

# Butterwick 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

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Requires improvement



Are services well-led?

Requires improvement



### Overall summary

Butterwick Hospice is operated by Butterwick Limited. The hospice was purposely built; is fully accessible and has appropriate facilities for day-care, therapies and family support.

The hospice provides adult hospice services that includes; palliative and neurological day-care, family support services for adults, children and young people

and a home visiting service for palliative care and end of life patients. The hospice does not have any inpatient beds. We inspected this service using our comprehensive inspection methodology.

We carried out a short-notice announced inspection on 3, 4 and 10 March 2020. During the inspection, we visited the hospice at Bishop Auckland and the day-care facility at Sedgfield community hospital. We also visited two patients at home who were receiving care from the home care team. We spoke with 15 staff including registered

# Summary of findings

nurses, health care assistants, reception staff, medical staff and senior managers. We spoke with seven patients and relatives using day-care services and two patients and their family members on home visits. During our inspection, we observed patient care and interactions and reviewed ten sets of patient records. We also reviewed other information and data about the hospice and provided by the hospice to make our judgements.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

We rated the service as requires improvement overall. We rated safe, effective, responsive and well-led as requires improvement. We rated caring as good.

We found areas of practice that require improvement:

- Patient risks were not identified, assessed and monitored in a consistent manner across all areas of the hospice and re-assessments were infrequent.
- Health and safety risks were not consistently identified, assessed and documented. They were not always escalated so they could not be adequately addressed and reviewed.
- Policies and processes regarding management of medicines did not meet the needs of all areas and were therefore unfit for purpose. This had led to inconsistent practice in different areas.
- Not all staff and leaders were clear about their roles and responsibilities in relation to governance and performance.
- The provider had a large number of policies and procedures that need to be brought up to date and in line with current guidance and best practice. This was an ongoing piece of work.
- Staff and managers were not clear about their responsibilities in relation to 'Duty of Candour'
- The hospice needed to improve the information it collected and how it used it, to improve services and

patient outcomes. Audits were infrequent and feedback and improvement actions were not monitored. These were not always checked to see if improvements had been made or sustained.

- The hospice did not monitor waiting times in all parts of the service or monitor the impact of long waits on patients.

We found good practice:

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so
- Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- Staff gave patients enough food and drink to meet their needs and improve their health. Staff gave patients and families practical support and advice to live well.
- Staff supported patients to make informed decisions about their care and treatment. Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. Staff felt respected, supported and valued and could raise concerns without fear. All staff were committed to continually learning and improving services.

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

**Ann Ford**

Deputy Chief Inspector of Hospitals, North

# Summary of findings

## Our judgements about each of the main services

### Service

### Rating

### Summary of each main service

**Hospice  
services for  
adults**

**Requires improvement**



We rated the hospice as requires improvement overall.  
We rated safe, effective, responsive and well-led as requires improvement.  
We rated caring as good.

# Summary of findings

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Requires improvement 

# Butterwick Hospice

## Services we looked at

Hospice services for adults

# Summary of this inspection

## Background to Butterwick Hospice

Butterwick Hospice is operated by Butterwick Limited. The hospice opened in 1984 and is an independent hospice in Bishop Auckland, County Durham. It has outreach centres at Sedgefield community hospital, Weardale community hospital in Stanhope and the Richardson community hospital in Barnard Castle. The hospice primarily serves the communities of the Durham Dales, Easington and Sedgefield clinical commissioning group areas.

Butterwick hospice provides adult hospice services which includes; palliative day care services with access to nursing care, physiotherapy and complementary therapies, diversional therapies and social interaction. It also provides a specialist neurological day care service and a palliative home care team which predominantly provides an overnight service. A family support work team provides support and counselling to those bereaved or affected by a life limiting illness. The family

support work team provides services to adults and children and young adults in the wider family. The outpatient complimentary therapies provision extends to patients with a life limiting diagnosis and carers.

The hospice has had a registered manager in post since December 2014 and is registered to provide the following regulated activities;

- Nursing care,
- Personal care,
- Transport services,
- Triage and medical advice provided remotely,
- Treatment of disease, disorder or injury.

This was the first inspection of the hospice using the hospital inspection framework. CQC last inspection of the hospice was 10 June 2015, published: 28 August 2015. It was inspected using the adult social care framework and was rated as Good across all domains.

