Butterwick Hospice Stockton

Quality Report

Middlefield Road
Hardwick
Stockton On Tees
TS198XN
Tel: 01642 617641
Website: www.butterwick.org.uk

Date of inspection visit: 05 November 2019 to 05 December 2019
Date of publication: 26/03/2020

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

Ratings

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

Overall summary

Butterwick Hospice Stockton is operated by Butterwick limited. The hospice has seven inpatient beds and a day hospice and provides care for adults from Stockton, Middlesbrough and surrounding areas. We inspected hospice services for adults.

Butterwick Limited is registered as a charitable trust and also receives funding from the NHS.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 05 November 2019 along with an announced visit to the hospice on the 06 December 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's

Summary of findings

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 only service provided was hospice services for adults.

Services we rate

Our rating of this hospital/service went down. We rated it as **Inadequate** overall.

We found the following issues that the service provider needs to improve;

- We saw significant safety concerns in areas such as disclosure and barring checks for staff and registered nurse's verification checks.
- There was insufficient attention to safeguarding. Staff did not have the right levels of safeguarding training to meet intercollegiate guidance (2019).
- Incidents were not always reported and investigations and learning from incidents was not adequately shared. This meant that the risk of incidents happening again was not reduced and we saw evidence of identical, preventable incidents.
- Staff were not supported with mandatory training and managers had no oversight of the training needs required for the role. Staff did not always have the right competencies to care for their patients.
- Patients' care and treatment did not always reflect current evidence-based guidance, standards and practice.
- There was no formal process to monitor patients' outcomes. We found there was little appetite by managers to drive improvement.
- Best interest decisions were not made for those patients lacking capacity.
- Staff did not understand the vision and values of the hospice. The strategy was not underpinned by detailed realistic objectives and plans.
- The governance arrangements and their purposes were not fully formed. Financial and quality governance were not integrated to support decision making.
- There was minimal evidence of learning and reflective practice.

However, we also found the following areas of good practice;

- Staff demonstrated a thorough knowledge of their patients' needs and we saw examples of caring, compassionate interactions with patients and their families.
- Patients and families using the service were very happy with the care they had received and felt they received
- The service was responsive to concerns when these were brought to its attention and the leadership team were eager to change practice to improve services

Following this inspection, we raised significant safety concerns with the provider. In addition, we told the provider that it must take some actions to comply with the regulations. We also issued the provider with 13 requirement notices that affected Butterwick Hospice. Details are at the end of the report.

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.'

Ann Ford

Summary of findings

Deputy Chief Inspector of Hospitals, North

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Inadequate 	Hospice services for adults were the only service provided by the hospice. We rated this service as inadequate because safety, effectiveness, responsiveness and leadership was inadequate. We rated caring as good.

Summary of findings

Contents

Inadequate

Butterwick Hospice Stockton

Services we looked at
Hospice services for adults

Summary of this inspection

Background to Butterwick Hospice Stockton

Butterwick Hospice Stockton is operated by Butterwick Limited. The organisation was founded in 1984 by Mary Butterwick. The current premises was purpose built in 1997 and is situated within the grounds of a local NHS hospital. The hospice primarily serves the communities of the North Tees area. It also accepts patient referrals from outside this area.

The hospice provides inpatient accommodation for up to seven patients. At the time of our inspection, four adults were accessing the service, all of whom did so on a respite care basis.

It receives funding from two local Clinical Commissioning Groups (CCGs) and through charitable donations.

The hospice has had a registered manager in post and was registered with the CQC since 2014.

At the previous inspection in February and March 2016, the provider was rated as good. The safe, effective, caring, responsive and well led domains were all rated as good. At this inspection, we inspected all five domains using our comprehensive inspection methodology.

The hospice also offers bereavement counselling services. These services are outside our scope of regulation and therefore we did not inspect these services.

Following this inspection, the hospice submitted action plans to demonstrate how they would be addressing the issues found during our inspection.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, another CQC inspector, and a specialist advisor with expertise in adult hospice care. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Information about Butterwick Hospice Stockton

The hospice has one inpatient ward and day hospice service and is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Diagnostic and screening procedures
- Transport Services, triage and medical advice provider

During the inspection, we visited inpatient and day hospice services. We spoke with staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with two patients and one relative. We looked at compliments and complaints received by the service as well as patient feedback surveys. During our inspection, we reviewed five sets of patient records.

The hospice had a board of trustees and two subcommittees that fed into this. Senior leadership was provided by the chief executive, and director of patient care and service development.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospice has been inspected four times, and the most recent inspection took place in March 2016, which found that the hospice was meeting all standards of quality and safety it was inspected against.

Summary of this inspection

Activity (June 2018 to May 2019)

- In the reporting period 215 patients used the services of the hospice. The majority of people (146) were over the age of 65, with the remaining 69 aged between 18 and 65
- The hospice employed three doctors, 25 registered nurses, 24 health care assistants and 64 other non-qualified staff. The majority were employed on a part time basis.

Track record on safety

- No never events
- Three serious incidents. One fall, one prescribing error and one failure / delay to identify fracture
- There were six formal complaints

Services accredited by a national body:

- Investors in People 2019
- Disability confidence level 2

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Pharmacy services
- Chaplaincy services
- Interpreting services
- Maintenance of medical equipment
- Infection prevention and control
- Physiotherapy
- Blood transfusions
- Consultant sessions

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

Our rating of safe went down. We rated it as **Inadequate** because:

We found the following issues that the service provider needs to improve;

- The service did not have enough nursing or medical staff with the right qualifications, skills, training or experience to keep patients safe from avoidable harm and to provide the right care or treatment.
- The service provided mandatory training in key skills to staff but managers did not ensure training was delivered in accordance with the individual clinical staff responsibility.
- Staff did not all have the correct training on how to recognise and report abuse and how to apply it.
- Staff did not complete and update risk assessments for each patient or removed or minimised risk. Risk assessments did not consider patients who were deteriorating and in the last days or hours of their life.
- Recording of controlled drugs was not accurate.
- The service did not always manage patient safety incidents well. Identical incidents happened more than once because appropriate action and learning had not taken place.
- The design, maintenance and use of facilities, premises and equipment did not always keep people safe and staff were not always trained to use them.

We found the following areas of good practice:

- The environment was visibly clean.

Are services effective?

