Butterwick House

Quality Report

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Date of inspection visit: 5 November to 11 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?	
Are services responsive?	Inadequate
Are services well-led?	Inadequate

Overall summary

Butterwick House is operated by Butterwick Limited. The service provides hospice care for children from Stockton, Middlesbrough and surrounding areas. The hospice cared for 42 patients in the last year.

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

The hospice has 6 inpatient beds, two of which are reserved for the provision of respite care.

We carried out an unannounced inspection over several visits from the 5 November to the 11 December 2019 using our comprehensive inspection methodology. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We inspected all five key domains. 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,

Summary of findings

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 only service provided was hospice services for children and young people.

Services we rate

Our rating of this 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 the hydrotherapy pool, which was being used without a lifeguard or staff with life saving training present
- Disclosure and barring checks for staff and volunteers were not updated regularly and the service did not hold a comprehensive record of when to update these
- 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 investigated. 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
- There was no cover by doctors at evenings and weekends to ensure that patients could be reviewed quickly if needed
- 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
- Patient records and assessments were incomplete and routine assessments were not completed for all patients, including those deemed to be high risk. Opportunities to prevent or minimise harm were missed
- 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
- Staff did not understand the vision and values and the strategy was not underpinned by detailed realistic objectives and plans
- The governance arrangements and their purposes were not yet 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 good knowledge of their patients' needs and we saw examples of caring, compassionate interactions with children, young people and their families.
- Most of the families and children using the service were very happy with the care they had 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.
- The team had developed an in-house pain management tool to meet the needs of children who did not verbalise pain and this had been well received and shared throughout the region

Following this inspection, we raised significant safety concerns with the provider and due to the number and level of concerns, the provider voluntarily suspended services. In addition, we told the provider that it must take some actions to comply with the regulations. We also issued the provider with 23 requirement notices that affected Butterwick House. 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

Summary of findings

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

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 children	Inadequate 	The only service provided was hospice services for children and young people. We rated this service as inadequate because the safe, effective, responsive and well led domains were rated as inadequate. The caring domain was not rated.

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Services we looked at
Hospice services for children and young adults

Summary of this inspection

Background to Butterwick House

Butterwick House is operated by Butterwick Limited who provide adult hospice services at the same site and a range of wider services to the local community. The hospice was purpose built in 1997 and sits within the grounds of a local NHS hospital. It provides specialist end of life care, day care, respite care and family support for patients with a range of life-limiting conditions living in Stockton, Middlesbrough and the surrounding areas.

The hospice appeal was formed in 1984 by Mary Butterwick. Day patients were the first to access services in Bishop Auckland the same year. Children's services were first offered following completion of the building of the current site.

The hospice provides inpatient accommodation for up to eight patients. At the time of our inspection, 36 children 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 the scope of our 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, two other CQC inspectors, an inspection manager and two specialist advisors with expertise in children's hospices and end of life services. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Information about Butterwick House

The hospice has one inpatient unit and is registered to provide the following regulated activities;

• Transport services, triage and medical advice provided remotely

• Diagnostic and screening procedures

• Treatment of disease, disorder or injury

Up to eight patients could be accommodated in the inpatient unit in separate, ensuite rooms. The hospice also housed a sensory room, main day room and day room for teenagers and young adults, and hydrotherapy pool. The hospice also offered day therapies and family support services which included adult and child bereavement support and counselling.

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.

During our inspection we spoke to staff, including senior managers, registered nurses, health

care support workers, doctors, therapy and domestic staff. We also spoke to one trustee.

We spoke to two patients or their relatives about the care they had received. We looked at compliments and complaints received by the service as well as patient feedback surveys.

Summary of this inspection

We observed care and treatment and looked at ten sets of patient notes and medicines administration records.

Activity (June 2018 to May 2019)

• In the reporting period 42 patients used the services of the hospice.

• A total of 79% were children aged between 0 and 17, and 21% were young adults aged between 18 and 25.

Butterwick Limited employed three doctors, 40 registered nurses, 30 healthcare support workers and 101 other staff. The majority were employed on a part time basis.

Track record on safety (June 2018 to May 2019)

- No never events
- Two serious injuries (one pressure sore and one aspiration requiring emergency transfer to hospital)
- One instance where Duty of Candour was applied
- There were no formal complaints

Services accredited by a national body:

- Investors in People 2019
- Disability Confident Employer Level 2

Services provided at the hospice under service level agreement:

- Pharmacy services
- Chaplaincy services
- Waste removal
- Infection control support
- Specialist equipment maintenance and testing

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 did not make sure that all staff completed it.
- Staff did not all have the correct training on how to recognise and report abuse and how to apply it.
- The service did not always control infection risk well. They did not develop infection prevention and control guidance for staff to follow when caring for the deceased.
- 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 patients' own medicines 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.

