

## Derwentside Hospice Care Foundation

# Willow Burn

### Inspection report

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### Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Requires Improvement ●

# Summary of findings

## Overall summary

Willow Burn Hospice provides a range of services focusing on relieving and preventing the suffering of people with life limiting illnesses. These include specialist day care services, palliative care and an outreach service. There were four people using the inpatient service on the day of our visit and approximately nine people attending the day hospice facility.

There was not a registered manager employed for this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service had appointed a very experienced manager [head of care] who had joined the service six weeks previously with a background in hospice care. During the inspection the provider clarified the position of the responsible individual [who also has legal responsibilities with CQC] in the temporary absence of the previous appointee.

Some of the systems and processes to ensure the hospice was well led had lapsed following the absence of a registered manager at the home. Work to review and implement improvements to the governance of the service had only been recently introduced by the present manager [head of care] and included joint work with staff, senior colleagues and an externally appointed consultant.

People and their families told us that staff were kind and compassionate. People told us that staff were caring and listened to them. People we spoke with who received personal care felt the staff were knowledgeable, skilled and their care and support package met their needs not just in terms of physical care but also in relation to their emotional support. People using the day hospice spoke very highly of the complementary therapies that were available to both people who used the service and relatives. The hospice provided family support, counselling and bereavement support which people told us made a massive impact to their lives.

The staff undertook the management of medicines safely and in line with people's care plans. The service had health and safety related procedures, including systems for reporting and recording accidents and incidents. The care records we looked at included risk assessments, which had been completed to identify any risks associated with delivering the person's care and their environment. The hospice environment was maintained and there were regular checks on safety and equipment.

People were protected by the service's approach to safeguarding and whistle blowing. People who used the service told us that they were safe, could raise concerns if they needed to and were listened to by staff. Staff were able to describe how they ensured the welfare of vulnerable people was protected through the organisation's whistle blowing and safeguarding procedures.

Staff recruitment processes were followed with the appropriate checks being carried out. There were

sufficient staff on duty to meet people's needs and the service had a team of volunteers who provided additional support. The hospice had a bank of staff who they could contact if they needed additional staff.

The service had a care planning system that we saw recorded people's admission assessment and on-going plan of care. Care plans were personalised to include people's wishes and views. Care plans were regularly reviewed in a multi-disciplinary framework. We observed staff caring for patients in a way that respected their individual choices and beliefs. There was evidence of advance care planning and specific guidance 'Deciding Right' [a good practice initiative] was used to capture people's choices and planning for future anticipated emergencies. Staff knew people's preferences about treatment as they approached the end of life stages and these were recorded. However the service did not follow best practice because there was not a specific care plan for caring for patients in the last days of life. CQC recommended that the provider considers best practice in advanced care planning.

Staff and volunteers received a thorough induction and regular training to ensure they had the knowledge and skills to deliver high quality care. However, although staff told us they felt supported, arrangements for one to one supervision, appraisal and clinical supervision for qualified staff [nurses] had only recently been introduced by the manager [head of care].

Staff told us they were very supported by their management and could get help and support if they needed it at any time. Staff members told us they felt part of a team and were proud to work for the hospice.

People had choices about their care and their consent was sought by staff and their rights were being protected whilst at the hospice. However records of the assessment of people's mental capacity was insufficiently detailed in relation to the Mental Capacity Act 2005 [MCA]. CQC recommended that the registered provider improve the capacity assessment documentation so that judgements in line with the MCA could be demonstrated.

People were supported to receive a nutritious diet at the service. Their appetite was assessed through talking to them which led to the chefs being able to give the person the type and amount of food they would be able to eat. There was a choice of menu on the day we inspected and drinks and snacks were available at any time.

People were confident expressing any concerns to staff at the service and knew who to approach if they were not satisfied with the response.

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

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service was safe.

Checks of the building and equipment were completed to make sure it was safe.

Staff were knowledgeable and there were systems in place to protect people from the risk of harm and abuse.

Staffing numbers and skills mix were sufficient to provide a good level of care to keep people safe.

Robust recruitment procedures were in place to make sure staff were suitable to work with vulnerable adults.

### Is the service effective?

Good ●

The service was effective.

People's healthcare needs were monitored and discussed with people who used the service and their family members.

The service needed to improve its assessment process to demonstrate people had the mental capacity to make decisions.