Inadequate

Our rating of effective went down. We rated it as **Inadequate** because:

We found the following issues that the provider needs to improve;

- The provider did not consistently apply best practice and evidence-based practice to policies and protocols.
- Staff did not routinely monitor the effectiveness of care and treatment. They were therefore not able to use findings to make improvements and achieve good outcomes for patients.
- The service did not always make sure that staff were competent for their roles. Staff files were not up to date and did not contain evidence to support safe staffing.
- Volunteer files had no record of DBS checks or training.

Summary of this inspection

- Limited support and advice on leading healthier lives was available to patients and their families.
- We did not see any best interest decision making and staff did not seek specific consent for those patient's lacking capacity.

We found the following areas of good practice:

- Staff gave patients enough food and drink to meet their needs.

Are services caring?

Good

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

We found the following areas of good practice:

- Staff treated people and their families with compassion and kindness, respected their privacy and dignity and took account of their individual needs.
- Staff provided emotional support to people, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved people and their families to understand their condition and make decisions about their care and treatment.

Are services responsive?

Inadequate

Our rating of responsive went down. We rated it as **Inadequate** because:

We found the following issues that the provider needs to improve;

- People could not always access the services when they needed it as the service had restricted times for accepting patients and did not optimise capacity.
- The organisation's complaints policy was out of date. Complaints were not always being dealt with appropriately and we did not see any learning from complaints leading to change in practice.
- The service planned and provided care in a way that met some of the needs of local people and some of the communities served. It did not work closely with others in the wider system to plan care.
- The service did not take account of people's individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Are services well-led?

Inadequate

Our rating of well-led went down. We rated it as **Inadequate** because:

We found the following issues that the provider needs to improve;

Summary of this inspection

- Leaders did not operate effective governance processes. They did not use systems to manage performance effectively. The service collected limited data and did not always have the capacity to analyse this well.
- Leaders and staff did not actively and openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, however it was not clear how this was aligned with other local or regional plans, or how progress would be monitored.

We found the following areas of good practice:

- Leaders were visible and approachable.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Inadequate

Hospice services for adults

Safe	Inadequate
Effective	Inadequate
Caring	Good
Responsive	Inadequate
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 did not provide mandatory training in key skills to all staff and did not make sure everyone completed it.

The provider did not have a training policy to define required mandatory training specific to job roles. Therefore, we were not able to review completion compliance rates for staff training, which was required for each staff role.

However, the provider told us that each member of staff completed an internal induction training which covered key aspects such as health and safety, moving and handling and safeguarding. We reviewed the induction booklet and saw it contained a very small amount of information on each subject and although staff had signed to say they had received this induction the amount of information provided would not constitute actual training.

Training completion and monitoring was the responsibility of each clinical lead. We saw senior staff maintained spreadsheets to show which staff had completed certain training, although due to the lack of organisational policy we were not assured that all staff were appropriately competent to fulfil their clinical roles due to the lack of clearly identified clinical competency framework or governance structure.

We raised our lack of assurance immediately with the provider and managers of the service took immediate steps to develop a training policy for the organisation and further develop the training spreadsheet used by clinical leads. This included key clinical competencies required for each job role and when refreshers training should be completed. In addition to these steps, the provider commenced a process for competency checks to be undertaken for all registered general nurses working for the organisation.

Safeguarding

Staff did not understand how to protect patients from abuse and the service did not work well with other agencies to do so. Staff did not always have training on how to recognise and report abuse, and they knew how to apply it.

The provider had developed a 'adults at risk' policy and the registered manager was the appointed adult safeguard lead. However, we reviewed the policy, which was developed in July 2019 but dated as approved in March 2019 and it had not been ratified by the board of trustees at the time of inspection.

The policy did not provide staff with guidance on how to escalate safeguarding alerts to the local authority and none of the nursing staff we spoke with were able to describe a safeguard alert that they had raised. However, we later spoke with the safeguard lead who provided a recent example.

The provider had also developed a safeguard 'children at risk' policy, which was dated August 2019 but again not ratified by the board of trustees at the time of our first visit. However, this was ratified on 25 November 2019.

We asked the provider for safeguarding training completion rates for staff. We saw the senior managers for the inpatient and day hospice service maintained training spreadsheets which showed 100% compliance for both adult and children's safeguarding training.

Managers of the service told us that all staff had received appropriate safeguarding training. However, we reviewed seven staff files and saw that none of those staff had received recognised safeguarding training, in line with intercollegiate guidance (2019).

In addition, we reviewed the files of four trustees and four volunteers and saw that none of these had received any form of safeguarding training. This was a potential risk to the service and not in line with the recommendations made in the Saville Enquiry Report of 2016.

We found not all staff and volunteers had received a Disclosure and Barring Service (DBS) check at the correct level for their role. DBS numbers were not routinely recorded in staff or volunteer files and the service did not have an electronic register of DBS checks or any way of prompting when these needed renewals. We brought this to the hospice's attention at the time of our inspection and systems were developed to address this after our inspection.

During inspection we saw volunteers working within the building and observed that they worked occasionally unsupervised. The provider had not completed a risk assessment to mitigate this. Staff providing direct unsupervised care or treatment were required to have these checks in place and therefore patients were potentially at risk as a result of these checks not completed.

As the provider did not have an up to date safeguarding policy in place at the time of inspection and safeguard training was not appropriate to the needs of the organisation we were not assured that the provider appropriately protected patients from abuse and as part of our powers of enforcement we raised significant safety concerns immediately with the provider.

Cleanliness, infection control and hygiene

The service kept equipment and the premises visibly clean. However, the service did not have specific infection and prevention control guidance for the control of infectious or contagious diseases. In addition, the provider did not have specific infection prevention control measures when caring for the deceased.

We reviewed all areas in which end of life care was delivered and saw that the environment was visibly clean and free from clutter.

The provider stated they followed the NHS national standards of healthcare cleanliness guidance 2019.

There were no instructions or guidance developed by the provider on how to manage patients with a communicable illness and therefore there was a risk patient would not be managed in accordance with national guidance and best practice.

The Hospice had a service level agreement with the local NHS hospital in which eight hours of annual infection prevention and control (IPC) advice was provided. In addition, bi-monthly infection control meetings were held with the hospitals infection prevention and control nurse and lead representatives from each hospice department.

We reviewed the minutes of the meeting dated April 2019 and saw that the trust ran infection control sessions in conjunction with the hospice.

