St Julia's Hospice

Quality Report

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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

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Overall summary

St Julia's Hospice is operated by Cornwall Hospice Care Limited. The hospice provided care and treatment within nine inpatient beds. Cornwall Hospice Care Limited also provided a service at Mount Edgecumbe hospice which was located within St Austell.

The hospice provides care and treatment for patients with a life-limiting condition aged 18 years or over.

We inspected this service using our focussed inspection methodology. This unannounced inspection took place on 18 July 2018. We focussed on the safe and well-led domains following concerns raised to us. The concerns were in respect of staffing levels, staff training, low staff morale and allegations of bullying.

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.

Summary of findings

There was a registered manager in post, Dawn Tame-Battell. 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.

During the inspection visit, the team spoke with 12 members of staff, including registered nurses, health care assistants, consultants, occupational therapist, administration staff, hospitality staff, community engagement nurse, head of care, the clinical lead, the chief executive officer, the medical director and the registered manager. We also spoke with four patients to seek their views of the service provided. We reviewed five sets of patient records and relevant documents, including policies, procedures and meeting minutes.

The Care Quality Commission last inspected the service in May 2016 and rated the provider as outstanding overall. We have not re-rated the service at this inspection.

We regulate hospice services but we do not currently have a legal duty to rate them when they are inspected as a focussed inspection. We highlight good practice and issues service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- Staff were familiar with safeguarding processes which ensured patient safety and knew how to safeguard adults from abuse.
- Systems prevented and protected patients from healthcare-associated infections. The hospice environment was clean and hygienic in appearance.
- Systems to manage the environment and equipment kept patients safe.
- Patients were monitored for deterioration in their condition.
- Eligibility criteria ensured patients were suitable to be admitted to the hospice.
- Sufficient staff were available to provide care and treatment for patients at the time of the inspection.
- Patient records were well maintained and stored securely.
- External professionals had access to a 24-hour support and advice line from the hospice. Patients and their representatives were advised to telephone the hospice directly following their discharge. This enabled a system of support to patients following their discharge.
- The leadership structure within the organisation was clear and staff were aware who they reported to.
- Staff were familiar with the organisation's strategy, vision and values and were provided with the opportunity to be involved in the development of these.
- The executive team had taken action to address low morale and allegations of bullying through the provision of meetings and reintroduction of the staff.

We found areas of practice that require improvement:

- The system for monitoring staff training did not ensure all mandatory and additional training had been completed. Safeguarding children training was not provided and not all staff had completed safeguarding adults training. This included volunteers, clinical staff, board members and trustees. Training had not been provided to all staff who were required to investigate incidents.
- There had been an increased turnover of staff at the hospice and this had resulted in staff not being able to be released to complete mandatory training.
- The system for checking resuscitation equipment was not fully compliant with the organisation's policies as weekly checks were not consistently undertaken.
- Staffing levels were not assessed in relation to patient dependency. There was no tool for assessing how many staff were needed in relation to patient dependency levels. Filling shifts at short notice was challenging for the ward and impacted on the work being undertaken.
- The management of prescription pads (FP 10) did not ensure an audit trail of prescriptions used.

While staff reported incidents, learning was not currently shared between the provider's two hospices and there was no agreed standard used to assess the seriousness of an incident. Medicine errors were investigated and appropriate action taken, but this learning was not shared across the organisation.

Summary of findings

- Staff were not familiar with relevant national guidance and recommendations to ensure they were providing up to date care and treatment.
- The board of executives and trustees were not always accessible to staff. The organisation was aware of this and had taken measures to address this.

Following this inspection, we told the provider it must take some actions to comply with the regulations and it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals (South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospices for adults		The hospice provided care and treatment to patients 18 years and older with a life limiting condition. The hospice was managed by Cornwall Hospice Care Limited who also provided services at a hospice located in St Austell. Staff were mainly based at this hospice but could work across both sites when required. We regulate hospice services but we do not currently have a legal duty to **rate** them when they are inspected as a focussed inspection. We highlight good practice and issues service providers need to improve and take regulatory action as necessary. We inspected the safe and well led domains as part of this focussed inspection.

Summary of findings

Contents

St Julia's Hospice

Services we looked at
Hospices for adults;

Summary of this inspection

Background to St Julia's Hospice

St Julia's Hospice is operated by Cornwall Hospice Care Limited. The service became part of Cornwall Hospice care in 2005. The hospice primarily serves the communities of Cornwall and provides inpatient services to people who are living with a life-limiting condition. It also accepts patient referrals from outside this area.

The current registered manager has been in post since 2015.

The hospice is also developing community services within neighbourhood hubs.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and a specialist advisor with expertise in palliative and end of life care. The inspection team was overseen by Mary Cridge, Head of Hospital Inspections.

Information about St Julia's Hospice

The hospice has one ward and is registered to provide the following regulated activity:

- Treatment of disease, disorder or injury.

During the inspection we visited the ward. We spoke with twelve members of staff including; registered nurses, health care assistants, hospitality staff, occupational therapist, administration staff, hospitality staff, community engagement nurse, head of care, the clinical lead, the chief executive officer, the medical director and the registered manager. We spoke with four patients to seek their views of the service they received. During our inspection, we reviewed five sets of patient records.

the team spoke with 12 members of staff, including registered nurses, health care assistants, consultants, occupational therapist, administration staff, hospitality staff, community engagement nurse, head of care, the clinical lead, the chief executive officer, the medical director and the registered manager.

There were no special reviews or investigations of the hospice ongoing by the CQC at any time during the 12 months before this inspection. The service was last inspected in 2016 when it was rated as outstanding.