Staff of all levels had access to on-going training to meet the needs of the people they supported.

### Is the service caring?

Good ●

The service was caring.

People told us that staff were kind and compassionate at all times and treated everyone with dignity and respect.

The service provided emotional support to people, their family and friends via a team of counsellors, nurses and healthcare staff on an ongoing basis.

People were supported spiritually. People were encouraged and supported to make decisions about their care and given time to make their own choices; this included their end of life care.

### Is the service responsive?

The service was responsive.

People told us they felt confident to express any concerns or complaints about the service they received.

People and their families were fully involved in assessing their needs and planning how their care should be given.

Staff delivered people's care in a person-centred way, treating them as individuals and encouraging them to make choices about their daily lives.

Good 

### Is the service well-led?

The service was not always well led.

Staff told us they felt supported by their colleagues but there was not an established programme for supervision and support.

The provider had very recently appointed a knowledgeable and experienced manager to lead the service.

Key areas of development were being planned for to safeguard current practice and implement improvements.

Requires Improvement 

# Willow Burn

## **Detailed findings**

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The provider was given 48 hours' notice because we did not wish to impact on the day to day running of the service and wanted to enable nursing staff to be available to speak with us.

On the day of the inspection there were three adult social care inspectors and a specialist advisor in end of life and palliative care who was a registered nurse.

Before the inspection we reviewed all the information we held about the service, this included notifications of significant changes or events. The registered provider had completed a provider information return [PIR] prior to the inspection in April 2016 and we updated this information with them during the course of the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

At the time of our inspection visit there were four people who used the in-patient service and there were 16 people using the day hospice facility. We spoke with two people using the in-patient service, two relatives and five people using the day hospice facility.

During the visits we spoke with nine staff, this included the head of care, human resources manager, the clinical governance and quality assurance advisor, the operations manager, the catering and housekeeping manager, three nurses and health care assistants.

Before the inspection we reviewed any information from people who had contacted us about the service since the last inspection. For example, people who wished to compliment or had information that they thought would be useful.

Before the inspection we reviewed information from the local safeguarding teams, local authority and health services commissioners in which the provider operated. Prior to the inspection we also contacted the

local Healthwatch. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work. Information given by these public bodies were used to inform the inspection process.

During the inspection we reviewed a range of records. This included four people's care records who used the hospice, including care planning documentation and medication records in both the in-patient and day hospice facility. We also looked at staff files, including staff recruitment and training records, records relating to the management of the hospice and a variety of policies and procedures developed and implemented by the registered provider.

## Is the service safe?

### Our findings

The people and relatives we spoke with confirmed the hospice was a safe place. Staff also felt the hospice was safe. One staff member said, "We are visible on the ward and regularly check patients' notes. Patients regularly tell us they feel safe here." Another staff member said, "We are a small staff group so people see the same faces. We know them by name so they feel safe." One senior staff member was the patient safety lead. They told us this involved them carrying out themed 'patient safety walk around.' For example, the last one had been based around improving communication. Actions identified included reorganising care plans and improvements to medicines records.

Staff showed a good understanding of safeguarding adults procedures, including how to report any concerns they had. They knew about various types of abuse and potential warning signs to look out for. For example, a person becoming withdrawn or being distressed after certain visits. Staff said they would report concerns straightaway. One staff member commented, "I would report concerns to the nurse in charge."

Staff knew about the provider's whistle blowing procedure. This is where staff are able to raise any concerns [tell someone] they have about how the service is being run to keep people safe. None of the staff we spoke with had needed to use the procedure whilst working at the hospice. One staff member told us, "Staff are willing to raise concerns, to challenge. We are a close knit team." Another staff member said, "Everyone would be confident to raise whatever concerns they have. I have known them for six years and I am sure."

We looked at two staff employment records which showed us that the provider operated a safe and effective recruitment system. The staff recruitment process included completion of an application form, a formal interview, previous employer reference and a Disclosure and Barring Service check [DBS]. The DBS check helps employers make safer recruiting decisions by identifying those who are unsuitable to work with vulnerable people. Checks of nursing qualifications had been carried out prior to nurses starting work and regularly thereafter, ensuring they were suitably qualified for their role. This showed the provider had taken steps to protect people using the hospice from unsuitable staff.