Regular inhouse audits were performed including hand hygiene and uniform audits. We saw the hospice had an external infection control inspection dated November 2019 which achieved 100% compliance with standard precautions, 91% for hand hygiene and 100% for environment. An action plan had been completed following the inspection, however the actions had not been addressed at the time of inspection.

In addition, we reviewed the audit completed in May 2019 which identified that staff were using patient en-suite sinks for clinical handwashing. Plans to add specific staff handwashing sinks were identified as part of future refurbishment plans but these were not currently identified within the organisation's risk register.

We requested policies in relation to cleanliness but saw that the provider had not developed any guidance in relation to infection prevention and control and therefore

there was a risk patients would not be managed in accordance with national guidance and best practice. This presented a specific risk to those patients who were immune compromised.

We reviewed the senior staff training spreadsheets and saw 100% training completion for clinical staff. Training records were not maintained for volunteers however and therefore we were not assured that all staff working within the unit had received appropriate training.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe and staff were not always trained to use them. However, staff managed clinical waste well.

Hospice facilities were situated on the ground floor and patients arriving on stretchers or by ambulance could be accommodated. Most patients were wheelchair users and we saw that the environment met their need, with wide corridors and double doors. Accessible toilets were available for patients, staff and families.

Also situated on the ground floor was a lounge, dining area, activities and games room, chapel and therapy rooms.

Car parking was ample and free to patients and their guests. All visitors entered the building through a main door into the ground floor reception, which was unlocked during the hours of 9am to 5p.m but was monitored by volunteer reception staff.

The hospice had an open visiting policy which meant that people could arrive at any hour, and staff explained how they would check someone was an appropriate visitor before allowing them access to the unit. We saw visitors being supported through the building during our inspection.

We saw the environment was clean and bright with clear signage in place to guide visitors through the building.

All staff we spoke with told us they had an adequate stock of equipment and were easily able to obtain new stock as required.

Records showed that electrical equipment was serviced, and safety tested. An external company provided clinical equipment and compliance checks.

We checked the emergency equipment in the unit. We saw a resuscitation box which was routinely checked by staff.

A fire safety and evacuation procedure was displayed in reception, and staff knew the procedure to follow in the event of a fire. Staff confirmed that regular fire drills had been conducted and reports completed and stored by the estates manager.

Staff told us that all individual equipment which was needed to care for patients at Butterwick was brought in by the patients at the point of admission. However, we did not see any procedures in which this equipment was checked to ensure it was safe and appropriate to use or back up stock of key equipment such as syringe drivers.

We saw oxygen and suction equipment was available. We asked to review the training files of three of the registered general nurses whom would use this equipment but there was no documentation to corroborate any training had been undertaken. We reviewed the clinical lead training spreadsheet and saw that 40% of the nurses had received specific suction training. 92% of staff had received oxygen training.

Assessing and responding to patient risk

Staff did not complete and update risk assessments for each patient or remove or minimise risks. Risk assessments did not consider patients who were deteriorating and in the last days or hours of their life.

The provider told us there was no policy to guide staff as to the frequency of clinical assessments and re-assessments.

Staff told us if they had any concerns in relation to patient deterioration, they would call 999 and notify hospice doctors of the deterioration.

We requested life support training staff training data and saw that 96% of clinical staff had completed basic life support training.

We reviewed the provider's resuscitation policy dated august 2010. The policy was due to be reviewed in August 2018, but this had not been carried out and it had not been ratified by the board of trustees. The policy did not outline what level of training staff were required to undertake.

We saw the provider had developed a risk management policy dated October 2014 and due for review October 2017. The policy had not been reviewed at the time of inspection. The policy outlined risk management procedures in relation to health and safety, lone working, infection control, vulnerable adults and children, incident and accident reporting and business continuity.

The policy outlined that all staff would receive a specific two-hour risk training session. However, we did not see any evidence of this training within the staff files we reviewed or the local training spreadsheet.

The provider told us that a policy was currently being developed to clearly identify how patients were assessed according to clinical need and staffing planned to safely manage these needs.

We reviewed three patient records. All three patients experienced complex clinical health conditions with associated risks such as tissue viability concerns, nutrition and hydration needs and confusion. In all three files we reviewed we did not see any clear evidence of risk identification and management. Nursing staff however did comment on how some of these needs were being managed on a day to day basis, for example behaviour due to confusion. However, we did not see a risk assessment specific to these concerns.

Therefore, we were not assured that the provider identified and managed risks to individuals appropriately and safely.

Nurse staffing

The service did not have enough nursing and support staff with the right qualifications, skills, training. We saw several vacancies across the service which led to inconsistent nursing cover.

Managers however, regularly reviewed and adjusted staffing levels and skill mix in relation to patient numbers.

The provider employed 15 whole time equivalent (WTE) nursing / allied health professional staff and 25 part time nursing / allied health professional staff. A total of 30 nursing / allied health professional staff were employed on zero-hour contracts.

In addition, the service employed six WTE health care assistants and 24 part time health care assistants, 17 of which were employed on zero-hour contracts.

The provider outlined several vacancies within the organisation. At the time of our inspection, this equated to three WTE registered nurses and three managers posts.

The hospice was not offering student nurse placements at the time of our inspection but had done so in the previous year. Health care support workers, therapists, nursery nurses and volunteers also worked within the hospice.

The registered manager was supported by one clinical sister, and two junior sisters.

We saw the numbers of patient admissions varied and day hospice patient numbers fluctuated. Staff numbers were flexed to accommodate this and managers reviewed patient numbers daily.

We saw staffing boards were visible to patients and visitors showing an image of the staff on duty and job role.

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.

Butterwick Hospice Care was registered to provide accommodation, medical and nursing care for seven patients with life limiting illnesses. Consultants from a local NHS trust provided the hospice with seven sessions of senior cover. Medical input was provided on a Monday-Friday by a 30-hour hospice physician and 22.5-hour senior hospice physician. The hospice also had an out of hours on-call service provided by GPs and trainee GPs and second line consultant telephone support.

The provider did not employ a medical director.

Records

Staff kept records of patients' care and treatment. However, records were not always clear, or

up-to-date and assessments although discussed verbally with patients were not always recorded formally. Records were stored securely and easily available to all staff providing care.

Patient records were in paper format and contained initial basic patient information such as date of birth, next of kin, and allergies.

Records took into consideration the rights and wishes of individuals approaching the last weeks and months of life and covered symptom management of acute and chronic illness such as pain and nausea and vomiting.