## Our inspection team

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

## Information about Butterwick Hospice

The hospice is a purpose-built day-care facility in Bishop Auckland, County Durham with outreach centres in Sedgefield community hospital, Weardale community hospital at Stanhope and the Richardson community hospital at Barnard Castle.

During the inspection, we visited the Bishop Auckland hospice site and the outreach day centre provided at Sedgefield community hospital. We also went on two home visits with the homecare team. We spoke with 15 staff including registered nurses, health care assistants, family support counsellors, volunteers and senior

managers. We spoke with two patients using day-care services and two patients and their family members on home visits. During our inspection, we observed patient care and interactions and reviewed 10 sets of patient records. We also reviewed other information and data about the hospice and provided by the hospice to make our judgements.

# Summary of this inspection

There were no special reviews or investigations of the hospice ongoing by the CQC at any time during the 12 months before this inspection. This was the hospice's first inspection using the current hospital inspection framework.

Activity (April 2018 - March 2019)

- In the reporting period April 2018 - March 2019 the hospice provided services to 645 service users. Of these 524 were adults and 121 were children and young people accessing family support. Of the adults, 44% were receiving services as palliative care patients and 56% of patients had a life-limiting illness.

The hospice employed 6 registered nurses, 8 care assistants, three complementary therapists and three family support counsellors. The hospice also employed administrative staff, volunteers and seven palliative home care staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

Zero - Never events

Clinical incidents: eight (in the last six months)

Zero - serious injuries

Zero - incidents of hospice acquired Meticillin-resistant Staphylococcus aureus (MRSA),

Zero - incidents of hospice acquired Meticillin-sensitive staphylococcus aureus (MSSA)

Zero - incidents of hospice acquired Clostridium difficile (C. diff)

Zero - incidents of hospice acquired E. coli

Zero - complaints

## **Services accredited by a national body:**

- Investors in people (2019)
- "Disability Confident Employer Level 2"

## **Services provided at the hospice under service level agreement:**

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

# 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 rated safe as **requires improvement** because:

- There were a number of environmental risks that the hospice needed to address. Some hand-wash basins were not compliant with current guidance. Access to staff only parts of the building and hazardous substances were not always secured.
- Although staff completed risk assessments when patients were admitted to the day-care service, there was no recognised standard or policy for how often patient risk assessments should be redone.
- Records were not always complete or updated regularly.
- The service did not have consistent systems and processes to transcribe, administer, record and store medicines. The medicines policies were not fit for purpose.
- Staff did not understand duty of candour. The duty of candour and incident policies did not completely reflect current best practice and legislation.

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

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned.

**Requires improvement**



### Are services effective?

We rated effective as **requires improvement** because:

- Many of the service policies required reviewing and updating to bring them in line with best practice and national guidance.
- Overall the service did not have a systematic approach to audits.
- Although data was collected, regarding patient outcomes, we were unable to see how these could be used to improve patients' outcomes.
- Home-care staff were concerned that patients may have to wait a long time for pain relief as they were currently unable to administer medicines in patients' homes.

**Requires improvement**





# Summary of this inspection

- There was no formal documentation for staff to use to support them in making and documenting best interest decisions.

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

- Staff gave patients enough food and drink to meet their and monitored patients regularly to see if they were comfortable or in pain.
- The service made sure staff were competent for their roles.
- All those responsible for delivering care worked together as a team to benefit patients.
- Staff supported patients to make informed decisions about their care and treatment.

## Are services caring?

We rated caring as **good** because:

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

**Good**



## Are services responsive?

We rated responsive as **requires improvement** because:

- Managers did not monitor waiting times for neurological day care services and patients could have extended waits, before being able to access this service.
- Managers did not assess the impact of waiting time on patients waiting to access the service.
- Although family support services had some targets in relation to waiting time from referral to assessment, they did not monitor waiting times for access to treatment or assess the impact of long waits.

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

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

**Requires improvement**



# Summary of this inspection

- Patients could access the specialist palliative care services quickly when they needed them.
- It was easy for people to give feedback and raise concerns about care received. The service acted on any concerns and complaints raised.

## Are services well-led?

We rated well-led as **requires improvement** because:

- Leaders did not fully understand and manage the priorities and issues the service faced.
- Leaders and teams did not have robust systems to manage all risks and performance effectively.
- Leaders did not have effective governance processes, throughout the service. There were gaps in information and oversight.
- Not all staff at all levels were clear about their roles and accountabilities.
- Clinical leads did not have regular opportunities to meet, discuss issues, propose improvements and learn from the performance of the service.