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;

- 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.
- The service provided care and treatment based on some, but not all national guidance and evidence-based practice.
- Limited support and advice on leading healthier lives was available to patients and their families.
- The service's policy and practice around consent was not clear and we were not assured that staff had the correct tools to make competent assessment of capacity

Summary of this inspection

- Staff did not always have the right skills and tools to support patients and their families to make informed decisions about their care and treatment.

We found the following areas of good practice:

- Staff gave patients enough food and drink to meet their needs.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Are services caring?

We did not rate the caring domain at this inspection as the provider was undertaking limited activity and there was insufficient information to make a judgement about this domain.

We found the following areas of good practice:

- Staff treated children, young 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 patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

However:

- We found evidence that some parents had chosen to remove children from the setting as they were unhappy with the care provided.

Are services responsive?

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

Inadequate 

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 had recently closed for a month. The service was not offering end of life care at the time of our inspection.
- It was not possible to say whether waiting times from referral to achievement of preferred place of care and death were in line with good practice as the service was not providing end of life care.

Summary of this inspection

- 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 peoples individual needs and preferences. Staff made reasonable adjustments to help patients access the 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;

- 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 children	Inadequate	Inadequate	N/A	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	N/A	Inadequate	Inadequate	Inadequate

Inadequate

Hospice services for children

Safe	Inadequate
Effective	Inadequate
Caring	
Responsive	Inadequate
Well-led	Inadequate

Are hospice services for children 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 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 that 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.

The service was supported by volunteers to help with specific tasks. Volunteer files did not always show evidence of a structured induction. A volunteer induction workbook was in development but was not ready for use at the time of our inspection.

Safeguarding

Staff did not understand how to protect patients from abuse. Staff did not all have the correct training on how to recognise and report abuse and how to apply it.

The provider had developed a safeguarding children at risk policy, which was dated August 2019 but had not been ratified by the board of trustees at the time of our first visit. This was ratified on 25 November 2019.

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 check or any way of prompting when these needed to be renewed. We brought this to the hospice's attention at the time of our inspection and systems had since been developed to address this.

Inadequate

Hospice services for children

There was no named children's safeguarding lead in post at the time of our inspection as the person named in the organisation's data return to us had left the organisation. A new children's safeguarding lead was in place after our inspection.

Staff did not have in depth knowledge about safeguarding risks posed by the wider family and were not routinely documenting who lived with and had contact with the patient. Leaders agreed that this was an area they needed to improve upon.

Staff we spoke with knew how to recognise abuse and neglect, and had received some safeguarding children training, although not always at the correct level. Only 31% of staff caring for children at the hospice had received Safeguarding Children training at levels two and three. This was not in line with national guidance.

Volunteers (including trustees) did not receive any safeguarding children training. This was a potential risk to the service and not in line with the recommendations made in the Saville Enquiry Report of 2016.

As the provider did not have an up to date and ratified safeguarding policy in place for some of the inspection period and safeguarding 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 partially controlled infection risk. Staff used some equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The service did not have specific infection and prevention control guidance for staff to follow which included appropriate infection prevention control measures when caring for the deceased.

The provider stated they followed national guidance for cleanliness and infection control but had not developed service specific guidance for staff to follow.

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

Patient areas we visited were visibly clean including the reception / waiting area.

Staff observed 'bare below the elbows' guidance and alcohol hand gel was available at the entrance to each child's bedroom. We saw staff washing their hands before providing care and treatment to patients. However, this was done in the hand basin in the patient's bathroom, which was not suitable. This had been previously highlighted to the organisation by an infection control nurse from the local trust who, through a service level agreement, provided regular advice and audits.

The hospice performed internal audits of practice such as hand hygiene and uniform. The most recent external audit performed by the trust's infection prevention and control nurse took place in May 2019. This found that the decontamination sink was not suitable for the decontamination of equipment. Cracked or loose tiles were seen in the main bathroom and pool areas. The hand washing facility within the decontamination area was also not adequate. An action plan had been completed following this visit. This showed that of the 11 areas highlighted as relevant to the children's hospice, only three had been completed.

Flooring in children's rooms was easy to clean and non-porous. There were no handwashing posters as a visual reminder in children's rooms. This was brought to the attention of staff at the time of our inspection. Hand sanitiser was available at the entrance to each child's room.