We reviewed internal training spreadsheets and saw that 90% of staff had undertaken record keeping training.

Staff told us on admission to the inpatient unit, patients were assessed by the medical and nursing team and a patient profile was created. This included assessments for nutrition, moving and handling and mouth care. From this, individualised care plans were commenced which were patient specific and were updated as the patient's condition or need changed. Each week an integrated palliative outcome scale (IPOS) was completed by each patient on the unit (where possible) which identified any issues or concerns that the patient may have.

We reviewed three individual patient records but did not see an admission assessment recorded. We spoke with the hospice physician who told us that assessments were fully completed but acknowledged that the recording of these discussions was absent.

Care plans did not appear to be reviewed. For example, we saw within one patient record that the patient was distressed and was experiencing some behaviour changes. We saw staff captured the behaviour within the daily nursing notes but there was no formal review of the care plan specific to behaviour.

We saw emergency health care plans were completed fully in all three files we reviewed but the provider did not have a policy to state when these should be reviewed.

We saw the provider undertook a record keeping audit once a year, but this did not look at how timely assessments were reviewed or updated.

Medicines

The service used systems and processes to safely prescribe, administer and store medicines. However, recording around controlled drugs was not accurate.

We reviewed the providers 'Management of medicines and medical gases' policy which was due to be reviewed August 2018. The policy had not been reviewed at the time of inspection and had not been ratified by the board of trustees.

Staff told us that guidance followed was based upon the palliative and end of life guidelines for northern England clinical networks.

The registered manager was the controlled drugs accountable officer and held regular medicines management meetings as part of a review group to look at issues across the whole of the service.

The provider had a contract with a local pharmacy to provide support to the clinical services. As part of the contract, a community pharmacist visited the organisation once per fortnight and conducted spot checks on the medication administration charts. On request, the community pharmacist provided professional advice to the medicine's management review group.

We reviewed the medicines charts of three individual patients. We saw anticipatory medicines were prescribed in line with national guidance and were clear legible and all within date. We saw discontinued drugs were clearly identified.

However, we saw several incidents which were specific to controlled drugs. Three incidents we reviewed were linked to controlled drugs not accurately counted at the point of admission. We did not see any additional training delivered to staff following these incidents.

We reviewed the training records of four registered nurses but did not see any evidence of medicines management training. Managers of the service told us that a medicines competency booklet had been developed and was due to be rolled out to all registered nurses. We brought the lack of training and incident concerns to the attention of the provider who took immediate steps to roll out this training to nurses whilst they were on duty.

Incidents

Inadequate

Hospice services for adults

The service did not manage patient safety incidents well. Although staff recognised and reported incidents and near misses, managers did not investigate incidents in a timely manner or share lessons learned with the whole team and the wider service.

The hospice had reported three serious incidents between July 2018 and June 2019. The first incident related to a fall, the second was a prescribing error and the third a delay in identification of a fracture. Only the third incident was classed as moderate or above in its severity. There had been no never events in the period. Never events are serious, preventable patient safety incidents which should not occur if preventative measures are in place.

Incidents were reported using a paper-based system. Staff told us that they knew how to report incidents and were encouraged to do so.

We reviewed six incidents that had occurred at the hospice since our last inspection. We saw varying levels of investigation and documentation.

For example, documentation following the delayed identification of a missed fracture did not show a thorough investigation including root cause analysis. We checked the patient's notes and found that they had complained of pain around the fracture on more than on occasion since their admission, but this had not been considered in the incident investigation.

We also saw that where an incident had occurred, and a member of staff not directly employed by the organisation was involved, there was a short statement from the person involved but they had not been involved in the investigation or learning process, which was something that could be improved.

We saw in one patient's notes that a prescription chart was missing staff signatures around the time that a serious incident had occurred. This was not documented as part of the incident investigation. We brought this to the attention of senior staff, who told us that they were aware of this omission. However, there was no documentation to show that this had been considered as part of either the investigation or learning process, and the patient's record remained unsigned.

The organisation's clinical governance meeting had a standing agenda item for incidents, but this consisted of the number and type of incidents that had occurred, and a record of the incident numbers in the minutes. What was absent was a discussion of actions taken and lessons learned, which was not documented at either this committee or board level.

Senior managers, with the governance lead, were reviewing incident investigation and management at the time of our inspection with a view to improving processes.

Duty of Candour (DOC) is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. There had been no duty of candour meetings recorded in the last twelve months. However, we saw that Duty of Candour should have been applied in at least one of the incidents we reviewed, so we were not assured that Duty of Candour guidance was always correctly applied.

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

Inadequate

Our rating of effective went down.We rated it as **inadequate.**

Evidence-based care and treatment

The service provided some care and treatment based on some national guidance and evidence-based practice. However, policy development against national guidance was limited.

The organisation was a member of Hospice UK, which provided newsletters and bulletins to the director of clinical services. Doctors were part of the north east hospice collaborative and could access regular network meetings. Sub-topic network groups, such as a transition working group also met monthly and provided guidelines on how to support children through transition into adult services.

We saw that anticipatory medicines for distress, agitation, seizures and pain were prescribed and given in line with National Institute of Health and Care Excellence (NICE) guidelines for the care of the dying adult in the last days of life and palliative care for adults.

Patients' needs were considered in line with national guidance such as 'Care of the dying adults in the last days of life and NICE quality standard QS144 regarding individualised care.

Patients had a personalised care plan that reflected their needs, however, this was not always up to date. Staff delivered care to patients in the last days of life that met the 'five priorities of care of the dying person'. Staff took account of patients' spiritual needs within end of life care plans.

Although the provided recognised the importance of the completion of the recommended Summary Plan for Emergency Care and Treatment (RESPECT), we did not see a policy to advise staff as to when and how to complete this document.

Therefore, we are not assured that the provider fully considered all national and best practice guidance in relation to end of life care.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff assessed the dietary needs of patients on admission, based on discussion with their family or carers.

Most patients had specific dietary needs which were catered for by staff. Food was prepared onsite by catering staff employed directly by the hospice. Pureed and other special diets were available. Staff could cater for specific needs such as vegan, gluten free or halal. The hospice had recently received a food hygiene rating of 5 out of 5 from the local council, with only two minor recommendations for improvement. Feeding and managing hydration were done in line with current NICE guidelines.