Activity (April 2017 to April 2018)

- 165 inpatient episodes of care were recorded at St Julia's Hospice.
- The average length of stay for patients at the hospice was 14 days, with 35% of patients being discharged to a home environment and 65% who died at the hospice.
- There were 53 outpatient total attendances in the reporting period; we did not inspect outpatient clinics at this inspection. There were 794 appointments with the lymphoedema specialist service. There were 86 patients who attended for care and treatment as day cases.

Track record on safety

- No never events
- Clinical incidents: 36 no or low harm and six moderate harm incidents were reported. No severe harm or deaths reported.
- No serious injuries.
- No incidences of hospice acquired Meticillin-resistant Staphylococcus aureus (MRSA). Meticillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (C.diff) or E-Coli
- One complaint.

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?

We regulate hospice services but we do not currently have a legal duty to rate them when they are inspected as a focussed inspection. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

- A system of annual mandatory training was provided for staff to ensure they were suitably skilled for their jobs.
- Staff were familiar with safeguarding processes to ensure patient safety and knew how to safeguard adults from abuse.
- Systems prevented and protected patients from health associated infections.
- Systems to manage the environment and equipment kept patients safe.
- Patients were monitored for deterioration in their condition.
- Staffing was managed to ensure sufficient staff were available.
- Patient records were well maintained and stored securely.
- Incidents were recorded and reviewed to provide learning and prevent reoccurrence.

However:

- Safeguarding children training was not provided and not all staff had completed safeguarding adults training.
- We saw weekly checks of resuscitation equipment were not consistently completed.
- Staffing levels were not assessed or related to patient dependency. Filling shifts at short notice was challenging for the ward and impacted on the work being undertaken.
- The management of prescription pads (FP 10) was not managed to ensure an audit trail of prescriptions used to minimise misuse
- The findings from investigations into reported incidents was not widely shared across the organisation to improve practice.

Are services effective?

We did not inspect this domain as part of the focussed inspection.

Are services caring?

We did not inspect this domain as part of the focussed inspection.

Are services responsive?

We did not inspect this domain as part of the focussed inspection.

Summary of this inspection

Are services well-led?

We regulate hospice services but we do not currently have a legal duty to rate them when they are inspected as a focussed inspection. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

- The leadership structure within the organisation was clear and staff were aware of who they reported to.
- Staff were familiar with the organisation's strategy, vision and values and were provided with the opportunity to be involved in the development of these.
- The executive team had taken action to address low morale and allegations of bullying with the provision of meetings and the reintroduction of the staff forum.
- The organisation had taken steps to improve the accessibility of trustees and executives to staff. Increased numbers of visits to clinical areas were being made and additional staff meetings were held.

Hospices for adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are long term conditions safe?

- A system of annual mandatory training was established for all staff.
- Staff were familiar with safeguarding systems and processes and knew how to safeguard adults from abuse.

Systems protected patients from, and prevented, healthcare-associated infections.

- Systems to manage the environment and equipment kept patients safe.
- Patients were monitored for deterioration in their condition.
- At the time of our inspection, staff were available in sufficient numbers to provide care and treatment to patients who were admitted to the ward.
- Patient records were well-maintained and stored securely.

Incidents were recorded and reviewed to provide learning and prevent reoccurrence.

However:

- Not all staff had completed the required mandatory training. Safeguarding children training was not provided and not all staff had completed safeguarding adults training.
- We saw weekly checks of resuscitation equipment were not consistently completed.
- Staffing levels were not assessed or related to patient dependency. Filling shifts at short notice was challenging for the ward and impacted on the admission of new patients.
- Prescription pads (FP 10) were not well-managed to ensure an audit trail of prescriptions used to minimise misuse

Mandatory training

- Staff undertook annual mandatory training to ensure they remained suitably skilled for their job. Staff were alerted when training was due to ensure they remained updated. Mandatory training included immediate life support, fire safety, moving and handling, infection prevention, safeguarding vulnerable adults, information governance and Mental Capacity Act and Deprivation of Liberty Safeguards. The mandatory training did not include any training for those living with dementia or learning disability, despite staff sometimes caring for patients living with these conditions. While not part of the mandatory package, training to support patients with mental health needs was provided
- The education lead confirmed some mandatory training had not been completed due to staffing issues. The provider had a mandatory training target of 80%. Mandatory training compliance was 83% overall.
- Staff had link roles to develop their learning and be a point of reference for other staff. These link roles included infection control and safeguarding. Link roles enabled nurses to undertake extended learning and access resources to cascade to other staff on the ward. When staff left and the link training for that specific area was not available, the training was sourced externally. For example, glucometer training (a device for measuring blood sugar) was available from the local hospital trust.
- Staff undertook an induction when starting work to ensure they had the needed to do their job. Staff confirmed the induction followed a booklet format which identified each area of familiarisation required, which was signed off as completed and competent. Staff told us they thought the induction was sufficient preparation for their employment.

Safeguarding

- Safeguarding processes ensured patient safety. The director of patient services was the safeguarding lead

for the service. A safeguarding adult policy and flowchart were available in the ward office. This detailed the actions to be taken and who to contact if there were adult safeguarding issues. No safeguarding alerts had been raised since the last inspection in 2016. Staff told us when they had safeguarding concerns they first discussed them with the nurse in charge and the head of care. Any alerts were made to the local authority and the flowchart would be used to ensure the process was correctly followed. Staff we spoke with confirmed they had completed the training and they had sufficient knowledge and confidence to raise a concern if needed.

- Not all staff had completed adult safeguarding training. Of the 68 staff employed, 36 had completed level two safeguarding training for adults as part of their induction and ongoing mandatory training in 2017. Of the 68 staff, 11 had not received any safeguarding training. This included nurses, doctors, administration and housekeeping staff.
- Safeguarding children training was not provided. Children could visit the hospice for extended periods of time and stay overnight. Staff were not trained to recognise or report safeguarding concerns in children.
- Female genital mutilation (FGM) was included as part of the safeguarding training. Staff confirmed training to recognise sexual exploitation had also been provided.
- There was no specific chaperone training provided. Staff told us patients could request a chaperone and staff would provide one.

