7 days a week, either direct from the community or transferred from hospital. We saw patients in the hospice who wanted to return home to die and they were well supported by staff to do so.

Clinical staff provided support to patients across the in-patient and community services. The team were well placed to decide what movement was needed to take place that day and what resources could be allocated to support this. The clinical team met daily to discuss patients' care needs. Staff discussed service provision at daily multi-disciplinary meetings. This included when appropriate patients would be discharged to their preferred place of care.

Inadequate

Hospice services for adults

During the inspection, we saw the hospice only had six patients on the inpatient unit, however, they had 12 beds available. Managers told us that this was due to not having any patients requiring admission. One patient was discussed at the morning meeting as requiring admission, and it was arranged for them to be admitted later that morning. Staff told us that it was rare that they did not have any patients waiting for admission to the inpatient unit. Admission numbers for the previous 12 months showed that most people could be admitted the same day.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. All patients we spoke with told us they knew how to raise a concern if they wanted to and would feel comfortable to do so. They told us they would be more likely to raise a concern verbally with a member of staff, than write one formally, but they were aware of both ways. The service clearly displayed information about how to raise a concern in patient areas.

All staff we spoke with were aware of the complaints procedure. Staff told us they always tried to resolve any issues or complaints at the time they were raised. If this was not possible, patients could be referred to the nurse in charge or a team leader in the first instance. The service placed emphasis on listening to the patient or relative to identify their needs and to address their concerns in a manner that improved outcomes for them, wherever possible. If concerns could not be resolved informally, patients and/or those close to them were supported to make a formal complaint. Staff told us the service received very few formal complaints, which was validated by the number received within the inspection reporting period.

Managers investigated complaints and identified themes. The service had received one formal complaint in the 12 months prior to the inspection and we saw that this had been fully investigated by the managers and feedback and learning was given to the staff. This complaint had been shared with us.

Are Hospice services for adults well-led?

Inadequate

Our rating of well led went down. Our rating is inadequate.

Leadership

Leaders did not always fully understand and manage the priorities and issues the service faced, however they had some of the right skills and abilities to run the service. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There was a clear management structure with lines of responsibility and accountability. The board of trustees had the overall responsibility of overseeing the hospice's business. There were various committees which made up the board which included the finance & general purposes committee, the clinical governance committee, and the Income generation committee.

Staff we spoke with were very positive about the leadership and told us that managers were approachable and visible. Staff knew the different managers and their areas of responsibility. Staff said they felt supported and gave examples of when they had received support with personal circumstances. During the inspection, we observed positive interaction between staff and managers. Staff told us they felt comfortable and able to raise any concerns they had with the management team.

However, when we raised serious safety and governance concerns found during the inspection with the management team, in particular in relation to infection prevention and pain management, leaders were unaware of these issues.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service had clear vision and values, and these were displayed throughout the hospice. The values of Caring, Respect, Inclusivity, Excellence, and Empowerment were the screensaver for all computers used by the hospice. In addition, the hospice's mission was to Reach more people, Constantly improve what they did, Extend their impact through collaboration, innovation and education, and Be an accountable and sustainable organisation.

The service had a strategic plan which was launched in 2019 and it was aligned with Hospice UK guidance, national strategy and the local sustainability and transformation partnership for end of life care.

Leaders were committed to developing their strategy, and part of this strategy was to develop sustainable partnerships with the local trusts. The senior leadership team and the board of trustees had the experience, capacity and capability to ensure the strategy could be delivered.

Strategic objectives were supported by measurable outcomes, which were cascaded throughout the organisation. Leaders understood the challenges and had an action plan to achieving the strategy, including effects of the pandemic and local health economy factors.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were positive about working at the hospice felt there was a "close knit team" and that it was a 'real family environment'. The hospice had an open and inclusive culture, where people were valued and treated with integrity and compassion. Staff were confident in raising any concerns and felt valued and well supported in their roles. Staff who worked remotely said they felt connected to the team and to the organisation, and extremely well supported by the management team. The service valued the contribution of its volunteers, who spoke positively of the management team and how they were supported during the pandemic.

There was an emphasis on the safety and wellbeing of staff. During the COVID-19 pandemic, staff had completed risk assessments to establish any risks to themselves and staff who were clinically vulnerable, were supported to work remotely if possible to maintain their safety. Staff felt well supported during the pandemic.

There was a very strong emphasis on equality and diversity within the service and staff felt they were treated well. Teams worked collaboratively, and we saw examples of positive cross-team working to provide joined up care for patients.

Governance

Leaders did not always operate effective governance processes throughout the service and with partner organisations. Staff at all levels were not always clear about their roles and accountabilities. They had regular opportunities to meet, discuss and learn from the performance of the service.

The service did not ensure the quality of care and service provided was regularly monitored and assessed, particularly related to pain assessment and management. The service did not have an appropriate system in place to regularly audit the management of patients' pain. The service did not have an appropriate system in place to regularly assess patients' pain or monitor the effectiveness of any interventions to relieve pain, and did not regularly audit the use of equipment used to administer pain relief.