Nurses supported patient's whom had percutaneous endoscopic gastrostomy or nasogastric feeding regimes. Although staff we spoke with told us they were trained in these areas, the records to support this were not in place at the time of inspection.

Patients told us the food was amazing and two patients told us 'You have basically anything you want here. They will make it for me and if they don't have it they will get it in'.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients in the inpatient unit regularly. Nursing staff checked on patients during medicine rounds and told us they would ask a doctor to review the patient if they had any concerns.

We saw that staff documented in patient notes when pain was present, and adjusted pain medication accordingly. Pain and symptom control was discussed by the whole team regularly and plans were made to adjust these as needed.

It was not clear if the provider used a specific pain scoring tool, however staff outlined how pain would be assessed for patients unable to verbalise.

We saw syringe drivers were used where appropriate to manage pain and staff told us patient's arrived for admission with their own pumps.

Plans had been made for an acupuncture trial, led by one of the medical staff, but this had been put on hold.

Patient outcomes

Staff did not routinely monitor the effectiveness of care and treatment. They were therefore unable to use findings to make improvements and achieve good outcomes for patients.

There was no clear approach to monitoring, assessing and benchmarking outcomes for patients. Staff accepted

that without benchmarking or objective measurement it was not possible to gauge with certainty any improvement in outcomes or satisfaction levels for patients.

The hospice provided a yearly audit plan. This covered expected areas such as record keeping, medicines, and the friends and family test. We saw that when audits were completed and these were discussed at the clinical governance committee. In some, but not all cases, action plans were produced following audit. The audit plan did not cover things such as quality of care, patient and family satisfaction, patient outcomes or measures such as access and demand. Record keeping was only audited once a year which was not frequent enough to provide ongoing assurance of the quality of records.

Work was ongoing to develop a quality dashboard for the wider organisation to provide regular assurance to the trustees and commissioners.

Feedback from staff and external pharmacy audits identified the need for an extra registered general nurse to be on duty each week to be responsible for the ordering and monitoring of stock and patients' own medications to ensure safe medicines management. However we did not see evidence of action by the provider.

Competent staff

The service did not always make sure staff were competent for their roles.

We reviewed five nursing staff files. They did not contain evidence that their registration had been checked with the nursing and midwifery council within the previous 12 months. Checks completed by inspectors and managers during the inspection confirmed that these nurses were registered appropriately. Registered nurses and health care support workers had not all completed additional role specific training. As we had concerns after reviewing these files, we asked the provider for evidence that those staff working over the coming days had a valid DBS check. This showed that some nurses and additional support workers did not have a record of a current DBS check.

Volunteer files had no record of DBS checks or training and emergency contact details dated back up to eleven years.

All staff had received their yearly appraisal.

The organisation had received an 'amnesty report' from Investors in People in June 2019 after standards were shown to not meet the criteria the previous year. This showed that people in management roles had felt supported to carry out their responsibilities, and other staff confirmed that there had been more structure to their roles since 2018. However, there was still more to do, and the report made further recommendations about embedding values and updating job descriptions. The service had not put any actions in place following the recommendations.

The provider had recently taken steps to reintroduce clinical supervision clinical for staff in the in-patient unit and day services, to comply with the mandatory four hours per staff member required each year. Clinical competencies were also developed for all clinical roles to ensure staff demonstrated the highest levels of clinical care.

E-learning for health had been introduced for staff and volunteers to access mandatory training and additional relevant modules to the workplace.

Multidisciplinary working

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

Staff demonstrated positive working relationships. We spoke to nursing staff, who told us that doctors were approachable and very much a part of the team.

Patients referred to the hospice were reviewed prior to admission. Staff told us that current medical information was sought from the associated consultant or GP prior to confirming an admission at the hospice.

The hospice held regular multi-disciplinary meetings (MDT) and we were told that the palliative care consultant from the neighbouring local trust had attended some of these. Meetings took place every morning, and included representation from the medical, nursing and clerical teams.

Inadequate

Hospice services for adults

Links with the local trust were basic but there were plans to improve this. For example, since our first visit to the hospice, leaders had discussed utilising scenario training through the trust. We did not see any clear links or work with local care homes.

Health promotion

Limited support and advice on leading healthier lives was available to patients and their families.

There was information displayed in the main entrance and lounge areas promoting health and wellbeing. This included yoga and relaxation, as well as advice and guidance leaflets specific to Dying Matters and Macmillan services.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment and followed national guidance to gain patients' consent and complete do not resuscitate forms. However, we were not assured that staff fully understand when consent should be applied due to the lack of documentation.

The Mental Capacity Act (2005) is designed to protect patients who may lack capacity, to make certain decisions about their care and treatment.

Staff we spoke with could describe the process of assessing capacity and the requirements for obtaining consent if the patient was assessed as lacking capacity. However, we did not see evidence that capacity was routinely considered on admission to the hospice.

We spoke to staff at length regarding consent to care and treatment and saw overarching consent was obtained at the point of admission. We were not assured however that staff fully understood best interest decision making as we saw no evidence of this during the inspection.

We reviewed three DNACPR (commonly known as 'do not resuscitate') forms. One of these was completed by the local trust, and the other two were completed in the hospice. All were well completed. All relevant sections had been covered, and the forms were signed and countersigned where required.

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.

We spoke with three patients during our inspection. Feedback from patients confirmed staff treated them well and with kindness.

The hospice collated feedback from users of the service through the friends and family survey. We reviewed the results from the latest survey and saw 20 responses were received. 13 respondents said they were extremely likely to recommend the service with the remaining respondent stating they would be likely.

In addition, we saw postcards encouraging visitors to share feedback through the suggestion box option during our inspection. We saw an abundance of thank you cards and words of praise for staff in and around the walls of the hospice.

Patient satisfaction questionnaires were also rolled out on a quarterly basis. We reviewed the results from the most recent questionnaire dated April 2019 to June 2019 and saw that 20 responses were received. All responses were positive and across the inpatient and day hospice services. We saw comments such as "Really happy with the level of care given. Staff are wonderful – kind and compassionate."

"Fantastic place."

"There is no way this level of care can be done in your own home. It eases people through the most difficult time."

"Because I have the experience of being here, the care I have received has been excellent."

"From day one we have been made welcome as a family. Also, the care for my dad has been fantastic. Nothing is too hard for none of the staff in here! Fab work ladies you all deserve a big medal"

Inadequate

Hospice services for adults

"The care is phenomenal. The staff are wonderful and caring."