Cleanliness, infection control and hygiene

- Systems protected patients from, and prevented, healthcare-associated infections. Staff could access the infection prevention and control policy on line. The head of care was the lead for infection prevention and control for the hospice.
- Good standards of hygiene were maintained. Housekeeping staff were clear in their responsibilities and there were procedures to reduce the risk of cross-infection. The housekeeping staff explained they cleaned all areas, but did not clean up bodily fluids that had been spilled: nursing staff cleaned up bodily fluids. The flooring used enabled staff to carry out appropriate cleaning to maintain a suitable level of hygiene and reduce the risk of cross infection. We saw completed cleaning rotas and we observed housekeeping staff working throughout the day.
- Clinical waste disposal systems were used which included sharps bins for the safe disposal of used needles and other equipment.
- There were staff vacancies in the housekeeping department with shifts being covered by current staff.
- Personal protective equipment was available to all staff and visitors. We saw staff wore the protective aprons and gloves when needed.
- Staff were bare below the elbow to ensure they could thoroughly clean their arms, wrists and hands, and to reduce the risk of cross-infection. Alcohol hand gel was available outside each room and we observed staff used this regularly. Handwashing facilities were available to staff, patients and visitors to the ward.
- Hand hygiene audits were completed quarterly and scored between 96% and 100%. Audits were completed across the ward, and included observation of a range of staff.
- There were effective arrangements for patients who had died. Systems ensured these patients left the hospice in a timely and dignified way and any risks of cross-infection were appropriately managed.
- Mandatory training for infection control showed eight staff had not updated since 2016 and eight staff had not completed any training. These staff included medical staff. This meant not all staff were fully trained within their roles to deliver safe care and treatment to patients.

Environment and equipment

- Systems for managing the environment and equipment kept patients safe. We saw maintenance staff working to repair faults. Staff confirmed there was an ongoing maintenance plan and any areas of repair needing immediate attention were addressed promptly. The environment looked well maintained and met the needs of the patients.
- Medical equipment was checked and serviced in line with manufacturers' guidance. Syringe drivers were serviced annually and when needed. All portable electrical equipment had been serviced and tested within the last year. Daily equipment safety checks were undertaken in line with local policies. These included checks of resuscitation equipment and blood monitoring equipment. However, the weekly checks of resuscitation equipment were not completed

consistently and we observed several gaps in this checking process. Staff told us this was because the weekly check was undertaken by the night staff who were often too busy to complete the checks.

- Each room was pleasant and comfortable and had bathroom facilities. A larger bathroom was available with a jacuzzi bath and hoists to enable all patients to have a bath if desired. Each room had TV facilities and a further day room was available should patients want company. All patients had access to a free guest internet service.
- Call bells were accessible for patients to alert staff. When used the call bells alerted staff to a panel to indicate which room was raising a call. When staff were working in the rooms with the door closed, they used the call bell, to summons other staff members if they required assistance.
- Rooms had piped oxygen. Cylinders were also available as a back-up supply or to allow patients to move areas. Cylinders were stored securely and correctly in all areas and there was an external secure store.
- There were no specific rooms for patients with any patients living with mental health issues or dementia. However, there was a dementia link nurse who could provide further support to staff and staff confirmed anybody with additional needs would be placed in a room nearest the office to allow extra observation and reassurance.
- Hoists were available for the safe moving and handling of patients. We saw that when not in use they were cleaned and stored safely. Staff told us they had a good relationship with the local equipment loan store and could access equipment quickly and easily. They gave an example of a recent patient discharge and the loan store had the equipment at the patient's home within three hours.
- Rooms accessible to staff by a secure key pad entry. For example, the rooms which held medicines and cleaning equipment were secured to prevent patient harm.

Assessing and responding to patient risk

- Patients were monitored for deterioration in their condition. Written records following care rounds had recently been implemented to provide assurances of the care provided and included an assessment tool, used to calculate how often the nurses would visit the patient as a matter of routine. During those visits they would ask about the patient's level of pain, changes of position to maintain skin integrity, help with fluids, and ensure a call bell was in reach. The staff could reassess at any time and change the timescale in line with the patient's needs. We observed that care records reflected the timescales recorded.
- Review processes ensured patients were suitable for treatment at this location. A 24-hour advice line was available, which was staffed by a non-medical team member or member of the nursing staff team. The advice line was the single point of access for referrals from the local trust and GP's. The staff member gathered information and requested support as needed from hospice medical staff. In some cases, this prevented admissions and other appropriate action was implemented. In other cases, it enabled admissions to take place quickly and easily.
- Resuscitation processes were clear for staff and training had been provided.
- Falls were monitored and showed a small increase between May and June 2018, with three falls recorded. There had been a total of 25 falls since August 2017.
- Pressure area care was assessed and monitored to prevent skin damage. Pressure area care assessments were completed and appropriate plans put in place to reduce the risk of skin deterioration. Pressure-relieving equipment was available and mobilisation was supported for patients where appropriate. Any assistance needed to change position in bed was provided. There had been 16 pressure injuries reported and investigated since August 2017. The majority of these injuries had been sustained prior to admission to the hospice.

Nurse staffing

- Patient numbers were managed to ensure sufficient staff were available. Although the hospice had 12 beds, there were only enough staff for eight beds. Three registered nurses and two health care assistants worked each morning and two registered nurses and two health care assistants in the afternoon. Overnight there were two registered nurses and one health care assistant. Patient admissions were reliant on staff numbers and there was a limited capacity to provide extra staff.
- There were several posts not covered due to long-term sickness. Filling shifts at short notice was challenging for the ward and impacted on the work being undertaken.