We looked at four children's bedrooms. All looked and smelled clean. 'I am clean' stickers were being used to show the last time equipment had been cleaned.

Patients approaching the end of their life used the Sunflower room, a bespoke room with inbuilt cooling to aid with body preservation after death. However, there were no formal procedures or protocols for staff setting out how often to check a body whilst in the room.

We reviewed policies in relation to care of the deceased 'Transfer to the sunflower room and guidance for the care of the child/ young adult when using the room after death'. This included the appropriate use of the cuddle cot cooling unit.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The hospice was on two floors, however there was no accessible lift to the overnight accommodation provided for families on the second floor. The inpatient unit was located 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.

The inpatient unit was not locked. Visitors accessed the service via the main doors and were met by staff. At night, they could be buzzed into the unit by 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.

The facilities manager had oversight of all facilities, premises and maintenance issues. An annual maintenance plan was in place and all reports and audits underpinning this were held by the facilities manager. We saw evidence that they attended wider staff meetings and were responsive to the needs of the organisation.

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

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 facilities manager.

Syringe pumps were maintained by the manufacturer on a regular basis. Information supplied to us by the hospice suggested that all relevant staff had received training on the use and checking of syringe pumps, but a conversation with a senior member of the team suggested that some of the newer members of staff had not yet received their training and would be supervised until this was completed

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 all the nurses had received specific suction training from the organisation's physiotherapist. Half of nursing staff had received oxygen training.

Rooms contained boards above children's beds. These had small magnets stuck to them which could present a choking hazard were one to fall within a child's reach or be inadvertently knocked off into the bed. Rooms had doors facing onto a small outside garden area. Blinds used in children's rooms had free hanging draw cords which could present a choking hazard for patients and families, particularly toddlers or people with intent to self-harm.

Resuscitation and emergency equipment was available onsite and easily accessible. We checked the emergency equipment in the unit. A resuscitation box was routinely checked by staff.

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.

The hospice also had a hydrotherapy pool with a maximum water depth of 1.15 metres. Staff told us that all children could use this facility. We reviewed documentation in relation to pool checks and saw that water checks and maintenance checks were not consistently recorded. We asked to review pool training for staff, for example the care of the deteriorating child however we saw no training was in place. In addition, we did not see any clear guidance for staff in relation to which children would not be able to be safely cared for in the pool. For example, those children likely to experience

rapid or sudden deterioration. We brought this to the provider's immediate attention who confirmed that the pool would no longer be in use until training, checks and guidance had been developed.

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.

We reviewed ten sets of children's notes. All included care plans and risk assessments. Families and patients knew the service and staff, so were aware what the plans were for their ongoing care. However, risk assessments were not regularly updated and did not always reflect changes in a child's condition. For example, we saw in one child's notes that they were being investigated for a new neurological condition that impacted upon their care, but no reassessment had taken place to reflect this. The provider told us there was no policy to guide staff as to the frequency of clinical assessments and reassessments.

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.

Staff managed difficult behaviour by assessing risk and mitigating this where possible. We saw that at least one child in their care regularly hurt staff. All occasions had been reported as incidents and staff had discussed and recorded changes in strategy to try and minimise this behaviour.

We looked at the records of a child using the service at the time of our inspection. They had an education health care plan (EHCP) dated May 2018. There had not been any review of this plan since this time. There were a variety of assessments including toileting, personal care, night time routines and nutrition and hydration, all of which had been completed in the week prior to our inspection.

A second child had had a recent stay in hospital. Their EHCP had not been updated to include any changes in condition or care and treatment following this admission.

Staff could not access senior review 24 hours a day. At night, if a patient deteriorated significantly, staff could call the 999 emergency number and arrange a transfer to the nearest hospital if required. As there was no doctor cover overnight and at weekends, it was not always possible to ask for medical input if needed.

The hospice had access to bag and mask resuscitation equipment. There was no other resuscitation equipment provided for children. Staff had undertaken basic resuscitation training which included the use of some paediatric dummies and equipment. No staff had a recognised paediatric resuscitation qualification.

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.

Nurse staffing

The service did not have enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment, although managers regularly reviewed and adjusted staffing levels and skill mix in relation to patient numbers.

The hospice had experienced the loss of five nursing staff, including the nursing lead, within a short period of time. This had left the service with significant vacancies, and the hospice had voluntarily closed for a month between mid-August to mid-September until new nursing staff were recruited. The hospice had been open less than a month at the time of our inspection and were relying on existing staff working extra shifts and bank staff while new staff came into post. There were two whole time nursing posts vacant at the time of our inspection. Most of the nurses employed at the hospice were children's nurses.