The service did not have an appropriate system in place to ensure that patients were treated as individuals. Care plans were generic and were not tailored to meet the individual's needs. The service did not have a system in place to regularly audit the delivery of individualised care including appropriate documentation.

The service held quarterly governance meetings were structured around a clinical services update, quarterly dashboard, wellbeing services, and infection prevention and control update. Minutes from the last three meetings were reviewed. Concerns around safety, including infection control and medicines, and concerns around the governance of pain management had not been identified or addressed, meaning the managers did not have clear oversight of the issues affecting patients.

There was a developed governance structure in place. The board adopted a governance calendar to ensure that it systematically reviewed key management information and data and governance meetings were held quarterly. The governance committee consisted of the chief executive, director of patient services, medical director, director of fundraising, quality improvement lead, and trustees; and was chaired by a trustee.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They did not always identify and escalate relevant risks and issues or identified actions to reduce their impact. However, they had plans to cope with unexpected events.

The service did not have a system in place to identify clinical risks to patients. They did not have a risk register for clinical risks, meaning there was a risk the service may not always have oversight of or identify clinical risks to patients, or identity actions needed to reduce the impact of the risks. The risk register provided by the service was strategic and did not reflect the breadth of issues identified on inspection, such as infection control.

The hospice did have a strategic risk register. Risks were scored before and after control measures, and RAG (Red, Amber, Green) rated to clearly identify the highest risks. Managers were able to tell inspectors what the highest risks for the service were. These included loss of income, loss of volunteers, loss of staffing and the impact of the COVID 19 pandemic.

The risk register was divided into major failure of infrastructure, staff risks, complaints, fundraising, shops, significant reduction in statutory income, inadequate governance and non-compliance.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service managed information well and kept patient records safe. There were systems and information to manage current and future performance. Information systems were secure and appropriate for use. For example, the electronic patient record system enabled data to be extracted and analysed accurately, as all entries were automatically timed, and date stamped. All staff we spoke with said they were confident in using the system.

Leaders used information in reporting, performance management and delivering quality care. Staff undertook audits to make sure information they used was accurate, valid and reliable. Leaders proactively collected information and analysed it to drive improvements in care. Information governance training formed part of the mandatory training programme for the service, and staff we spoke with understood their responsibilities regarding information management.

The service had appointed a Caldicott Guardian who had clear understanding of the Caldicott principles and had undertaken further training to support them in their role. Caldicott principles are fundamental rules and regulations that guide a patient's confidentiality. They are the basic rules every healthcare personnel must follow to ensure there is no breach of confidentiality. Staff spoke about sharing information only in the best interest of the patient and as disclosures to protect patients.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The hospice had a joined up approach to gather feedback from people who used their services. All this feedback was reviewed. Themes and trends were identified to improve the future service the hospice provided. Feedback was overwhelmingly positive and identified the care and empathy given to all patients using the hospice's services.

The hospice redesigned some services as a result of direct patient feedback. For example, a recent patient and carer survey highlighted a desire for virtual services. This has now been implemented with virtual clinical services such a physiotherapy, and well-being services such as virtual gardening and celebration of religious events such as Diwali.

The hospice was planning a stakeholder event, to get feedback from the community external experts, with a focus on inclusion.

The hospice worked collaboratively with the local health and social care groups to deliver services needed in the areas they covered During the pandemic, the service worked collaboratively with the local NHS hospital to identify suitable patients for referral to the hospice as early as possible. This reduced the burden on frontline hospital staff and aimed to reduce hospital admissions for people near or at the end of life. The service actively engaged staff, so their views were reflected in the planning and delivery of services and in the shaping of the culture.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Leaders supported safe innovation and staff had objectives focused on improvement and learning. Managers encouraged staff to use information and regularly take time out to review performance and make improvements.

The hospice had developed a training programme with the London ambulance service (LAS) to educate staff on end of life care, and how to support people in the community. Leaders told us that the feedback from LAS was overwhelmingly positive and as a result of the training, less patients were being taken to hospital and were continued to be supported in the community.

The hospice provided bespoke advance care plan and verification of death training to local care homes, pharmacists and district nurses. This enabled patients to be cared for in the community, if they wished, and in line with their wishes. Educating other health professionals on verifying deaths meant staff other than doctors could verify that a patient death, often more quickly, meaning the loved ones could arrange removal of the body after death more quickly if that was their wish.

During the COVID 19 pandemic, the service developed a range of support videos that were available on their website to support carers during the pandemic. for example, how to turn and position patients. The hospice also developed a bereavement support after Covid-19 leaflet, to provide support to those who had experienced the death of a loved one due to Covid-19, or whose death was impacted by it.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	S29 Warning Notice Regulation 12, (1) (2) (e) (g) (h), Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17, (1) (2) (a) (c), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.