While the service had access to bank and agency staff to cover shifts as and when required, the specialist nature of the service meant the numbers of bank staff were limited and restricted the use of some agency staff.

- Staffing levels were not assessed in relation to patient dependency. A number of staff told us staffing levels were set historically and had not been reviewed. The registered manager told us a staffing review had taken place in 2015 using the Royal College of Nursing's (RCN) staffing tool. This information had been combined with the registered manager's experience. There was no tool used to assess how many staff were needed in relation to patient dependency levels. Senior staff confirmed that should a patient being considered for admission have complex needs which could not be met by current staffing levels they would not be admitted.
- The skill mix on the ward on the day of our inspection did not ensure experienced staff familiar with the service were working together. Of the four staff on the ward, three had been employed for less than six weeks. The two health care assistants were on induction. The third member of staff on shift was absent for the morning at the multi-disciplinary meeting. The clinical lead was working at the hospice and was able to offer staff support when needed.
- Staff turnover was varied. We saw nine nursing and health care assistants had left since September 2017. Prior to this the staff team had remained a stable and experienced team.
- The hospice had a bank of staff who were available on an 'as and when' basis. Should those staff not be available the hospice would use agency staff. Since August 2017 there had been 716 hours covered by agency staff and 777 hours covered by bank staff. Bank and agency staff had received an induction and every effort was made to ensure that a consistent group of staff were used. There were limited numbers of agency staff who worked at the hospice due to the specialist nature of the work.
- Staff sickness was 4% over the hospice and the sister hospice.
- There were full time vacancies for therapy staff. Until recruitment was completed, staff from another hospice were supporting St Julia's. Therapy staff attended the multidisciplinary meetings and worked with nursing and medical staff to provide person-centred care.

Medical staffing

- Medical staffing was provided 24-hours a day with a 'consultant of the day' rota. Staff confirmed there were sufficient medical staff to meet patient's needs. Since April 2018 the hospice had been working with the local acute trust to transfer and care for patients across the two locations. This meant a consultant was on-call who had input into the two services. There were five consultants in the rota. There was a consultant available each day who covered both hospices, community patients, completed a ward round and responded to the advice line queries when required. They were able to delegate some tasks to two middle grade doctors. The consultant was not always available in the hospice but was on-call to support the middle grade doctors.
- Medical staffing was provided 24 hours a day with a 'consultant of the day' rota. St Julia's Hospice has two speciality doctors working as a whole time equivalent working for the five weekdays supported by a GP registrar. There was three routine consultant ward rounds in the working week and access to the consultant of the day at other times. Staff confirmed there was sufficient medical staff to meet the patient's need. Since April 2018 the four consultants employed by Cornwall Hospice Care had been working as an integrated team with the consultant from the hospital trust. This ensured a 1in 5 consultant rota. This meant a consultant was on-call and had input in the two services
- The middle grade doctors included doctors training in general practice or doctors from the local acute trust. These doctors were also available to see patients, liaise with local general practice doctors and respond to questions from the helpline.
- The medical staff were supported by the clinical director who was also a consultant on the rota.

Records

- Patient records were well-maintained and stored securely. Each patient had two sets of records; medical records, including results from investigations, and the ongoing doctor and nurses' records. These were stored securely in a locked cupboard with access restricted to medical and nursing staff. The ongoing monitoring records were kept with the patient to enable staff to review and record observations.
- Records we reviewed during the inspection provided an audit trail of the care provided. We reviewed five sets of records and found them complete and readable.

Records reflected the person's specific requests and included details of spiritual care. We saw records focussed being on what the patient could do, not what they could not.

- However, not all nursing records had been written clearly and completed as required. Audits of the nursing records had taken place across the two hospice locations in April and May 2017, looking at 10 sets of patient records. Results showed only 50% had been written clearly, only 60% were dated and only 50% were dated and timed. Recommendations were made and a re-audit planned for six months later. There was no record to show this had been undertaken. There was no action plan, no corresponding addition to the risk register and no system to monitor the progress needed. Therefore, while the records we reviewed were complete this did not ensure that the organisation had assurance all records would be.
- There was no clear audit trail of changes made as a result of the records audit. Medical records were audited in December 2017 and January 2018 and results varied. While 80% were written clearly, only 50% were signed and only 20% had alterations dated, timed and signed. There was no action plan, no corresponding addition to the risk register and no system to monitor to follow the progress needed.
- Records did not leave the hospice and were stored and archived securely. Discharge letters were used to inform the patient's GP and care services in the community of the care each patient needed on discharge. A copy of that letter remained in the patient's record. The only record which left the hospice was the patient's treatment escalation plan, which identified the patient's requests for care and treatment. All patient notes were identified during transport by use of an orange bag.
- Electronic record systems did not communicate effectively to the electronic systems in the community and local trust. Any exchange of information from the electronic system had to be managed verbally and in written form which provided a risk that information could be missed.