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

- The hospice had a strategic five-year plan for 2019-2024 which outlined its priorities and the enabling actions required.
- Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services.
- Staff felt respected, supported and valued and could raise concerns without fear.
- All staff were committed to continually learning and improving services.

**Requires improvement**








# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

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

# Hospice services for adults

Safe	Requires improvement 
Effective	Requires improvement 
Caring	Good 
Responsive	Requires improvement 
Well-led	Requires improvement 

## Are hospice services for adults safe?

Requires improvement 

We rated safe as **requires improvement**.

### Mandatory training

**The service provided mandatory training in key skills to all staff and made sure everyone completed it.**

Nursing staff received and kept up-to-date with their mandatory training. Training data showed that mandatory training compliance was good, all modules were over the 75% compliance target.

Staff we spoke with all told us they were up to date with mandatory training and that they received alerts from their manager when updates were due in the next month. Most mandatory training was completed online, and volunteers told us they had also received appropriate training for their role.

Staff we spoke with who had been with the hospice for up to one year told us they had received an induction and enough training to ensure they felt competent to be able to carry out their role. The first two weeks in their post was as a supernumerary member of staff.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training included; health and safety, fire safety, information governance, record keeping, moving and handling, infection control, basic life support, adult and children's safeguarding and mental capacity act and deprivation of liberty standards.

Managers monitored mandatory training and alerted staff when they needed to update their training.

### Safeguarding

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

All staff received training at an appropriate level for their role on how to recognise and report abuse. Staff we spoke to told us they had received safeguarding training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They were able to explain their role in raising concerns, understood their responsibilities and were aware of who they could go to for help and support.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff provided a specific example of a patient who had disclosed concerns about abuse, and we were assured that they had taken all correct and necessary action in relation to the information received.

Home-care staff we spoke with gave us examples of when they had raised concerns with their line manager or members of the multi-disciplinary team. They told us the community nurses tended to take a lead when they raised safeguarding concerns. They described how they had followed up to check the concerns had been addressed by the community nurse and alerted their own managers of the issue.

### Cleanliness, infection control and hygiene

# Hospice services for adults

**The service, controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

The hospice was clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. There was a process in place to ensure flushing of water outlets on a weekly basis.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff adhering to 'bare below the elbow', washing hands, using hand sanitiser and using PPE appropriately.

An infection control audit was undertaken annually by an external infection control and prevention matron, as part of a service level agreement. The latest audit in June 2019 gave an overall score of 91% compliance. Areas for improvement were display of hand washing posters, not all furniture was easily cleaned and not all patient wash bowls had been washed and stored correctly.

Comments at the end of the audit indicated there were areas of the hospice that needed to be upgraded and that these issues had been highlighted in previous years' audits. For example, it was recommended a carpet in the quiet room be re-placed with hard flooring, some clinical hand washing basins needed upgrading as they did not meet current recommendations, a bucket sink needed to be removed from the laundry room and some other decorative features and furnishings in the quiet room needed repairing / replacing to make them easier to clean. There was also a need for a clinical hand washing basin in the quiet room.

We could see from the audit action plan that any areas that could be addressed were fed back to the clinical teams for immediate action but there was no evidence of ongoing audit to check that actions were taken, and improvements sustained. The action plan indicated that upgrades to sink and environment would be addressed when funding allowed but these issues had not been escalated to the risk register, despite being recommendations from previous years' audits.

Although there was still no hand wash basin in the quiet room, we saw there was hand gel available.

A uniform audit in February 2020 showed 100% compliance with; bare below the elbow, no wrist watches or inappropriate jewellery, nails – short, clean and no polish, uniform correct and hair tied back. The only area for action was staff carrying personal hand rub, 56% of staff were compliant. All clinical staff had their own hand gel and the non-clinical staff and volunteers were using gel at room entrances.

Feedback from a carers survey rated the general condition and cleanliness of the hospice premises as excellent.

We observed a care worker using alcohol hand gel before assisting a patient to re-position. When checking catheters, disposable gloves were used, and the care worker washed their hands with soap and water immediately after completion of the task. Separate towels were provided in the home environment for care workers to use.