The hospice used the Leeds dependency tool to calculate the dependency needs of children using the service for respite care. Staffing was planned based on the calculated dependency of those children booked to come in. The service was not offering emergency placement at the time of our inspection and we did not see any evidence that this could be accommodated given the hospice's recruitment position. However, end of life care had been offered in the previous six months.

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.

Nursing skills and competencies for new starters were observed and signed off by existing members of nursing staff. However, these staff were not always up to date with their own learning. Staff working at the time of our inspection did not all have the right skills, including safeguarding children, medicines management and manual handling, to safely care for the children in the hospice. We brought this to the attention of leaders, who took the decision to use alternative staff with the correct skills and competencies to care for the children in the hospice until they went home, and once the hospice was empty, to close the hospice to allow staff to bring their skills up to date.

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

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

Medical staffing

The service did not have 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.

At the time of our inspection, the senior hospice physician was based in the hospice three days a week. Consultant input from a local trust was available with seven sessions of senior cover.

The provider told us that consultant cover from the NHS trust was not formally agreed and therefore varied in consistency. There was no agreed arrangement for the review of a deteriorating child. At the time of inspection, the hospice physician was an annual leave which resulted in only 22.5 hours of agreed physician cover. At weekends and evenings, there was no medical cover. Out of hours GP cover available to the adult hospice did not extend to this location.

We spoke with the physician who told us they would flex to accommodate patient bookings. However, we raised the lack of consistent medical cover with the provider and sought immediate assurance around consistent medical cover on a day to day basis.

The provider did not employ a medical director.

Records

Staff kept records of patients' care and treatment. Records were clear, up-to-date, mostly stored securely and easily available to all staff providing care.

We looked at ten sets of children's records, which were all in paper format. All had visited the hospice within the last six months. We saw that consent to share information with the relevant people had not always been correctly obtained and recorded.

Care records contained clear person-centred care plans which clearly identified patients' emotional, social and spiritual needs alongside their physical health and communication needs. Staff completed care plans appropriately and recorded when care was carried out in line with the care plan.

Navigation through the records was difficult due to the lack of an index system but staff told us they found the documents helpful to complete. Patients' needs were considered in line with national guidance and NICE quality standard QS144 regarding individualised care.

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.

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.

We observed a patient being admitted however and saw that full assessment discussions were completed and recorded.

Patient records were stored in an area only accessible to staff. Staff completed care plans and records in this area, where they could not be seen by people who did not have the right to see access the records.

The service planned to audit patient records once a year. We requested a copy of their most recent audit results, but these were not supplied.

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.

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 services to the hospice. 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.

Each room contained a lockable medicines cabinet for the storage of non-controlled medicines. Nursing staff told us that they brought a tray into each child's room and made up medicines in the cupboard. When children were sleeping, this could be dark and difficult to see, and while they used the light in the cupboard, they were looking into a change of practice whereby medicines could be made up and checked outside the room and then brought to the child. We later heard that additional lights were available within the child's room, but some staff did not like to disturb sleeping children by using these when dispensing medicines.

Controlled medicines were stored securely. Fridge temperatures were monitored regularly and the provider had a procedure in place to follow if the temperature was out of range or the fridge stopped working.

In the medicines room where controlled drugs were stored, we found a file containing out of date printouts on medications dating back to 2003. We raised this with medical staff as this was not the most up to date information. We were told that this folder was no longer in use, so we asked that staff dispose of it. Staff showed us the current version of the BNF (British national formulary, a medicines information book) and NICE guideline NG61 which provided more up to date guidance.

A six-monthly internal medicines audit was completed by senior members of the nursing team. The most recent audit from July 2019 showed 100% compliance with all aspects except policies, which were not up to date.

We reviewed the medicine charts of three individual patients. We saw anticipatory medicines we prescribed in line with national guidance and were clear legible and all within date. However, the inspection team found evidence that the transcribing of medicines (transferring vital information about a child's medicines and how they take them) had not always been done in line with policy. The policy itself was inconsistent and in need of review, which the organisation were aware of.

We reviewed the training records of two 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

The service did not always manage patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents but there were limited lessons learned

which were not shared with the whole team or wider service. Identical incidents happened more than once because appropriate learning and action had not taken place.