Medicines

- The hospice had systems to manage inpatient medicines safely. Policies were available for general medicines and controlled drugs. These policies were due for review in April 2018, but a review had not been completed. This meant there was a risk that staff were provided with out of date guidance.
- Medicines were prescribed on prescription and administration charts. Allergies were recorded in the patient care record and on patients' individual drug charts.
- Stock medicines were monitored to ensure there were enough available and ordering processes were clear. Night staff ordered the required stock, which was delivered the following day.
- Medicines were stored correctly. Patients each had a box by their beds and all routine medicines were dispensed from there. Controlled drugs were appropriately stored in line with legislation. We saw the temperature of areas used to store medicines was recorded, and was within safe limits. Parenteral fluids were stored correctly and appropriately monitored for temperature and expiry.
- Pharmacy support was available and stock levels and prescription reviews by two pharmacy staff took place each week. Any areas of risk or note were recorded on the prescription chart and amended by the doctor. The pharmacist attended the multidisciplinary meetings to ensure medicine changes were correctly managed.
- Administration of medicines and intravenous fluids to patients was managed safely. All intravenous fluids, medicines and syringe drivers were checked and administered by two registered nurses. Staff told us sometimes patients had to wait to be assisted because of the amount of medicines needing two staff to administer. Staff provided reassurance that in these instances pain relief remained a priority. This did not omit the risk of patients waiting for their medicine. On the day of our inspection, five patients had syringe drivers which needed changing by two nurses. The entire process of checking, administering and disposal could take approximately 40 minutes in each case.
- There were no extra considerations around staffing levels when these medicine changes were needed overnight. This meant potentially the two trained nurses would be occupied for extended periods while the health care assistant was alone on the ward. The systems would not enable the trained staff to know where the health care assistant was. All patients were cared for in side rooms and should the health care

assistant not be able to summons help in an emergency the registered nurses would not know which patient they were with. However, no incidents had been recorded as a result of these arrangements.

- Disposal of medicines was managed safely. All medicines were kept for seven days after discharge and then disposed of by the pharmacist. Controlled drugs were neutralised correctly before disposal. Destruction records were well maintained. The director of patient services was the accountable officer for controlled drugs and had overall responsibility for ensuring appropriate destruction of controlled drugs. Staff explained a safe disposal process.
- The management of prescription pads (FP 10) was not well managed. This meant there was no audit trail of the prescriptions used and potential for misuse There was a system to record the serial number but the prescription pads were not monitored so it would not be possible to identify if any were missing. We immediately alerted the head of care to this who amended the system to reduce the risk.
- Training was provided for staff for specialist medicine administration. Not all trained staff had the required competences to administer chemotherapy. Should this be required the duty rota was changed to ensure appropriate staff were on duty.
- All trained staff had undertaken syringe driver competence training and were updated annually. Staff also received anaphylaxis (severe allergic reaction) training to enable them to recognise and respond appropriately to any allergic reactions. When new staff started at the hospice, unless written evidence of competence in all areas of medicine management was available full competence assessments were undertaken.
- Any medicine errors were investigated and learning fed back to staff through safety alerts. All errors, including omissions, were recorded and audited so learning could be spread to all staff. However, this learning was not shared with the other hospice in the group. Since August 2017 there were 17 recorded medicines errors, all of which had been investigated and had appropriate action taken to prevent reoccurrence.
- The hospice had a blood transfusion policy and provided training for staff for the issuing of blood. Staff were fully aware of how to manage the process safely and described the process to us.
- Medicines on discharge were well-managed to ensure patients had what they needed. Each patient was given a yellow card on discharge which listed all their medicines and any instructions needed. Staff took time with the patient prior to discharge to go through the card and explain all the medicines and how to take them.

Incidents

- Incidents were recorded and reviewed to provide learning and prevent reoccurrence. Incident reports were handwritten and included a check sheet to enable auditing. This was a new system recently implemented. However, learning was not shared across both hospices in the county which meant the incident could occur again. An overview of incidents was discussed at clinical meetings.
- Staff were encouraged to report incidents. This included if working below what was considered standard staffing levels. Staff told us that at times they worked below the staffing establishment. However, we checked the incident reports and did not see that this had been reported. This did not provide a clear audit of the staffing levels to lead to improvements.
- Incidents were not consistently managed. An incident policy was available and the policy identified the level of investigation depending on the level of the incident. However, the severity level of the incident was not assessed or recorded so it was difficult to identify the appropriate response. This meant themes and trends could not be identified and used to improve the service.
- Incident investigations were overseen by the head of care with investigations being delegated to the appropriate head of department. The head of department was responsible for completing the investigation and putting together a response. The head of care then reviewed all responses. Training had not been provided for all staff involved in incident investigation. This meant there was a risk of inconsistent investigation and outcomes
- From April 2017 to April 2018 there were 58 incidents reported, of which 25 were falls, 16 were pressure damage and seven were medicines issues.
- In the last 12 months there had been no never events. Never events are serious incidents that are entirely

preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Staff had a clear understanding of the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and 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.

Are long term conditions effective?
(for example, treatment is effective)

We did not inspect this domain as part of the focussed inspection.

Are long term conditions caring?

We did not inspect this domain as part of the focussed inspection.

Are long term conditions responsive to people's needs?
(for example, to feedback?)

We did not inspect this domain as part of the focussed inspection.

Are long term conditions well-led?

- External professionals had access to a 24-hour support and advice line from the hospice.
- The leadership structure within the organisation was clear and staff were aware of who they reported to.
- Staff were familiar with the organisation's strategy, vision and values and were provided with the opportunity to be involved in the development of these.
- The executive team had acted to address low morale and allegations of bullying with the provision of meetings and the reintroduction of the staff forum.
- The organisation had taken steps to improve the accessibility of trustees and executives to staff. Increased numbers of visits to clinical areas were being made and additional staff meetings were held.

Leadership

- The Chief Executive Officer (CEO) held day-to-day responsibility for running the organisation and had been in post since 2005. The executive board was comprised of the CEO, medical director, director of patient services (who is the registered manager), the director of HR and director of finance. They were supported by the board of trustees who included people from both clinical and business backgrounds.
- The CEO stated they spent two days at St Julia's Hospice each month. The registered manager worked at St Julia's at least one day a week. Their offices were located in the organisations' other hospice in St Austell. The medical director had an office at St Julia's Hospice and was therefore more accessible to staff. The board meetings alternated between the two hospices which provided opportunities for the clinical staff to meet with the executive team.
- Staff commented they did not often see members of the board at the hospice. This had been reported to senior staff and as a result, following the board meeting held at St Julia's, members of the executive team and the trustees visited the clinical areas to give staff the opportunity to speak with them and raise any concerns they may have. An open-door forum was due to commence at the end of July 2018. Members of the executive team told us this would consist of a rota, which would identify times when the team would make themselves available for staff to raise or discuss any issues, concerns or changes within the services.