Home-care staff carried PPE and hand sanitiser with them and told us they could top up whenever they needed to.

Cleaning cupboards onsite were secure and a reference file with guidance for each substance used was stored in these areas.

## Environment and equipment

**There were a number of environmental risks that the hospice needed to address. The hospice needed to upgrade the hand-wash basins where they were not compliant with current guidance. We also found a number of risks where access to staff only parts of the building and hazardous substances was not secured. However, equipment and premises were well maintained, and staff managed clinical waste well.**

Patients could reach call bells and staff responded quickly when called.

An infection control audit had identified that two hand-wash basins needed upgrading to be compliant with current recommendations. The hand-wash basins in the treatment room and domestic cupboard were domestic basins (with overflows) which are unsuitable for

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clinical settings. The quiet room needed to have a hand wash basin installing. These recommendations had been made annually for the last three years but the hospice had not added this to the risk register or taken any action.

The service had suitable facilities to meet the needs of patients' families

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely however, there were a number of risks regarding potential unauthorised access to certain areas, chemicals and razors. We found razors in an unlocked cupboard in the bathroom, a key had been left in a door in the sluice, giving access to the mains gas switch. In the area used by children there was a key left in the lock leading to a staircase giving access to a loft containing aerosols, other hazardous materials and access to a large drop of approximately four metres.

There was a maintenance programme in place for premises and equipment and we found planned maintenance took place as needed. We checked equipment such as hoists, oxygen and suction and found they were checked within the last 12 months. Equipment was labelled with when the next service or electrical test was due.

There was a process in place to ensure flushing of water outlets on a weekly basis. We saw this was recorded on the maintenance log for the hospice environment and equipment.

Staff cleaned equipment such as hoists and commodes after each use and labelled them as clean and ready for use. Staff checked and charged batteries on items such as hoists weekly.

The home care service did not provide any equipment for use in patients' homes other than disposable infection prevention materials used by workers when caring for patients. All equipment was provided by the local trust who retained responsibility for maintenance and collection of these. However, care workers told us that if a piece of equipment was found to be broken or not working correctly, they would report this to the local district nursing team.

When someone was using the hospice's quiet room and chapel, they could not be observed from the corridor

outside which maintained their privacy and dignity. However, there was no alarm system in these rooms so if a patient was using the space and fell ill, they could be unnoticed and unable to raise the alarm.

Quiet rooms and spaces that could be used by patients or visiting children had ligature risks which had not been individually assessed. Ligature risks were blinds and string bags. However, staff were aware of the risks and told us that patients and visitors were not left alone in these rooms. Managers had risk assessed this on another hospice premises and alerted staff in these areas.

The main hospice day room was bright and appeared clean. Chairs of varying heights with wipeable covering were available for patients to use. Corridors and signage were dementia friendly including signs with pictures and text.

## Assessing and responding to patient risk

**Although staff completed risk assessments when patients were admitted to the day-care service, there was no recognised standard or policy for how often patient risk assessments should be redone. This meant frequency of risk assessments was infrequent and although some patients had been formally reassessed regularly others had not.**

Staff completed and updated risk assessments for each patient on admission to the service. Risk assessments included mouth-care, manual handling, falls, skin, nutrition and a carer needs assessment. Staff told us that they re-visited risk assessments and care plans three-monthly. However, there was no policy or process to provide guidance to staff regarding frequency and it was not clear from the records we looked at that this standard was not always adhered to. Although, one set of records clearly showed a re-assessment had been completed after three months and a falls re-assessment had also been completed following a fall at home. Another patient who had attended the service since 2016 did not have evidence of any re-assessments of their original risks but a recent new risk assessment had been added to this record regarding the patient's mental health and well-being.

Staff were trained to respond promptly to any sudden deterioration in a patient's health. They were

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knowledgeable about what action to take when an emergency arose. All staff were trained in basic life support and the emergency response included using the 999 service.

We found that where patients had do not attempt cardio-pulmonary resuscitation (DNACPR) in place, a copy of the form was kept at the front of patients notes. Patients who had these were asked to carry the original on them when attending the hospice to ensure staff acted according to their wishes and advanced decisions.

We found generic patient risk assessments in each of the clinical areas. For example, in the physiotherapy room and Sedgfield outreach centre we found assessments that included choking, collapse, exposure to bodily fluids, use of oxygen and suction and anaphylaxis.