Through our observations and discussions with people and staff members, we found there were enough staff with the right experience and skills to meet the needs of the people who used the service. We reviewed duty rotas and spoke with the care team about staffing levels and shift patterns. All of the staff we spoke with during the inspection told us they thought there was sufficient staff on duty to meet people's needs. Staff told us everyone worked well together as a team. People and relatives said there were enough staff on duty. One person told us, "They are on the dot when I press [my buzzer]. They are there before I have taken my finger off the buzzer. They are always passing [my bedroom] backwards and forwards." One relative said, "If you ring the buzzer they are there straightaway." Staff confirmed staffing levels were appropriate. One staff member said, "I have never had issues with staffing levels." Another staff member commented, "Staffing levels are brilliant. Patients like us to sit and talk, we are not rushing all over the place." A third staff member told us, "Staffing levels are spot on."

The hospice was working with limited medical cover which was provided by the person's own G.P and 'out

of hours' medical cover. Nursing staff we spoke with told us the hospice was prioritised by GPs but acknowledged that the practicalities did mean there was sometimes a time delay in getting symptom control, for example at weekends. However, the hospice had just appointed a head of care who was an experienced palliative care nurse and was also a non-medical prescriber in relation to medicines. Non-medical prescribing is the prescribing of medicines, dressings and appliances by health professionals who are not doctors. This showed the provider had taken steps to improve their response to urgent changes in people's medical needs. Another nurse was undertaking their training to undertake non-medical prescribing. This showed the provider took actions to ensure the service changed and adapted to meet people's needs.

We looked at the way medicines were managed within the hospice. We found patients were protected against the risks associated with medicines because appropriate arrangements were in place to manage medicines. There were clear, comprehensive and up to date policies and procedures covering all aspects of medicines management.

The head of care was the 'Accountable Officer' for medicines management. The Accountable Officer is a person designated by the provider under The Controlled Drugs [Supervision of Management and Use] Regulations 2013 to ensure appropriate arrangements are in place for the secure and safe management of controlled drugs in the hospice. The head of care's dual role as a non-medical prescriber and the 'Accountable Officer' had been identified as a potential conflict of interest. The manager [head of care] had addressed this with a plan to liaise with a neighbouring hospice that will oversee and support Willow Burn. This showed the provider had considered circumstances where professional judgements needed to be verified or overseen by an independent practitioner.

Medical prescribing was provided by the patient's own GP or 'Out of Hours' medical provider. Regular and 'as required' oral medicines were prescribed and administered at the hospice. All patients using the hospice had a record of the medicines they were taking. Safe prescribing was observed to follow regional palliative care and end of life care best practice guidelines. Copies of these guidelines were readily available at the service and used by nursing and medical staff for reference purposes.

Some people preferred to administer their own medicines, which the hospice supported. A patient information leaflet which explained the process was available to each person. People had a locked cupboard in their individual rooms. On the day of the inspection one person was self-medicating some of their medicines using this system. Nursing staff administered medicines for other people as required. This showed people were encouraged to remain as independent as possible whilst ensuring their safety was promoted.

There were arrangements in place to ensure the consistent supply of medicines from two pharmacists. One supplier had regularly visited the hospice to assist with advice, stock checks and storage or return arrangements.

Homely remedies such as paracetamol and other 'over the counter' [OTC] medicines were administered by nurses with instruction from the GP, from telephone consultation or faxed instructions. There was a separate document called 'frequently prescribed medication' which listed the homely remedies that could be used. This document supported the administration of two doses. If further doses were required then a prescription would be sought and recorded on the Community Patient Medication Administration Record. This showed that the service could quickly respond to minor changes in a person's medication needs.

Some people had injectable anticipatory medication prescribed for all five core symptoms at end of life with

the addition of a prescription for sedation in the event of a serious medical incident. This was prescribed in line with Regional palliative care and end of life care guidelines.

Some people used specialist equipment such as a syringe driver to administer regular medicines automatically. We observed the procedure nursing staff used when administering the syringe driver for one person [with their permission.] Nursing staff demonstrated the use of a syringe driver checking document which recorded how this medication was used. This document was completed at four hourly intervals during the infusion period and demonstrated that nursing staff utilised safe medication practices.

We found suitable arrangements were in place for the storage of medicines to keep them safe and at the correct temperature. We saw additional measures were in place for controlled drugs. Controlled drugs are medicines which can be misused and are therefore subject to greater levels of oversight and security. We carried out a check of controlled drugs and found records were consistent and matched stocks present. This showed that the registered provider took steps to ensure the safe storage and administration of all medicines used at the Hospice.