The hospice had reported two serious incidents and no never events in the previous 12 months. Never events are serious, preventable patient safety incidents which should not occur if preventative measures are in place. One incident was the development of a grade two pressure ulcer, and in the second case a child was transferred to hospital after aspiration of fluids which led to pneumonia.

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 11 incidents that had occurred at the hospice in the last six months. Five of these related to the same child and their behaviour. Despite repeated incidents of the same or similar nature, there was limited learning although it should be acknowledged that different approaches to the same task were attempted. Some of the 11 incidents had documentation that included a lessons learnt sheet, which was complete. Others did not, particularly from August 2019 when the hospice experienced its first nursing shortfall. When incidents happen, it is important that lessons are learned to prevent the same thing happening again.

We saw evidence of an incident in August 2019 when a child's medicine was administered by the incorrect route. The person who administered the medicine did not return to the setting, and there was no learning recorded for this incident and therefore no change in practice. An identical incident recurred two months later. This was not reported as an incident but was recorded in the child's notes. The administration of medicine by an incorrect route was added to the risk register in March 2019, prior to both incidents. The organisation rated the likelihood of occurrence as low due to mitigations. We did not see any link between this risk entry, the reported or unreported incident.

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 trustee 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 one duty of candour meeting in the last twelve months. This was triggered by two serious incidents, which related to the same child.

Are hospice services for children 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 care and treatment based on some but not all national guidance and evidence-based practice. Care was not always delivered in line with best practice evidence to achieve effective outcomes.

The organisation was a member of Together for Short Lives, which provided newsletters and bulletins to the director of clinical services. Doctors were part of the northern palliative care network and could access a monthly network meeting. Sub-topic network groups, such as a transition working group also met monthly and provided guidelines on how to support children through transition.

Patients' individual needs were assessed once accepted for referral. Up to date information on their current

medication was received, and a date for first admission set. Parents would always stay upstairs in accommodation overnight during a child's first admission.

Managers told us that due to staffing shortages only children who were already known to the service were accepted to minimise risk. However, we saw that this was a very recent arrangement, and this was not identified within the organisation's risk register.

Each patient had an individual care plan. All patients we reviewed also had an education health care plan (EHCP). When questioned, staff said they did not use advanced care plans as the EHCP was in place. Staff were not auditing or monitoring fulfilment of people's preferred place of death, as the service was not providing end of life care at the time of our inspection. As there was no audit process or outcomes in relation to the care of the dying we could not be assured that national guidance was being used to effectively manage patient care in the last days and hours of life.

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.

We saw staff had designed flash cards to enable children to identify what they would like to eat, including food choices during trips out of the hospice.

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. The service used nurse prescribers if pain relief was needed when a doctor was not present. Staff explained that the children using the service had been coming for months or years, and they were used to the non-verbal cue's children used to show they were experiencing pain.

The hospice used a tool developed in house by specialist staff. They recognised that while there were a range of available tools to assess pain in children there was little for children with complex needs or those who communicated non-verbally. A presentation of this tool at the local network was commended. We saw in patients' notes that this was being used correctly and revisited as needed.

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

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. On an ad-hoc basis, we were told that as most of the children attending the hospice did not verbalise their feelings, they would look for eye interaction and smiles as an indication of active participation and enjoyment of the activity provided. 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 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.

The hospice was not submitting data to Hospice UK's clinical benchmarking project for children's services. While this was noted in an update to the clinical governance sub-committee and an aspiration was expressed to do so in the future it was not clear what the current barriers to doing so were or how progress towards this aim would be monitored.

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

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. Registered nurses and health care support workers had not all completed additional role specific training. 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.

Nursing staff did not all have the correct skills or competencies to care for the children in their care. For example, neither of the two nurses caring for children overnight had current medicines management or moving and handling training. Both children required hoists and regular medicines as part of their care. Five of the eight nurses on duty during the day and night on one day of our inspection did not have the correct level of safeguarding training and three had no recorded suction training. Nurses leaving the service reported feeling unsupported and not equipped with the correct skills and support to work effectively.

There was no nominated lead for learning disabilities or autism, but we heard that four of the nursing staff had a learning disability specialism and one of these had Makaton and sign language skills.

Nursing staff accompanied children in the hydrotherapy pool. A basic checklist was completed before a child used the pool. However, staff had not been given any lifesaving or water safety training. The organisation agreed to suspend visits to the pool until these competencies had been put in place.

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. Nursing staff worked closely with doctors who were an integrated part of the team.

The hospice held regular multidisciplinary team meetings and we were told that the palliative care consultant from the neighbouring local trust had attended some of these. Each child had a designated nurse as a key worker and they met every six months with the rest of the child's team including colleagues from social care and continuing health.