We did not see evidence of environmental risk assessments for all the risks we identified, such as whether the relevant rooms were suitable or safe for children or for items such as window blinds which could potentially be a ligature risk. However, the hospice had done a risk assessment of window blinds and cords as a cross location risk and had identified and implemented appropriate mitigations.

Before starting any complementary therapy, a therapist would carry out a home visit to perform an assessment. This included; advising the patient of the treatments available and how often they could be carried out; they would carry out a patch test to ensure it was safe to use treatments and they would give the patient an information leaflet and contact number.

The service could access counselling and specialist mental health support, if staff were concerned about a patient's mental health. Staff told us they could gain direct access to counselling and family support and they could refer into other primary care services and GPs when needed.

Staff would refer patients to GPs or mental health services for mental health assessments for any patients thought to be at risk of self-harm or suicide. Other patients could be referred with conditions such as anxiety and depression.

Staff working in day-care received a morning handover every day. This was accompanied by a sheet giving details of patients and any specific needs or things for staff to consider when providing care. Handover information

included all necessary key information to keep patients safe. For example, food allergies and dietary requirements, risks, mobility, relevant medical history / condition and care interventions that would be required were included.

Outreach service staff told us they held a briefing three times a week.

Staff were receiving alerts and information about the corona virus outbreak and posters were on display for patients and relatives.

Within the home-care service we found that patient held documentation was being replaced with a newer version of a daily living and needs assessment and associated risk assessments. One of the home-care assistants showed us the new paperwork updated as an improvement action following a CQC inspection at another location. They told us that staff had received information and talked through with managers how they should complete the documents. The HCA told us the new documentation was being rolled out over the course of their next visits.

The new documentation included a holistic assessment of daily living activities and needs and included risk assessments for skin and a body map, mouth care, nutrition, and moving and handling.

Healthcare workers providing care to patients in their own homes worked alone. They had an electronic lone worker system linked to a central call centre which provided extra security by logging workers in and out of their visits and provided an hourly call back service if required. Additional backup was provided by a senior member of staff who held an emergency telephone number on a rota. Hospice staff worked closely with the district nursing team and Marie Curie support staff and would contact them to provide extra support if required.

## Staffing

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



# Hospice services for adults

The service had enough nursing and support staff to keep patients safe.

The hospice employed six registered nurses, eight care assistants, three complementary therapists and three family support counsellors. The hospice also employed administrative staff, volunteers and seven palliative home care staff. The accountable officer for controlled drugs (CDs) was the registered manager.

There was a minimum staffing level of two registered nurses and two healthcare assistants for each clinic. Staff told us they planned ahead for day care sessions and could adjust staffing levels daily according to the needs of patients by requesting additional staff.

The service had low vacancy, turnover and sickness rates.

The hospice had its own pool of bank staff so additional staff were familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service and what was expected of them.

Staff in the day care centres felt there were enough staff to deliver good, safe care. They told us they looked at patient acuity for those patients attending for day care and were able to request an additional member of staff if needed. Staff told us they had plenty of time to spend with patients and develop relationships. A member of staff explained that “people trust you, they have time to open up to you.”

Home-care staff worked alone and primarily provided a respite service for a patient’s carer. There was a process in place for them to contact the district nursing or local authority home care team for help if necessary. Home-care staff told us this would usually only be necessary if something untoward happened or if a patient’s condition had changed unexpectedly.

There was a lone worker system in place to help keep staff safe.

## Records

**Records were not always complete or updated regularly. However, records were stored securely and available to all staff providing care.**

Staff had access to up-to-date, medical information on patients’ care and treatment. However, this needed to be

requested from GPs who would download a summary from their electronic system to share with the patient’s consent. This information was not available in all of the care records we looked at and there was no standard process regarding how often the hospice would request an update from patients’ GPs.

The service did not have direct access to electronic patient care records so could not access and download this information directly.

Patient notes were stored securely, and all staff could access them easily

Staff recorded daily evaluations of the care provided at the day centre or in the patient’s home. Healthcare assistants providing day-care did not write directly in records but would bring anything relevant to the attention of nurses leading sessions who would record this.

We looked at nine sets of patient notes. These contained initial care plans detailing people’s personal health, financial and spiritual needs. However, we saw that some of these plans dated back to 2016 and had not been updated since then. Others had been updated annually. Records of care were clear, and we could see that where further assessment such as care plans for fatigue, anxiety, dyspnoea or pain were needed, these were appropriately completed.