Vision and strategy

- The organisation had a strategy in place which had been developed by the board following discussions between executives and trustees. The strategy had been implemented to develop services to enable more people to access them in line with national recommendations and developments in hospice care. This had resulted in the development and implementation of neighbourhood hubs. The aim was to make clinics and services for advice and support within local communities more accessible. There was a neighbourhood hub located in the west of the county, which linked with St Julia's hospice. There were plans to develop further hubs to reduce the travelling times for patients requiring advice and support.

- Information regarding the strategy, including the implementation and development, was shared with heads of departments at monthly meetings. There was an expectation the information would be cascaded to all staff following these meetings. Staff views of the strategy had been sought, but the senior management team reported this had been minimal and considered this was because staff were aware of the strategy and forthcoming changes.
- A series of workshops had been held by an external consultant to develop the organisation's vision and mission statement. Three workshops were held for different roles of staff: senior leadership team, trustees and the staff. The chief executive told us each workshop group had held the same values and therefore the final vision, values and missions were unanimously agreed by all staff.

Culture

- There was a culture of low morale and concerns about bullying in the hospice. Before our inspection we received concerns regarding the leadership, low staff morale and bullying of staff. During the inspection we found evidence which partly supported these issues. Staff spoke of low morale and said they had concerns in approaching senior leaders with these issues and had fears about reprisal. Documentation also supported this, for example staff appraisal forms.
- The executive board were aware of the unhappiness amongst staff, which they said had started following the development of neighbourhood hubs. As a result, a series of meetings known as 'Let's talk' workshops had been held. This had helped to familiarise staff with the board of executives and trustees and provided an opportunity for questions to be asked. The workshops were due to be reintroduced in autumn 2018 led by all senior managers, members of the board and trustees.
- A staff survey had been carried out in 2018 and had identified that while staff were proud to work for the organisation there was also a feeling of low staff morale. The staff survey was the first survey carried out by the organisation and there were plans to repeat it in 2020. The CEO and registered manager explained this was to allow sufficient time to elapse to enable actions and workstreams to embed before repeating the survey. There were no plans to carry out an interim survey.
- Members of the executive team said they were proud of the organisation and the work carried out by the staff. However, they acknowledged staff morale and unhappiness was a concern within the organisation.
- All staff we spoke with acknowledged there had been a period of change and this had been difficult for some members of staff. Some members of staff told us it was difficult to approach the registered manager with concerns as they did not feel listened to and at times were intimidated. This aligned with information we received prior to and after our inspection. One person also said it was difficult to discuss issues with the head of care. However, these were not the views held by all staff and positive comments were also received about the middle and senior management team. There had also been a number of senior nursing and therapy staff who had left the organisation. This had left some staff feeling vulnerable due to the loss of experience. Many staff we spoke with were positive about the changes and how the service was developing.
- The staff forum had been re-started and representatives were available from different areas of the organisation to take issues from staff to meetings for discussion. We were told staff wanting to raise issues were not able to do this anonymously and some staff said they would not feel confident raising concerns as a result.
- Staff had access to occupational health for emotional support when necessary. We were told that following the death of a patient staff accessed the service for bereavement support should they require this. Staff could also access counselling through this service.
- We reviewed the annual appraisals for 10 members of staff. Three out of the 10 members of staff had identified low morale among their colleagues. Reasons offered for the low morale included changes taking place within working practices without clear rationale of why the change was required and a lack of training and opportunities for staff. The appraisal records showed two members of staff had requested training for two years in succession but this had not been provided. We discussed these issues with three members of the executive team who acknowledged the concerns. The training programmes were being reviewed and developed

Governance

- The organisation had governance systems to assess the quality of the service delivered. The medical director

and director of patient services both have responsibility for clinical governance within the organisation at executive level. In this role they attended the monthly information governance committee and clinical governance meetings. They also provided feedback to the executive team from these meetings.

- The monthly clinical governance meetings reviewed incidents including any falls, pressure damage and infection control issues. Data collected from the clinical service meeting held every three months was shared with the clinical governance committee and local commissioners of care. The clinical service meeting was led by a subcommittee of trustees and clinical issues were reviewed and escalated when necessary.
- The executive board and trustees were provided with assurance about safe staffing levels by the clinical governance committee. A staffing review had taken place by the registered manager six months prior to the inspection. We requested but were not provided with the written record of this but were told by the registered manager the review had used a national tool to assess the staffing requirements. Additional staffing was sourced if staff highlighted patient dependency had increased. This was achieved either by hiring agency staff or by permanent staff undertaking additional shifts. However, there was no formal system for assessing or reporting increased patient care needs.
- The organisation undertook audits to ensure outcomes for patients were positive. The audits were either completed annually, such as infection prevention and control and completion of medical records, or as a response to an identified need. A recent audit had been undertaken as there had been concerns treatment escalation plans (TEP) had not been completed fully or in sufficient detail. Following the audit, staff had been provided with an action plan in which they were reminded of their responsibilities when completing the TEP. This had improved consistency in countersigning the forms. Another audit had been completed following a change in protocol for the use of antibiotics, which was led by the local acute hospice to ensure staff were complying with the new protocol.
- The organisation ensured staff were recruited through robust procedures. Qualifications and character checks were undertaken, with records held in individual personnel files. Applicants were required to sign a declaration regarding the Rehabilitation of Offenders Act and complete a Disclosure and Barring Service check to ensure they were suitable to work with vulnerable adults. Professional registration checks were made to ensure registered nurses and medical staff were suitable for ongoing employment. We reviewed five sets of recruitment records for staff working at St Julia's Hospice. These showed systems had been followed when recruiting the staff members and appropriate checks made to ensure the suitability of the person to work with vulnerable adults. We also saw annual checks of the professional registration status of registered nurses working on the ward.
- Annual appraisals were provided for all staff. Records showed these were up to date and provided staff with the opportunity to raise any ongoing work or training issues. There had been issues raised regarding training required by staff but it was not clear this had been addressed and was raised again at the following year's appraisal. The action plans in place did not appear to be reviewed between appraisals.
- The organisation had received one formal complaint in the past year. This had been investigated thoroughly. The complaints process ensured complaints were investigated thoroughly and escalated to senior managers and/or board directors as required.
- Staff had been provided with the current Ambitions for Palliative and End of Life Care document. This is a national framework for local action between 2015 and 2020. Staff were not aware of the document and the education lead confirmed she believed some staff had not read it. This meant there was a risk staff would not be following current good practice recommendations.