There was also a system to receive and act upon national drug safety alerts which are produced by government to inform users and providers of care, of any issues relating to medicines or medical equipment.

Care records we looked at during the inspection contained a number of risk assessments specific to the needs of each person and records showed how there were assessed, managed and reviewed. Everyone who was admitted to the service was assessed by nursing staff using a comprehensive initial nursing assessment. The initial assessment was complemented by assessments covering a range of potential risks, such as poor nutrition, skin damage, moving and handling and falls. Although we did not find any omissions, it was not possible to identify any formal routine structure to indicate when staff should repeat these risk assessments. Where reassessments had taken place these tended to give a narrative description written into the paper records rather than a measurement [scoring] of identified issues which may be more difficult for staff to track and respond to changes in risks for that person. The manager [head of care] told us that changes to the ways risk assessments were carried out would be taking place as part of service development.

We met with the operations manager who oversaw the health and safety checks undertaken at the service. They had a robust system in place for the regular checks of fire safety equipment, such as fire doors and fire-fighting equipment. They also reviewed procedures such as fire drills to show any learning requirements from such events. Tests of the fire alarm were completed on a regular basis to make sure it was in safe working order. All fire zones within the hospice were tested and the service had an up to date fire risk assessment.

We looked at records which confirmed checks of the building and equipment were carried out to ensure health and safety. We saw documentation and certificates to show relevant checks had been carried out on the nurse call system, emergency lighting and gas and electrical safety. We saw records that showed water temperatures were taken regularly. We saw all water temperatures were within safe limits and Legionella checks were carried out by qualified contractors.

We saw checks in relation to moving and handling equipment under Lifting Operations and Lifting Equipment Regulations [LOLER] regulations had been carried out. People and staff were also protected by a plan to monitor infection control risks. This plan to cover health care acquired infections covered staff training, cleanliness audits, clinical governance, downtime deep cleaning and waste disposal measures. We met with one of the housekeeping staff who was knowledgeable about infection control procedures and

they explained their cleaning routines. This showed the service had procedures to keep people safe.

We looked at the arrangements in place for managing accidents and incidents and preventing the risk of reoccurrence. We found appropriate arrangements were in place to help avoid known risks and also learn from incidents should they occur. No significant incidents had occurred at the hospice.

## Is the service effective?

### Our findings

People told us skilled and experienced staff provided their care. One person commented, "The staff are more than experienced."

One staff member told us, "I feel very supported with the [manager] head of care. I have always felt supported. We are a very close team, we always help each other." Another staff member commented, "I am very, very supported." There were opportunities available for staff should they require any emotional support. One staff member said, "If we have a particularly difficult time there is the family support service and a counsellor."

The Mental Capacity Act 2005 [MCA] provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards [DoLS].

Staff we spoke with understood the importance of seeking consent before providing any care or support. One staff member commented, "We always ask them first. I always explain what I am going to do, families are usually there." Staff confirmed they would respect people's right to refuse. One staff member told us, "We have to respect their wishes. If it is part of their treatment we would mention to the staff nurse."

Individual care records indicated that attention was paid to making sure that people were supported to give consent and make decisions about their care and treatment if their conditions changed or deteriorated. We saw that people's treatment wishes were documented in their records. It was clearly recorded what people's end of life preferences and preferred place of care were and these decisions had been reviewed.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our visit, there had been no applications to place a restriction on a person's liberty. When people were first admitted to the hospice they were asked if they were happy to be cared for at the hospice. If staff had concerns about restricting people's liberty then they were to consider making a DoLS application and ensure appropriate support for decisions to be made in their best interests. There was a policy in place to enable staff to assess people's mental capacity, should there be concerns about their ability to make decisions for themselves, or to support those who lacked capacity to manage risk. However the assessment and care plan records we viewed was not detailed enough to describe the capacity assessment. The manager [head of care] told us that the assessment currently in place was to be improved so that the service was assured it was supporting people to make decisions, or to make decisions with them under the 'best interests' principle of the MCA. CQC recommended that the registered provider improve the capacity assessment documentation so that

judgements could be demonstrated in line with the MCA.