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, and formalising senior paediatric input.

A physiotherapist visited once a week to work with the children. We were told that they documented their interventions in children's records but there were no records of goal setting or clinical assessments in the records of the children who were in the hospice at the time. Leaders acknowledged that this was an area that needed improvement.

Health promotion

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

Inadequate

Hospice services for children

There was some information stored in the doctor's office relating to child exploitation, and depression. In the main entrance area to both the children's and adult hospices, Dying Matters and Macmillan leaflets were available. No health promotion information was on display in the children's hospice itself and staff could not give any examples of any other support they provided to families that would be classed as health promotion.

Consent and Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always have the right skills and tools to support patients and their families to make informed decisions about their care and treatment.

The organisation's resuscitation policy had not been revisited since the recommended review date in 2018. Advice given in part 6.14 (2) stated that in the absence of a do not attempt cardiopulmonary resuscitation (DNACPR) document, children should not be resuscitated if they were in the terminal stages of an irreversible illness and this had been documented in their notes. This was in contradiction with NG61 "End of life care for infants, children and young people with life limiting conditions" published by the National Institute of Health Care and Excellence. This states in point 1.3.1 that resuscitation should always be attempted if there is no DNACPR document in place. We saw from children's medical records that resuscitation had been used within the children's hospice on multiple occasions since our last inspection. As current hospice policy did not reference all relevant and current guidance, decisions made about resuscitation were being made without consideration of up to date and relevant best practice.

Hospice policy stated that DNACPR forms should be reviewed when a child moved from one setting to the next, or at a minimum, within five days after arriving at the hospice. Of the people currently using the service, three had a DNACPR form in place. A total of 24 people had a care plan setting out their wishes as part of their hospice documentation, but none had an Advance Care Plan, child's and families 'wishes' document or RESPECT (recommended summary plan for care and emergency treatment) in place.

The hospice recorded deprivation of liberty, but was not yet using the MCA2 form, the recommended tool. Processes for assessing the ability to give consent and who should be giving this were not clear and the organisation accepted that there was some more work to be done in this area. Parents consented to their children's treatment and care on admission, however it was not clear how consent was sought on a day to day basis as needed.

Following inspection, the provider developed a new form to clarify and address specific capacity issues.

Are hospice services for children caring?

We did not rate the caring domain at this inspection as the provider was undertaking limited activity and there was insufficient information to make a judgement about this domain.

We visited Butterwick House on two occasions during this inspection. When we first visited, there were only two children using the service, and the service was closed when we returned for a second time. As the service had been closed for over a month during the summer and was not providing end of life care at the time of our inspection, there was limited feedback available from families who had used the hospice.

The family we spoke to were very complementary about their child's care, and comments supplied by the hospice from other families echoed this. However, we also saw evidence of families who had chosen to cease using the hospice as they had been unhappy with the care provided.

Are hospice services for children 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.

Hospice services for children

The hospice received demographic information through their membership of Together for Short Lives and served a community in an area of deprivation. Leaders told us that they had not really done any gap analysis to see who was not using the service or less likely to do so, and there had not really been enough resource to identify that kind of need within the local population.

Some work had been done with existing service users around the needs and wants of teenagers and young people using services but there had been no real engagement with the wider population.

Leaders recognised that the children's hospice had not really forged links with other similar providers in the region, and this was something that they hoped to address in future. They recognised that there were opportunities for good practice sharing, benchmarking and work around transitions, which could ensure a better support network across the region.

Translation services were available, and staff knew how to access the service. However, there were no visible signs to let people know that this was available.

Meeting people's individual needs

The service did not always take account of children, young people and their families' individual needs and preferences. Staff made some reasonable adjustments to help patients access services.

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 plans in place to fund 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.

Staff told us that they built relationships with most families as they returned over months or years for respite care. As a result, they explained that they found it easy to discuss planning for the death of a child with the family and could identify how much and at what stages family would like to be involved. However, we did not see any such discussions in the notes of the children we checked who had received recent care at the hospice.

We heard of good examples of encouraging the interests and needs of children using the service. One child had loved washing machines and could watch them under supervision. A second liked vehicles, so a visit from a fire engine was arranged.

The hospice could make reasonable adjustments for people living with a disability. Learning disability nurses formed part of the team and several of the team had additional skills including Makaton they could call on. The service was not compliant with accessible information standard legislation.

However, 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.