The hospice had not undertaken any recent records audits

## Medicines

**The service did not have consistent systems and processes to safely transcribe, administer, record and store medicines. The medicines policies and procedures were not fit for purpose.**

The hospice was reviewing medicine policies and procedures as part of a whole system review of policies and were aware the current medicine policies and procedures were not fit for purpose.

Policies were inconsistent and staff were unable to follow them in some areas. Staff in some areas had introduced new ways of working to make areas of medicines



# Hospice services for adults

management safer. However, the policies had not yet been reviewed and the new practices had not been formally accepted and rolled out across all teams and centres.

Some policies and or procedures appeared to be have written for a specific area of the hospice without consideration of other teams or settings. For example, the procedure for transcribing of medicines to be administered by staff appeared to have been written for the children's inpatient unit. The procedure did not meet the needs of staff in the day-care setting or those providing care in patients' homes.

There was a clear need for a robust transcribing procedure and supporting policies to be in place for some of the current patients. We met a patient who could not administer their own medicine but attended the hospice on a rolling programme. There was also the potential that as patients' conditions progressed, they would become unable to self-administer because of a decline in either their motor or cognitive skills.

There were mixed messages from staff in day care settings as to whether they transcribed and administered medicines or not. In one setting, nurses told us practice was to transcribe a patient's medicines onto a medicine administration record (MAR) and two nurses checked the medicine and the patient identity before administering. This practice was not fully supported by the hospice policies. Other nurses told us they did not need to administer medicines as patients kept their own medicines and self-administered.

There was no formal or consistent risk assessment for self-administration of medicines in the hospice environment although we did see that this had been considered in some of the admission documentation.

Health care assistants in the home-care team told us they did not give medicines, however they also told us that they felt it would be beneficial to be able to administer 'as required' pain medicines when a patient was struggling to self-administer. They described a process where they would ring a community nurse or a family member to attend the patient if they required pain relief. Staff were concerned that a patient could potentially be in pain or discomfort for lengthy periods if nurses or family

members were unable to come immediately. Managers were aware of this concern and were reviewing what training, policies and procedures would be needed for home-care staff to be able to do this.

The service had systems to ensure staff knew about patient safety alerts and incidents. These were cascaded to all staff through emails and handovers.

The hospice had a controlled drug (CD) cabinet for any patient medicines that fell into this category and other medicines were kept by the patient. A controlled drug register was used to record CDs being added to the store and for medicines taken out and given back to the patient. The key to the cupboard was kept securely where it could be accessed by the registered nurses who needed it.

The registered manager was the accountable officer for CDs. The hospice held a current Home Office licence for controlled drugs.

## Incidents

**Staff did not understand duty of candour. The duty of candour and incident policies did not completely reflect current best practice and legislation or guide staff to make appropriate judgements regarding level of harm and when to implement duty of candour. However, staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and ensured that actions from patient safety alerts were implemented and monitored.**

Staff we spoke with knew how and when to report incidents. Although written policy information about being open with patients and duty of candour was unclear, it was clear from examples that staff gave us, their first responsibility was to patients and families. Staff did not understand the legal requirements of duty of candour and when this should be implemented.

The Duty of Candour (DoC) is a legal duty to inform and apologise to patients if there have been mistakes in their care that has led to moderate or significant harm. The incident policy did not guide staff in judging level of harm or indicate when duty of candour should be implemented. However, managers were aware of the limitations of the current policies and these were being reviewed.

# Hospice services for adults

Managers had just implemented a weekly incident review group and had held their first two meetings. They felt the meetings had been worthwhile and would give them a much better oversight of all incidents across the hospice locations to be able to identify any themes, share learning and make improvements. The group looked at all new incidents and followed up any outstanding actions from previous incidents. There were six new incidents in the first and second week of the reviews taking place and one of these was a fall at the hospice. The incident review had clearly identified areas of practice to be reviewed as part of the incident investigation.

There were eight incidents reported during the six-months before this inspection.

The service had no never events in the previous 12 months. Never events are serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Managers investigated incidents thoroughly while being supportive of staff involved. A 'look back' exercise was undertaken for any emergency transfers or emergency situations such as deterioration of a patient to ensure staff were able to debrief and to determine if there were any opportunities for learning.