Staff told us about the training they had completed and we saw their training records which confirmed this. They had completed training in subjects which included moving and handling, advance care planning, syringe driver, fire safety, dementia, safeguarding and the MCA including DoLS.

The staff we spoke with demonstrated a sound knowledge base in specialist palliative care in keeping with roles and responsibilities and the service specification. The manager [head of care] had completed clinical skills training. People confirmed they had been visited by a range of health professionals whilst in the hospice. One person told us they had seen the heart nurse, the warfarin lead and the community nurses.

Staff understood the importance of seeking consent before providing any care or support. One staff member commented, "We always respect the patient's decision. We would never do anything without speaking with the patient."

People gave us positive feedback about the meals they received. One person told us, "For breakfast, I had what I requested. I came in on Wednesday and hadn't eaten for three days. They offered me eggs and bacon and mushrooms. I couldn't resist it and ate it all. I couldn't believe it." They went on to say, "If you don't want what is on the menu they will make you anything. You wouldn't get better service in a hotel." Another person commented, "The food is excellent. You can have what you like. There is a set meal for lunch. If it doesn't agree with you, you can have something else. All in all it is great." One relative said, "[My relative] drinks a lot. They will give an ice lolly as a change."

Food and nutritional needs were met with individualised care and evidence of care planning in the records we viewed. We had a discussion with the chef during the inspection. They told us a member of the catering staff visited everyone who was newly admitted on to the in-patient unit and discussed their likes and dislikes and any special dietary requirement. There was a menu in place for when the day hospice was running sessions as this provided a three course meal for people but otherwise people were given the choice of choosing the dishes they wanted to have. The chef had a good understanding of nutritional needs and had just completed an NVQ Level 3 in food and nutrition. The chef told us how they visited people on a daily basis and as such could 'cajole' and encourage people to try something different or to use a piece of equipment that may make eating or drinking easier. They told us; "I noticed a person struggling with their soup. I talked to them about trying it from a beaker and I would blend the soup. The next day they tried it and gave me a big thumbs up. I didn't want them to lose their dignity and it felt great."

The manager [head of care] told us they had addressed the need for good communication across the hospice as part of their on-going improvement work. Other nurses told us they felt the service could be improved through greater integration with the day hospice and the manager [head of care] who had been in post for six weeks had an improvement plan to address these and other issues such as care planning documentation.

The hospice ran a service three days a week at the day hospice which gave people a care plan to enable them to participate in a variety of therapeutic activities with qualified staff. Sessions include complementary therapies such as reiki and massage as well as sessions such as craft and exercise. The day hospice carried out a full nursing assessment of their needs and reviewed people at six and eleven weeks to support them for discharge. People were also invited in for a week to have some taster sessions to see if they wanted to use the hospice services.

## Is the service caring?

### Our findings

People and relatives gave us consistently good feedback about the care provided at the hospice. One person commented, "They have been great with me. Absolutely, I love it. I can't thank them enough for everything they do." Another person told us, "It is the best thing this place. I can't say enough about this place, it is so good." One relative said they were "very happy" with their relatives care.

The chef told us; "We are a great team here, I have some volunteers from the bereavement group help in the kitchen on a Friday, we laugh and cry together and I help people with little lessons about cooking and food preparation. This showed that staff right across the hospice shared the commitment to caring and compassion.

Kind and caring staff provided people's care. One person said, "Everybody is so friendly. I have never known such an organisation. It is 110% respect that you get from every member of staff, they can't do enough for you. They look after you; see to all your needs. The staff know me and I know them and that makes a difference. They get to know your idiosyncrasies." One relative said staff were "very considerate". They went on to say, "Staff are very caring, they look after [my relative's] dignity. They are exceptionally good. [My relative] likes the staff."

We observed staff interacting with people. This was warm and friendly but always professional. We also overheard staff having social conversations with people.

People were treated with dignity and respect. One relative told us, "My [relative's] personal care is looked after. They keep [my relative] nice and fresh. There is a lot of dignity. They look after the person. They have the interests of patients at heart." Staff gave us examples of how they provided care in a dignified and respectful way. They told us about how they had helped one person with an advanced medical condition affecting their mobility to have a bath. They said this was the person's request as they had been unable to have a bath at home. Staff told us they would tell the person everything they were going to do and always get their consent. Staff also said they would encourage the person to do as much for themselves as possible. For example, they would ask the person whether they wanted to wash their own hands and face when supporting them with washing.