Managing risks, issues and performance

- The organisation had systems to manage risk and monitor performance.
- There was a local risk register for the ward but this did not include risks regarding equipment or environment risk. However, there was an ongoing workstream reviewing and developing the risk registers to ensure they accurately reflected all identified risks.
- Consideration had been given prior to opening additional beds in the hospice to ensure that it was safe to admit more patients. The organisation had considered the impact of opening the additional beds against the current staffing levels. The CEO stated the board had been provided with information regarding the staffing levels at the hospice and the management of the proposed new beds and review of staffing. The

director of patient care had benchmarked the staffing levels against those in other hospices. Discussions and assurances had been provided by the registered manager. The senior leadership team had been asked to seek views from the staff on the required staffing levels to safely staff the wards with the increased beds. It had been acknowledged the layout of the ward would impact on the plan to increase the number of beds. A new ward office had been installed to ensure staff would be in the centre of the ward and accessible to all beds. This was not being used at the time of our inspection as the bed numbers had not increased. This demonstrated the organisation took staff concerns seriously.

- There had been an increased turnover of staff in the last year. The staff team had previously been stable. Senior staff told us that while some staff had retired or moved to other posts to further their career, some vacancies had occurred due to staff being challenged by organisational change. Exit interviews were carried out prior to staff leaving the organisation to understand the reasons and a programme of recruitment was ongoing.
- There was a local risk register and organisational risk register. The board had been concerned the local risk registers were generic and not service-specific so a project to develop these had been led by the clinical leads for nursing and medical staff. The risk registers were reviewed every three months by the executive team and serious risks were discussed. The board meeting agenda had been developed to enable more time to be spent on the identified risks and provide assurance the risks were rated appropriately using a red, amber, green (RAG) scale. Significant risks and those which impacted across the organisation were included on the organisational risk register following this meeting. The risk registers identified the member of staff with responsibility to resolve the issue. This provided assurances that appropriate action was being taken to mitigate against the risk.

Managing information

- The organisation was not fully compliant with the General Data Protection Regulation (GDPR) 2016 but were working towards full compliance. GDPR became mandatory in May 2018 for all organisations and replaced the Data Protection Act 1998. The organisation was working towards making changes to ensure they complied with the GDPR requirements. The policy and procedure regarding data protection had been reviewed and developed to reflect the GDPR requirements and the hospice have confirmed their view that they are now compliant.
- The director for finance was also the information governance lead. Part of the director's role was to chair the information governance meeting, which met every three months or sooner if there was an issue to address.
- Confidential and personal information was stored securely. The organisation had provided lockable notes trolleys for the storage of patients' confidential and personal information following a number of patient records being found unattended in an unlocked office. There had also been an incident within the organisation where a patient's details had been stored on a member of staff's personal electronic device. Because of these information governance issues, policies and procedures had been updated and shared with staff to protect confidential and personal information of patients using the service. We asked to see the incident reports and associated investigations for these incidents but were told by senior staff there had not been an incident report completed as action had been taken. This did not demonstrate staff reported incidents appropriately and a clear record was not kept of the events and the associated actions.

Engagement

- Staff reported they did not have regular contact with the executive board or the trustees. The executive board had been made aware of this through the staff survey and conversations with senior clinicians. Following each board meeting one of the executive team and a trustee would visit the clinical areas to meet and talk with staff. The senior management team expressed concerns the staff were not currently engaging with them and attributed this to the low morale and dissatisfaction among some staff
- The staff forum had been reformed and restructured to give staff representatives an opportunity to form links between the executive team and their colleagues. Issues could be raised by staff and responses from the executive team or other relevant departments were then provided. Staff were required to submit their points to be raised four weeks prior to the meeting and identify themselves as the person raising this. We were told staff were not confident in raising some issues as they felt this would have a negative effect on their employment.

The staff forum meetings were attended by 19 members who worked across the organisation. We were told the most recent meeting in May 2018 was attended by the human resources director who provided feedback from the staff survey. This was because low staff morale had been discussed at the previous meeting. A member of the staff forum told us the organisation listened to the staff and provided examples of action that had been taken regarding raised issues. For example, the provision of a cold water dispenser and maintenance and refurbishment of the garden at St Julia's hospice.