Staff told us they received feedback from investigation of incidents and learning was shared through team meetings and at handovers.

There was evidence that changes had been made as a result of feedback. Managers and staff were able to tell us about the action taken involving the transport service.

Home-care staff told us about an incident that had occurred in the patient's home and how they had first informed the carer and then how they reported the incident to their line manager.

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

Requires improvement 

We rated effective as **requires improvement**.

### Evidence-based care and treatment

**Many of the service policies required reviewing and updating to bring them in line with best practice and national guidance.**

There was an ongoing review of all policies to bring them up to date and in line with best practice and national guidance. The policies had all been risk rated, prioritised for review and allocated to named individuals to lead the improvement.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

### Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

The hospice held a current food hygiene certificate and scored five out of a possible five. Staff food hygiene training certificates were on display in the kitchen. Staff told us they were able to cater for a variety of religious and cultural needs, and we saw a folder in the kitchen providing detail on main world religions and the dietary needs and preferences of followers of those faiths.

# Hospice services for adults

Patients attending the day hospice were offered a range of hot and cold drinks, served by a volunteer.

The kitchen provided a full hot meal for patients. Kitchen staff held a full list of each patient's allergies, and copies of any special dietary needs. Where this included pureed food or liquid food, a copy of the relevant speech and language assessment was held in the kitchen. Adaptive cups, mugs and cutlery was available and a list of people requiring assistance to eat was held by staff. Nurses and healthcare assistants' competency to assist patients with feeding was assessed by the hospice.

Feedback from a carers survey rated the quality of catering and access to food and drink at other times as excellent.

## Pain relief

**Staff assessed and monitored patients regularly to see if they were comfortable or in pain. They took action to make patients more comfortable and to assist them taking pain relieving medicines when needed.**

Staff supported patients to self-administer pain relief when they needed it and in one area of the hospice, staff administered pain relief to patients when needed. Where staff administered pain relief, they recorded this accurately and evaluated the effect of the medicine given.

Home-care staff expressed a concern that they were unable to administer pain relief in patients' homes. Although they had a system in place to contact a family member or a member of the district nursing team to attend the home to do this, they felt that this could result in a delay and patients would have to wait for pain relieving medicine.

Service managers were aware home-care staff would like to be able to administer pain relief in patients' home and they were undertaking a review of what training and policy adjustments would be needed to enable staff to do this.

We observed a care worker supporting a patient in their own home ask more than once if the patient was in any pain. The patient said they weren't, but their body language and general demeanour made the care worker

think the patient was in some pain that they were not disclosing. They made a note asking the district nurse to review the patient and conduct a thorough pain assessment.

## Patient outcomes

**Overall the service did not have a systematic approach to audits which could be used to check improvement over time. Some data was collected regarding patient outcomes, but we were unable to see how these could be used to improve patients' outcomes. In some areas of the service, staff monitored the effectiveness of care and treatment and used the findings to make improvements and achieve good outcomes for patients.**

Managers and staff did not carry out a comprehensive programme of repeated audits to check improvement over time. However, there was a programme of a small number of annual audits which included infection control audits and record keeping.

There was no evidence that managers used information from the audits to improve care and treatment.

The service collected some outcome information for patients. For example, The Phase of illness (POI) and Australian Karnofsky Performance Status (AKPS) were scored on each patient on admission and two to three weekly after. While this information was analysed by the hospice it was difficult to draw any conclusions from this other than the patients participating were relatively stable, as the data showed little change.

The hospice team wanted to work on the training and implementation of the Integrated Palliative care Outcome Scale (IPOS) which is a measure of global symptom burden as reported by patients. It was planned that this information would be used to direct discussion within the clinical team, to ensure the current patient care plan is up to date and ensure the hospice approach is patient centred. However, this work had not started.

The hospice collected information using the Support Team Assessment Schedule (STAS) on a weekly basis to assess clinical outcomes and intermediate outcomes of palliative care. STAS has nine core items covering physical, psychosocial, spiritual, communication, planning, family concerns and service aspects. To evaluate the effectiveness of holistic intervention of

# Hospice services for adults

palliative patients accessing Day Hospice services. This information showed that although over time some patients scores deteriorated, the majority remained stable and all patients remained in the lower range with scores between 0-25. Scores in this range indicated that patients had minimal problems with a low likelihood of admission to hospital

The hospice had a number of key performance indicators that it needed to achieve and report to commissioners on a quarterly basis. From October to December 2019 100% of patients in day-care / outpatients had a care plan in place.