A lack of insight about the potentially unmet needs of the wider and marginalised population meant that no work or plans to address this was underway and there appeared to be no use of tools such as the Together for Short Lives diversity toolkit.

Access and flow

People could not always access the service when they needed it as the service had restricted times for accepting patients and had been recently closed for a month. As the service was not offering end of life care at the time of our inspection, it was not possible to say if waiting times from referral to achievement of preferred place of care and death were in line with good practice.

Most referrals to the hospice were funded by continuing health care packages. We saw from board and governance meetings that discussions about how to publicise the service had taken place, and some information had been sent to local healthcare providers but at the time of our inspection, income came from a single source. No end of life care was being provided.

Inadequate

Hospice services for children

Leaders explained that in the previous 12 months the service had taken fast track or emergency referrals but would not be in a position to do so at the moment as many of the newer members of staff had not completed all their training and competencies.

The provider did not have a formal process to accept emergency admissions but told us that when they were accepting these, they would work swiftly with individuals, should emergency provision be requested.

Occupancy rates were low. The hospice had closed for a month from mid-September to mid-October and had only been open again two weeks at the time of our inspection. There were only one or two children using the service at any time during our inspection. The hospice closed again in November. Prior to the two closures, the organisation's chair had expressed concern in May 2019 that the percentage of beds being unused was approaching 20% and that staffing levels, which were sufficient to provide care for a full unit, were not sustainable.

Learning from complaints and concerns

As the service had not received any formal complaints, it was not possible to say if it was easy for people to give feedback and raise concerns about care received, and whether complaints investigations and lessons learned were of good quality.

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. The policy did not give details of what avenues were open to complainants if they were not happy with the response, nor mention independent investigation. The policy was not child friendly.

We were told that a complaints poster was on display in communal areas but could not find a copy on display at the time of our visit. The service had not received any formal complaints in the past year, so we could not test out the hospice's assertion that learning from complaints was disseminated at monthly care meetings.

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

An incident from August 2019 documented a call from the child's parents, who said they had been unhappy with their child's care at every admission. The person who took the call did not offer to record these concerns as a complaint but advised the parents to contact the director of patient care and service development if they wanted to make a complaint. No complaint was made.

Are hospice services for children 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 led by the 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.

Nursing leadership was provided by an interim inpatient unit manager. The hospice had recruited a new leader who was due to start in early 2020. The director of patient care and service development was also a registered nurse.

Senior managers within the service demonstrated some knowledge of the demographics in the area and had developed some relationships with allied health professionals, addressing sustainability of the service. All managers working with in the service had significant experience of managing teams and individuals.

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.

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 many meetings. Established trustees attended board meetings and chaired quality committees feeding into the board, however we saw there were no clear lines of accountability and if any non-chair trustee scrutiny was applied to concerns raised, this was not adequately reflected in meeting minutes.

Trustee recruitment files did not exist for those trustees who had been appointed more than a year prior to the time of our inspection and the service could not assure us that all trustees had a current DBS check. Trustees did not receive any role specific training.

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 organisation had recently developed a strategic plan to run from 2019-2024. This stated that it had been developed due to changing national demographics, i.e. the direction of travel towards integrated health and social care. It did not mention how these had manifested locally or any specific factors relevant to the local community. The strategy stated that the team had met with staff and listened to the views of patients and carers but did not say in what form this had taken, nor was there any engagement with the wider local community. There was no reference to national recommendations and the direction of travel for hospice care for children.

The plan stated that "this strategy and the supporting plans will be driven by the board and the senior management team through action plans and regular monitoring." There were no service development or improvement plans underpinning the strategic plan, and board and committee minutes did not mention the five strategic priorities identified. The strategy had not been translated into meaningful and measurable plans at all levels of the service. We saw that plans had been proposed by the hospice governance lead for a change to the clinical managers meeting agenda to include this, but this had not yet been implemented.

Culture

Staff were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

All staff we spoke with at the hospice told us that they felt the culture had 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. Staff working at the hospice felt respected and valued, although there was some apprehension about its future, given the recent closure. There had been a high turnover of nursing staff in the last 12 months and the service was still not up to full capacity.

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.

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, Managing risks, issues and performance, Managing information

Leaders did not operate effective governance processes throughout the service and with partner organisations, although plans were in place for implementation. 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. 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, and we heard that the organisations had plans to increase their governance resource still further.

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 was not 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.

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. There was little understanding or management of risks and issues and there were significant failures in audit systems and processes.

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.

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.

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 hospice'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. Personal evacuation plans were in place for inpatients, but these were stored on reception and not kept with the patient.