We saw staff protected patients' privacy and dignity when providing care and treatment and patients confirmed this. Patients told us staff treated them with dignity and respect when carrying out personal care and they felt comfortable with staff delivering this. We saw staff closed the doors to patients' rooms when carrying out care and treatment and knocked before entering.

Staff demonstrated knowledge of how to manage care after death sensitively. This included an understanding of last offices and training in the verification of death. Staff described informing patients about death certification, bereavement services and funeral directors in a compassionate manner.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

We saw staff were positive and attentive to the needs of patients at the hospice.

Bereavement and counselling support services were available for patients through the family support team. This was offered either through support group such as the sibling group or one to one session. This support was offered to all patients and their families both before and after death. The provider told us there was also no end date in which this counselling could be offered.

One patient told us 'The staff take the time to listen to me. There is no rush. Nothing is ever too much trouble for them'.

A manager told us that time is spent with each patient supporting them in their own individual way. An example was given of one patient who missed the sensation of playing with her hair. As she had lost her hair during treatment, she asked staff if she could play with a member of staff's hair as an emotional comfort. Staff took time to enable her to do this as and when additional comfort was needed.

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.

Patients we spoke with felt they were involved in their care. On patient told us that the hospice doctors had enabled several choices of analgesia to be offered which reduced the contraindications with the other medicines that were needed. One patient told us 'they didn't just give me the standard drugs. They knew how I felt and found different drugs that worked best for me. That takes time and they took the time for me'.

We saw several activities and outings which were designed and agreed by the patients and their families using the service. For example, going out to the coast and shopping trips at Christmas.

Open visiting times meant they could be with patients whenever they wished, and accommodation was provided for families who wanted to stay overnight. Relatives were encouraged to bring in personal or sentimental items to promote individuality.

Activities and outings were planned in collaboration with patients and their families.

Are hospice services for adults responsive to people's needs?

(for example, to feedback?)

Inadequate

Our rating of responsive went down.We rated it as **inadequate.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met some of the needs of local people and some of the communities served. It did not work closely with others in the wider system to plan care.

Staff told us they had good links with local funeral directors and the fire service and encouraged community involvement through the organisation of events and talks. These included talks by the chaplain, craft days and bereavement and support groups.

Families were offered accommodation and a place to sleep if they wanted to stay with their loved one and refreshments were available 24 hours a day.

The hospice had not done any gap analysis of those using the service and those who were not but felt that those using the service were representative of their local community. There had been no needs analysis undertaken to see what unmet need there was locally.

Meeting people's individual needs

The service did not take account of individuals' needs and preferences. Staff made some adjustments to help some patients access the services. However, information was only provided in one language and facilities for worship and prayer were limited.

Care plans were in place for patients. These were person centred and we could see that people and those important to them had had the chance to discuss them and contribute.

The hospice had given notice on the service level agreement it held with the local trust who provided chaplaincy services. This had reduced, but not ended at the time of our inspection and we saw a local trust chaplain chatting with day patients in the adjacent adult hospice. All chaplains were Christian, and the chapel contained non-removable Christian iconography. There were no formal plans in place to formalise spiritual support in the future, but leaders told us they hoped that this would be provided on a voluntary basis. If patients had their own faith leader, they were encouraged to ask them to visit if they felt this would be helpful.

There was no dedicated quiet or multi-faith room.

Information on practical support and resources for families after bereavement was available, and emotional support for both children and adults was provided by the hospice's family support team.

Translation and interpretation services were available, and staff knew how to access the service. However, there were no signs in patient or public areas to let people know that this was available.

There was a lack of insight or work taking place around those who may be vulnerable because of their circumstances. There was no regular patient or public involvement group or strategy, and there had not been any work with people or groups with protected characteristics within the last year.

The hospice made some adjustments for people with a disability. Staff were able to call upon extra resources to support this such as the learning disability nurses based at the adjacent children's hospice.

Since 1st August 2016 onwards, all organisations that provide NHS care and / or publicly-funded adult social care are legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss". We saw the provider displayed posters in and around the corridors to show how they met this standard. However, we did not see any electronic system or similar to consistently record and share this information. Complaints information was provided in English only, with no process in place to provide policy and guidance information in other languages and formats.

Access and flow

People could not always access the service when they needed it. Arrangements to admit and treat patients were not in line people's needs.

The hospice only accepted admissions before 2pm on weekdays. Admissions did not take place at weekends or after 2pm.

The provider did not have a formal process to accept emergency admissions but told us that they would work swiftly with individuals, should emergency provision be requested. Equally, staff told us that patients wishing to die at home were supported and arrangement made to organise discharge swiftly.

Occupancy rates were low. The organisation stated that they used a dependency tool to calculate the needs of the current patients and what capacity they had to admit patients. Despite this, there were only two patients using the service during our inspection. The most recently available board minutes, from March 2019 showed a current occupancy of 84% based on seven beds, however, figures showed that the true occupancy level averaged

between 60% and 70% for the previous 12 months. Information provided to commissioners showed that the hospice was working with a local cancer information unit and the local trust to try to increase the number of patients accessing services.

The hospice offered day care for up to 18 patients on a Tuesday, Wednesday and Thursday for those who remained in the community during their illness. Board minutes showed that day care operated at around 90% capacity, although on the day we visited there were only two patients using the service. There was no emphasis on discharge from day care and some patients had accessed this for months.

Learning from complaints and concerns

The hospice complaints policy was due for review in November 2019. While a timeframe was given for the acknowledgement of complaints (within 72 hours) there were no timescales outlined in the policy for completion although information submitted as part of the organisation's data request suggested a timescale of 20 working days.

There was no patient experience lead or strategy, and as a result work to improve feedback rates of all types was not a priority.

The complaints policy did not give details of what avenues were open to complainants if they were not happy with the response, nor mention independent investigation. Information submitted to us by the hospice suggested that if a complainant made a formal complaint this would be 'investigated and fed back as a duty of candour meeting'. As the duty of candour and complaints processes should be entirely separate, each with different legal requirements, we were therefore not assured that the organisation had good oversight of the complaints process and how to apply this.

Are hospice services for adults well-led?

Inadequate

Our rating of well-led went down.We rated it as **inadequate.**

Leadership

Leaders had some of the right skills and abilities to run the service. They did not always understand and manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The hospice was overseen by a board of trustees and led by a chair. The senior leadership team was made up of the chief executive and director of patient care and service development. We interviewed one trustee who told us that they had a positive working relationship with operational leaders.