People were in control of their own care. One person said, "I can't accept all the help at once. So they don't push me. I say can I leave it a little bit, they are fine with that." Another person commented, "You can please yourself what you do. If you want to stay in bed you can stay in bed. One relative told us, "We don't want anything done without consent. They have been that way. At each stage they have involved in any decisions."

Staff actively aimed to promote people's emotional wellbeing and social needs. One person told us, "They have offered me a place over there [day centre]. I have had my hands massaged, it really relaxed me. She [nurse] is going to do my neck next. It's that little bit extra care. Staff are always available to come and chat." One relative said, "They have the time for people. There is a lot of individual care and thought for each

person." They went on to tell us, "[My relative] has become content and she likes what she is getting. They have been excellent, they are here for us."

People had the opportunity to discuss their future care plans when they were admitted to the hospice. Staff told us advanced care plans were discussed with people, such as their preferred place and whether they wanted to be resuscitated or refuse treatment. The requests were documented into an advanced care plan.

Staff provided information for people openly and honestly. One person commented, "They explained everything to me. They were definitely there for me. They have put all the cards on the table. One relative told us, "If you ask a question, they always answer. They are very good with information."

Following a death in the hospice staff told us they would support relatives with contacting an undertaker. Relatives would be supported to take as much time as they needed to say goodbye before the person's body was moved. One staff member said, "We care for the family here. We are very keen on not letting the family leave until they are in a good place. There are lots of hugs and tears. It is always well received." Bereavement support was available to relatives should they require support following the death of a relative. The family support team visited on admission to discuss the support which could be offered. This included attending a monthly bereavement group. The provider had recently started a bereavement buddy group where people could make friends for life.

## Is the service responsive?

### Our findings

People and relatives knew how to complain. Nobody we spoke with had any concerns or complaints. One person commented, "Absolutely none [concerns], they are caring for you." One relative said, "We are happy, we wouldn't leave [my relative] in a place we weren't happy with."

When we visited the hospice we looked at individual's records to see how their care was planned, monitored and co-ordinated. Core care plans were in place to support individual plans of care for all patients. Core care plans were used to support people's care and managed with additional text descriptions to personalise the plans in line with their individual needs. Recognition of symptoms and management was evident in each person's records and these were supported by a specific symptom management pain assessment tool. This included a body chart identifying areas of pain, pain descriptors and 'Visual Analogue Scales' [to help define the pain] in the assessment.

We spoke with staff who told us every person who visited Willow Burn had a care plan. They described to us how people were cared for and showed us how this was written in their care plans. Staff all spoke about 'person centred care' being a priority where individual care is centred on the patient's wishes and choices. Evidence of people's care being managed around what was important to them, was evident.

The nurses we spoke with described their assessment technique which included methods to support each person to score and describe their pain and this matched the services documentation. There was also evidence that scoring was used to assess pain with people when intervention had been provided, such as when pain relief medicines were provided. However it was difficult to monitor the effectiveness of the intervention provided from the documentation. This had been recognised by the manager [head of care] through their own clinical governance processes that they needed to improve the recording of outcomes for people in relation to managing palliative care and so were undertaking planning and training in relation to implementing the use of a focused outcome measurement tool in the future in line with best practice.

Staff told us they discussed peoples' preferences with them about how they wanted their treatment to take place as they approached the end of life stages. We found these requests were known and recorded in people's care plans. Best practice such as 'The One Chance' guidance document incorporating the 'Five priorities for caring for the dying person' from the Leadership Alliance for the Care of Dying People' advises that specific focused care plans for caring for patients in the last days of life. CQC recommended that the provider considers best practice in advanced care planning.

We found that some people who used the service had a Do Not Attempt Cardiopulmonary Resuscitation [DNACPR] in place. Records showed the decisions were dated and approved by a lead clinician or GP [when DNACPR was initiated in the community] and on all of these there was a clearly documented reason for the decision recorded on the form with clinical information included. Although all lead staff knew which service users had a DNACPR in place these were located inside the paper based section of the care plan and could be difficult to find in if clarification was needed in an emergency. We did not find evidence that the DNACPR had been reviewed prior to admission to the service which could help to ensure that these remained up to

date and accurate. Staff told us that if people did not have a DNACPR form then they would respond to a cardiac arrest by attempting resuscitation and requesting emergency services via 999.