Policies and procedures were held centrally and available electronically on the service's shared drive. However, many key policies and procedures were overdue a review, such as medicines management, and others, such as the business continuity plan and volunteer policy had not yet been ratified.

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 there was not much enthusiasm from families and the uptake was low. The hospice did not regularly use any other methods of seeking patient, staff or wider community feedback.

Inadequate

Hospice services for children

The hospice had a good presence in the local community with a number of local charity shops, the neighbouring adult 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 no 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.

Learning, continuous improvement and innovation

Staff were able to provide limited examples of learning and improving services. Due to capacity issues this was not an ongoing priority.

There was limited innovation or service development, no obvious knowledge or use of improvement methodologies, and minimal evidence of learning and reflective practice.

The service was in the early stages of developing links and forging working relationships with other children's hospice providers in the area. Plans to share good practice were in their infancy.

The inpatient unit nursing lead vacancy and closure of the unit due to nursing staff shortages had meant that there had been little focus on continuous improvement and innovation in the past twelve months. However, the development of an in-house pain tool had been well received at a regional network event, and staff spoke of other trials and plans they had for when the unit was staffed at a more sustainable level.

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 the assessment of risk of children is systematic, underpinned by policy, regular, and that care plans reflect this. Regulation 12 (2) (a)
- 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 that relevant health and safety concerns are always included in people's care and treatment plans, assessments or pathways. This includes allergies, contraindications and other limitations relevant to the person's needs and abilities, and update documents regularly to reflect any changes in these. Regulation 12 (2) (b)
- The hospice must ensure that staff working with patients, including bank staff and volunteers, have the correct competencies to meet the needs of children and young people. Regulation 12 (2) (c)
- The hospice must store current, easily accessible records of its staff's competencies, skills and qualifications and ensure these are always up to date. Regulation 12 (2) (c)
- The hospice must ensure that all equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way. Regulation 12 (2)(e)
- 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 any fixtures and fittings identified as an infection risk, such as cracked tiles, are replaced or repaired. Regulation 15 (1) (a)
- The hospice must ensure that the hydrotherapy pool is not used without appropriate supervision by trained and competent members of staff. Regulation 15 (1) (d)
- The hospice must ensure that complaints can be taken by any member of staff, either verbally or in writing. Regulation 16 (1)
- The hospice must ensure that information and guidance on how to complain is available and accessible in appropriate languages and formats to meet the needs of those using the service. Regulation 16 (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)

Outstanding practice and areas for improvement

- The hospice must keep timely and relevant information about staff and ensure that this information is created, amended, stored and destroyed in line with current legislation and guidance. Regulation 17 (2) (d)
- The hospice must appropriately recruit or subcontract medical staff to ensure that there are sufficiently suitably qualified, competent and experienced staff on duty to meet the needs of children and young people using the service. Regulation 18 (2) (a)
- The hospice must provide appropriate ongoing supervision and training to ensure staff can carry out the duties they are employed to perform. Regulation 18 (2) (a)
- The hospice must appropriately recruit nursing staff and volunteers and assure itself that staff are able to meet the requirements of the relevant professional regulator throughout their employment. 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 review the current practice of monitoring children overnight and the methods in place for doing so to clarify if this is enough
- The hospice should review the practice of dispensing and giving medicines in low lit areas to minimise the risk of error
- 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
- The hospice should revisit the range, frequency and quality of audits including the once yearly records audit to provide regular assurance to leaders and the board
- The hospice should continue to work towards contribution to national audits
- The hospice should review its health promotion offer to see if more can be done to promote positive lifestyle choices, not just for children and young people but also the wider family
- The hospice should ensure that it can show compliance with, or evidence of working towards, with a definitive implementation date, the accessible information standard

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 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The provider did not ensure that consent was always gained appropriately, when needed and regularly reviewed.

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: The provider did not ensure that children were regularly risk assessed and that this was underpinned by policy. Staff working with children and young people did not have the correct competencies. Incidents were not properly reported and investigated, and learning was not embedded to prevent similar incidents occurring in the future. Robust infection control policies were not in place to appropriately care for the deceased. Equipment was not always safe for use or being used in a safe way. Regulation 12 (2) (a) (b) (c) (e) (h)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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: The provider did not ensure that effective and robust systems were in place to support the management of governance, risk and performance. Regulation 17 (2) (a)

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. Regulation 18 (2) (c)

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:

This section is primarily information for the provider

Requirement notices

The hospice did not demonstrate

consideration of duty of candour when reviewing all incidents.

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.