Senior managers within the service demonstrated some knowledge of the demographics of the area, the needs of the local population, relationships with allied health professionals and sustainability of the service. However, this was limited, and we did not see any collaboration with organisations outside of the local area. All managers working with in the service had vast experience of managing teams and individuals.

Local clinical leaders within both the inpatient and day hospice service also held several years clinical experience the registered manager had worked within the organisation for over ten years.

Leaders we spoke with had some understanding of the challenges to quality and sustainability of the service and we saw in board minutes that these were regularly discussed. However, there were few examples of leaders making a demonstrable impact on the quality or sustainability of services.

In September 2018, two junior sister posts were established for the in-patient unit. The aim of this role was to provide senior support to the running of the unit and develop policies and procedures to improve medicines management.

However, due to sickness and the eventual vacancy of one of the posts, managers stated that it was difficult to fulfil organisational plans fully.

All staff within the hospice told us that leaders of the service were visible and approachable and felt that they were very much part of the future of the hospice. However, we saw that key priorities were not actioned. For example, audit action plans were not completed, staff meetings were not consistent, and incidents were not investigated in a timely manner. Although managers

recognised that work was very much ongoing, priority for undertaking these tasks was not clearly outlined and accountability lines were blurred. None of the outstanding areas of clinical work and review were outlined within the organisation's risk register.

The hospice had recently recruited new trustees, strengthening numbers, having recognised that this had fallen to a low level in the previous year. However, these additional trustees had just taken up post and had not yet attended any meetings. Established trustees appeared to attend some of the clinical governance meetings, but these meetings were occasionally cancelled, and we saw no evidence of challenge regarding this or requests for information from the managers. We saw there were no clear lines of accountability within the hospice in relation to trustees. It was unclear if trustees applied any level of scrutiny to any of the concerns raised at the hospice.

Vision and strategy

The service had a vision which was focused on service sustainability. However, it was not clear how this was aligned with other local or regional plans and how progress would be monitored.

The Hospice has launched its five-year strategy in July 2019 following analysis within each department. The objectives from the strategy would be monitored in the monthly management meetings. The hospice had restructured the management meetings and a new governance structure had been implemented within the last six months to ensure effective communication is cascaded up to the trustees and back down to the individual hospice departments. However, meetings were occasionally cancelled, and we saw that the agenda varied. We were therefore not assured that key issues and trends were routinely addressed or aligned to the overarching strategy.

Staff were also invited to comment on the design and progress of the strategy through a series of communication exchanges and open forum events. We saw these had been arranged across all locations to encourage staff to visit at different times.

The hospice chief executive met with each member of the management team to ensure the objectives of the five-year strategy were progressing.

A clinical strategy action plan was also recently developed replicating the organisation's objectives. Local clinical leads told us that they felt involved in the development of the action plan. We saw some limited involvement of stakeholders, although they were provided with the strategy objectives.

Culture

Staff felt respected, supported and valued. They was some focus on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear. However, formal feedback from staff was not actively sought through the use of staff surveys.

All staff we spoke with at the hospice told us that they felt the culture had significantly improved and we observed positive and supportive interaction between colleagues and health care professionals.

Nursing staff told us there was a no blame culture and told us issues such as medication incidents and concerns were reported swiftly without fear or concern. However, there was an acceptance amongst the established staff group of suboptimal policies and procedures.

A new code of conduct had been launched and we saw this displayed around the hospice. This new code of conduct was developed by managers following feedback from staff exit interviews and provided a bench mark of expectation regarding behaviour and professional respect between colleagues.

The service had a whistleblowing policy which was available to all staff and information on how to raise concerns was available within this document. Staff we spoke to knew how to raise concerns.

Leaders of the service had not collated a recent staff survey, but we saw ongoing feedback from staff was sought through the open forum events and newsletters. In addition, all members of the nursing team were recently allocated time to attend the weekly Butterwick Hospice multi-disciplinary team meetings as part of their professional development. All staff we spoke with told us they felt valued by the organisation and although issues such as comparative pay rates with NHS colleagues remained an issue, all feedback we received was positive.

The equality and diversity of staff and volunteers was not always respected. Not all staff files contained information about their protected characteristics, and we heard that this information was not being collected for volunteers at all.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were not clear about their roles and accountabilities and did not have regular opportunities to meet, discuss and learn from the performance of the service. Governance arrangements were ineffective, unclear and clinical risk was not identified.

The registered manager was also the director of patient care and service development and had overarching responsibility for governance and quality monitoring of clinical services. In June 2018, a new role of quality and governance lead was introduced to assist with incident investigations, policy review and clinical compliance.

We reviewed minutes of the last three board meetings, which were held at irregular intervals, with two months between the first two meetings and four between the second and third. Attendance was on average around six to seven people, five to six trustees (including the chair) and the chief executive or nominated deputy with additional staff in attendance. At the November 2018 board meeting, it was identified in the chief executive's report that current governance structures did not provide the board with the right information in the right way for board members to be sufficiently assured of quality. Plans for an overhaul of the organisation's meetings and governance systems were outlined with the intention of establishing a more robust system incorporating elements such as standardised reporting, dashboards and KPIs. At the time of our inspection, this had not been fully embedded although we saw full plans for future implementation. There was a recognition that extra governance resource was required to meet the organisation's needs.

Managing risks, issues and performance, managing information

Leaders and teams did not use systems to manage performance effectively. They failed to identify and escalate relevant risks and issues or identify actions to reduce their impact. There were limited plans to cope with unexpected events.

The organisation had a strategic risk register which had been recently developed and ratified by the board in September 2019. Information supplied by the hospice showed that a task and finish group had been set up to revisit, streamline and update all risks but we did not see any evidence that this had yet taken place.

At a departmental level, individual risk assessment sheets were filled in for each new risk and an index of completed sheets was available. Minutes of the October governance meeting showed that work was underway to collate these as a more formal register.However, there was little understanding or management of risks and issues and significant failings in audit systems and processes.

There was a disconnect between departmental level and strategic risk. For example, medicines management featured at departmental level but there was no mention on the operational tab of the strategic risk register of risk of serious injury or death due to error or incidents. Departmental risks scoring above an eight were to be escalated to the strategic risk register but we could not find evidence that this had been implemented.