We saw that the service provided transition services for people's families to offer them a carers group, a bereavement support service and then on-going counselling if this was needed for people. This meant that families were supported by the hospice and its service right through the journey of supporting someone with a life limiting illness and through the grieving process by trained and professional staff.

## Is the service well-led?

### Our findings

Although staff told us they felt supported, there were no formal opportunities for staff to have one to one supervision and appraisal. We also found there was no clinical supervision taking place for qualified staff [nurses]. One staff member said, "There are no one to ones. Appraisals have now commenced. The plan is to have regular one to ones and appraisals. These are all to be done at the very latest by the end of August. There is no clinical supervision; we are going to develop RGN competencies." The manager [head of care] told us that arrangements for clinical and non-clinical supervision and staff appraisal had been a priority and improvement plans were being put in place as part of the hospices development.

This is a breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] 2014.

Relatives and staff described a good atmosphere in the hospice. One relative said, "As soon as we came in it felt homely straightaway. It just felt right." One staff member said, "There is something about this place. We try to give hope and comfort. There is a good, positive environment." Another staff member said the atmosphere was "so calm, friendly and peaceful".

There were opportunities for staff to give their views about the care provided at the hospice. One staff member said, "We have staff meetings once a week on a Monday. Suggestions are well received; they are open to any suggestions." They gave us an example of a change made to cover staff holidays following a suggestion from staff.

All staff we spoke with demonstrated a positive culture. They were all enthusiastic in their work at the hospice and they acknowledged that they were working with some changes and challenges which had extended over several months. However did not seem to detract from their care, compassion and determination to keep the focus of the patients at the centre of their work.

Staff told us the appointment of a manager [head of care] at Willow Burn recently has reinstated a level of support which was previously vacant. Staff told us they felt that senior management support was now easily accessible, visible and responsive to needs of staff at all levels.

The registered provider was also registered charity. The hospice was run by a board of trustees who were responsible for governance of the hospice. Their role was to ensure the charity functions within the law in accordance with the charity commission rules and also that the resources are managed efficiently. They met regularly to determine the strategic direction of the hospice and ensure policies and procedures were in place to manage risk.

The provider's responsible individual, who also has legal responsibilities to CQC, was unexpectedly temporarily absent from their position and likely to remain so for the short term. The provider subsequently took steps to appoint the chairperson of the Council of Management to the role of responsible individual in the interim so that assurances for the responsibility of the service could be demonstrated. We gave feedback

to the chairperson and representatives from the organisations management who gave assurances that the governance and leadership of the organisation was satisfactory.

When we visited the service we found that the provider had appointed a manager [head of care] six weeks earlier who was in the process of contacting CQC to begin the registration process. The manager [head of care] demonstrated that they had significant experience of palliative care and of managing hospice services and their skills were being used to organise and review the policies procedures and operation of the hospice. Throughout the inspection process the manager [head of care] demonstrated knowledge and skills which in a short space of time had impacted positively on progress at the service. The provider had also supported the manager [head of care] with the support [in the short term] of a part time consultant who also had significant experience in public healthcare and hospice provision.

The registered provider acknowledged that the lack of cohesive leadership over the past ten months had limited the services expected development in that time. The responsible individual told us that a programme of modernisation of the hospice service had been expected but in the absence of key personnel in the organisation this had not taken place.

The manager [head of care] had sought to review and update managements systems to ensure that the hospice was operated efficiently and safely. Measures to ensure that the quality and safety of services were monitored, assessed and improved were planned and some, for priority areas, had been put in place. However the manager [head of care] acknowledged that this process was not yet completed though management plans and timescales were in place.

The provider took steps to ensure that feedback from people using services and those who were important to them, was sought. This gave the provider an opportunity to ensure that the hospice was providing services in the ways that people who used the service wanted. The manager [head of care] told us that any comments which required actions to be taken were dealt with appropriately. Although no serious concerns were identified, the manager [head of care] and staff told us any errors or omissions were examined as a team in order prevent them reoccurring and also to look at ways for improvements to be made. This showed the provider had an honest and open culture which promoted transparency.

The manager [head of care] had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities and had also reported outcomes of significant events.

This section is primarily information for the provider

## Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance  Systems and processes to ensure staff received appropriate support were not in place at the hospice