- Information was provided to staff regarding the developments of the organisation and how this would affect their roles. A heads of department meeting was held monthly and attended by the registered manager, clinical director, the head of care and the education lead. Information was cascaded to staff through monthly team meetings.
- A newsletter was published within the organisation to provide staff with relevant information. We reviewed a number of the newsletters and saw such information included: proposed changes to staffing roles and recruitment of new staff, applying the organisation's vision and values, access to training, and celebrating staff achievements.
- A monthly team briefing was prepared by the senior leadership team to keep all staff up to date with key issues. The team briefing was shared at staff meetings. This included a brief summary of items discussed in the most recent board meeting, the financial status of the organisation, clinical and organisational updates, staff statistics, outcomes form the staff survey, media coverage, a copy of the organisational risk register, and events running within the county.
- The senior management team were aware of a disconnect between the hospices at ward level and had discussed ways in which to bond the staff teams. Mandatory training was now carried out at both hospices, alternating the venue. This led to staff from each hospice meeting and completing training together.
- Group meetings known as 'Let's talk workshops' were started in January 2018 and were mandatory for staff to attend. The purpose of the workshops were to inform staff of changes to the running of the hospice services, including the purpose of developing community services. There had been previous concerns that information had not been cascaded to all staff effectively and the purpose of the workshops was to provide staff with an opportunity to meet with senior managers and raise any questions, concerns or queries.
- A community engagement manager had recently been employed by the organisation. Their role was to link with users, potential users, external organisations and the community at large and to support the ongoing development of the community offering.
- The organisation engaged with other providers of services in the area. A partnership had been formed with the local acute trust to provide support to both patients and medical staff at the hospital. Consultants rotated between the hospice and acute trust. This had led to better integration and developed relationships. We were provided information which showed 90% of patients attended the hospice for care and treatment for cancer. The senior management team was working with the acute trust to increase services for patients with other life-limiting conditions. There had been limited joint work with the community palliative care teams, which were provided by the local mental health trust. The registered manager linked with the hospice for children in Cornwall to provide support to the patient, family and staff during transition from children to adult services.
- There had been engagement with a group of GPs located in the west of the county. The organisation had contributed to a project led by the GPs, which had been focussed on living well and dying.
- The local commissioning group held an end of life strategy board which included the service. This led to positive joint working practices with the commissioners.
- The registered manager shared with us the vision of the organisation to reach harder to access groups of people, such as the homeless, those experiencing addiction, LGBT (lesbian, gay, bisexual and transgender) and travelling groups. Links had been formed with LGBT and addiction support groups in the local areas but the registered manager stated there was little diversity in Cornwall. There had been no work to reach homeless people who required services.
- There was limited engagement with patients and the wider public regarding the development of the service. Feedback was obtained from patients and relatives after the provision of care and treatment. Following the death of a patient or an inpatient stay, the patient, their relative or representative was contacted to provide the opportunity for the bereaved to ask any questions or

provide feedback. The registered manager said the feedback was collated and had been 'overwhelmingly positive'. The friends and family test results received were also positive. This feedback had not been used to develop or improve the service.

- The lymphoedema service requested feedback from patients regarding their care and treatment, which was based on the friends and family test questionnaire. Outcomes from the survey showed patients were satisfied with the care and treatment provided and would recommend the service to their friends and family.

Learning, continuous improvement and innovation

- Care pathways had been implemented to ensure patients who suffered a higher level of distress would receive prompt and appropriate care and treatment from external professionals. The organisation had reviewed the care provided to patients experiencing psychological distress. A recognised distress tool had been implemented through the multi-disciplinary team meetings and this had been audited. The distress tool identified the level of distress experienced by patients and identified the support and clinical care required to manage their distress. The audit showed the level of distress patients had experienced in the previous year had been at a level that had been managed by the organisation's staff.
- Clinical issues identified in other services either locally or nationally were considered to inform the care provided by the organisation. Policies and procedures were reviewed and developed when necessary to reflect findings. For example, the policy and procedures for prescribing and administering opioid medicines had been reviewed thoroughly and additional guidance provided to staff.
- The organisation was undertaking a mortality review following updated national guidance. This was in progress at the time of our inspection so we were unable to review the findings.
- The organisation was involved with integrated working with external providers to promote early intervention for patients with a life-limiting illness or condition. This was in line with national guidance and research which showed patients experienced significant benefits in quality of life, planning of care and communication when referrals occurred early in their care pathway.
- The clinical team from Cornwall Hospice Care had received national recognition for their work. In 2017 they were a finalist in the British Medical Journal (BMJ) 'care team of the year' award for their work in rolling out anticipatory prescribing guidance in the dying phase to over 1,000 health professionals. In 2018 they were shortlisted for the BMJ 'palliative care team of the year', recognising the joint working in oncology clinics in the acute trust.

Outstanding practice and areas for improvement

Outstanding practice

- The organisation was involved with integrated working with external providers to promote early intervention for patients with a life-limiting illness or condition. This was in line with national guidance and research which showed patients experienced significant benefits in quality of life, planning of care and communication when referrals occurred early in their care pathway.
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Areas for improvement

Action the provider MUST take to improve

- Ensure safeguarding children training is implemented.
- Ensure safe processes for the management and storage prescriptions pads

Action the provider SHOULD take to improve

- Assess training attended by staff against a recognised target.
- Ensure the emergency resuscitation equipment and associated medicines are checked and ready for use.
- Ensure all staff who chaperone patients were competent to do this.
- Ensure staff are aware of and guided by nationally recognised frameworks for the provision of care.
- Ensure staffing levels and the skill mix of staff on duty provide patients with the care and treatment they require promptly.
- Ensure failings identified through audits result in actions to remedy deficiencies identified.
- Ensure all staff report incidents appropriately, incident investigators are appropriately trained and competent to carry out investigations, and learning is shared across the organisation to promote learning.
- Ensure incidents are assessed and graded to ensure a consistent response.
- Enable staff to feel they can report any issues and/ concerns confidentially and without fear of reprisal.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13(1) Service users must be protected from abuse and improper treatment in accordance with this regulation. 13(2) Systems and processes must be established and operated effectively to prevent abuse of service users. Safeguarding children training was not provided for staff. Children were able to visit the hospice and stay overnight.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. The management of prescription pads (FP 10) did not ensure an audit trail of prescriptions used.