Significant issues found on inspection such as the lack of consistent palliative medical cover, gaps in staff competencies and training were not viewed as active risks by the service provider.

There was a standing agenda item for national medicine and equipment alerts as part of integrated governance meetings. These were logged centrally, and the appropriate departments took appropriate action in response.Information used to monitor performance was not being used systematically and there were significant failings in systems and processes meaning that the limited data available was not used well to inform service provision.

There was a draft business continuity plan that had not been ratified by the board. In the event of a site-specific major incident, plans for staff to operate from the organisation's Bishop Auckland site were in place. However, plans for patients were less clear other than to

evacuate and decide next steps. No arrangements for patient care with the co-located local trust or other bodies were in place in the case of an emergency evacuation.

Policies and procedures were held centrally and available electronically on the service's shared drive. However, many key policies and procedures were well overdue review, such as safeguarding and capacity and consent. The business continuity plan and volunteer policy had not yet been ratified.Consequently, we were not assured that current policy reflected best practice.

Public and Staff Engagement

Leaders and staff did not actively and openly engage with patients, staff, equality groups, the public and local organisations to plan and manage services. There was some collaboration with partner organisations to help improve services for patients, although limited.

Hospice staff explained that they used the friends and family test to seek views, but response numbers were low and limited appetite to explore feedback further.

The hospice did not regularly use any other methods of seeking patient, staff or wider community feedback.

The hospice had a good presence in the local community with a number of local charity shops, the neighbouring children's hospice and a third hospice site in Bishop Auckland providing day-care services.

There was no annual recognition ceremony or similar celebration event for either volunteers or staff.

There were some open forum events for staff which had been introduced recently but we did not see any evidence of how feedback from these events would be used to improve the services delivered.

There were limited staff engagement mechanisms and no regular opportunities for staff to meet to provide feedback. Leaders told us that the last staff survey took place 18 months ago.

Engagement

There was limited collaboration with partner organisations to help improve services for patients, although limited.

The provider worked in collaboration with the local NHS trust and nearby hospice to establish the outcome assessment and complexity collaborative through sharing progress and ideas with other professionals within the organisations.

Patients were asked to complete evaluations of the 'hub' (a social day ran on a Monday from day care nurses and health care assistants, morning and afternoon sessions). The results of that evaluation demonstrated that the social aspect of the day was the biggest benefit to them. A social drop in session was also offered and ran by family support volunteers in the wellbeing centre.

The hospice had a good presence in the local community with several local charity shops, the neighbouring children's hospice and a third site in Bishop Auckland providing day-care services.

Learning, continuous improvement and innovation

Staff were able to provide limited examples of learning and improving services. There was limited innovation or service development, no obvious knowledge or use of improvement methodologies, and minimal evidence of learning and reflective practice.

Access to secure email had been given to all nurses in the in-patient unit and day service, as referrals could be sent securely both internally and externally. This enabled the clinical units to suspend use of fax machines.

Following feedback from staff through team meetings, and incident reviews it was identified that a process of reflective practice was necessary due to the high emotional burden and difficulties the team encountered in their daily work. Since July 2019, monthly reflective sessions had been delivered by a psychologist. The sessions aimed to help staff understand and take responsibility for their thoughts, feelings and behaviours, and facilitate changes that help them in their working environment.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The hospice must ensure that consent to care and treatment must be treated as a process that continues throughout the duration of a person's care and treatment, recognising that it may be withheld and / or withdrawn at any time. Regulation 11 (1)
- The hospice must ensure that consent to treatment and care is correctly recorded, obtained and signed for, and staff are assured that the correct person is giving this consent. Regulation 11 (1)
- The hospice must ensure that staff working with patients, including bank staff and volunteers, have the correct competencies to meet the needs of all patients. Regulation 12 (2) (c)
- The hospice must ensure that incidents are properly reported and investigated, and that learning is embedded to prevent similar incidents occurring in the future. Regulation 12 (2) (b)
- The hospice must ensure robust infection prevention and control policies are in place to appropriately care for patients with infectious diseases and the deceased. Regulation 12 (2)(h)
- The hospice must ensure that all staff and volunteers receive appropriate safeguarding adults and children training, at the correct level, and that this training meets intercollegiate guidance Regulation 13 (2)
- The hospice must ensure that effective and robust systems are in place to support the management of governance, risk and performance. Regulation 17 (2) (a)
- The hospice must collect appropriate and timely information and develop key performance indicators so that leaders have an overview of the effectiveness of the service. Regulation 17 (2) (a)
- The hospice must monitor progress against plans to improve the quality and safety of services, including the hospice strategy. Regulation 17 (2) (a)
- The hospice must review the current risk register so that there is a robust system for the identification and assessment of risk and risks are regularly revisited and monitored. Regulation 17 (2) (b)
- The hospice must appropriately recruit or subcontract staff to ensure that there are sufficiently suitably qualified, competent and experienced staff on duty to meet the needs of all patients. Regulation 18 (2) (a)
- The hospice must appropriately recruit nursing staff and volunteers and keep good recruitment records, so it is assured that there are sufficiently suitably qualified, competent and experienced staff on duty to meet the needs of patients. Regulation 18 (2) (c)
- The hospice must ensure duty of candour is consistently applied when reviewing and investigating complaints and incidents. Regulation 20 (1)

Action the provider SHOULD take to improve

- The hospice should continue to work towards improving access to the service to ensure that it provides a responsive service that meets people's needs when they need it most.
- The hospice should consider a gap analysis to identify any unmet need in the local community, and likewise any groups of people with protected characteristics who may experience barriers to using the hospice's services.
- The hospice should ensure that the complaints policy and procedure is easy to read, and that a low language or easy read version is available for younger service users

This section is primarily information for the provider

Requirement notices

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Incidents were not properly reported and investigated, and learning was not embedded to prevent similar incidents occurring in the future. Equipment was not always safe for use or being used in a safe way. Regulation 12 (2) (a) (b) (e)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: The provider did not ensure that all staff and volunteers had appropriate safeguarding adults and children training, at the correct level, and that training met intercollegiate guidance. Regulation 13 (2)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

The provider did not ensure that effective and robust systems were in place to support the management of governance, risk and performance.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: The provider did not keep sufficient recruitment records to assure itself that there were sufficiently suitably qualified, competent and experienced staff on duty to meet the needs of patients.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour How the regulation was not being met: The hospice did not demonstrate consideration of duty of candour when reviewing all incidents.