For the hospice at home service performance for: a record was made as to whether patient has a care plan was 100%.

The family support team had 100% compliance with written assessment of needs and action plan agreed with patient.

The physiotherapists and complementary therapists used assessments to chart the outcomes for their patients and to change care plans where needed to improve individual patient outcomes. However, they did not collate this data for monitoring purposes or to track trends over time.

The family support team evaluated individual sessions and the bereavement groups they provided. Evaluation forms were given to service users after each session which helped the counsellors evaluate the session resources used and how useful / enjoyable the children and young people found them. Individual evaluation forms could be used to inform the next session and results were collated on an annual basis to ensure resources were acceptable to the children and young people.

From September 2018 to April 2019, the service had provided six groups of six weeks duration to children and young people. The groups were accessed by 41 children and young people and attendance was 100%. The children reported positive outcomes such as feeling happier at school, arguing with the teacher less, enjoyed making new friends who had also lost someone, things were better at home and that its okay to be sad sometimes when you've lost someone you love.

There were family support services evaluations from July to September 2019 and October to December 2019. The service sent evaluations to all patients on discharge (adults and children.) Out of 36 evaluations sent 28 were returned and all feedback was positive.

Positive outcomes reported by patients using the family support services included: "Always felt lighter afterwards", "It really helped more than I could have hoped for", "My counsellor was amazing, really helped me so much", "Before I started counselling, I wasn't sure about it and didn't think it would help. After a couple of weeks, I realised it was helping and would encourage anyone to go."

Anecdotal evidence and patient feedback indicated that following the group programmes given by the family support team, members of the group had continued to meet and effectively made their own support systems in the community.

Feedback from a carers survey indicated that relatives felt involvement with the hospice had a positive impact on their loved one's quality of life and overall, they were very satisfied with care.

## Competent staff

**The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Staff told us the training and support they received enabled them to carry out their roles competently. Staff told us they accessed much of their training online.

Managers gave all new staff an induction tailored to their role when they started work. Staff told us they were given a workbook to complete over a twelve-week period and that these were signed off by a senior member of the nursing team when completed and assessed as competent.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their

# Hospice services for adults

skills and knowledge. Managers gave staff the time and opportunity to develop their skills and knowledge. Managers were providing bitesize training for staff to facilitate access.

Managers made sure staff received any specific training for their role. Nursing staff, including health care assistants received additional training regarding topics such as; mouthcare, catheter care, tracheostomy care, blood pressure, blood glucose and continence care.

There was a clinical educator who visited the hospice one day a week to support the learning and development needs of staff and to deliver training sessions. Staff told us they had recently had a session regarding lone worker safety. Staff told us they could make requests for refresher training to address their learning needs.

Senior staff told us they assessed the competence of support staff through observation and discussion.

Managers supported staff to develop through yearly, constructive appraisals of their work. Qualified nurses including the registered manager were supported through revalidation. A six-month review had recently been introduced in response to feedback from staff.

The hospice was continuing to develop competencies for staff roles and had begun to ask staff to complete these. However, we saw in staff appraisals that they had asked for refresher training in topics such as catheter care but that these had not been provided yet.

Hospice data showed that compliance with annual appraisals was 65.5% against a target of 75%. This figure was explained to some extent by new starters and leavers however four of eight bank staff were overdue their appraisal, two of these staff had been appraised, one was a new starter and the other had a documented reason for their appraisal being overdue.

Managers had recently sought help from a partner organisation to develop a policy for clinical supervision. Four members of staff within Butterwick Ltd had been trained to be facilitators for other members of staff. The policy stated that staff would access clinical supervision four times a year.

Complementary therapy staff told us they were supported to access regular, constructive clinical supervision of their work.

Members of the family support team were trained to degree level and demonstrated a high commitment to ongoing training and development. This was necessary to maintain a high level of expertise and to maintain registration as a counsellor. The clinical lead for the service had strong links with the local college which was a source of many of the volunteers. The service supported students to achieve their client hours.

All counselling staff including volunteer counsellors received clinical supervision once a month. The lead counsellors accessed their counselling supervision through an external provider, and they provided supervision for the volunteers.

There were compulsory bi-monthly supervision meetings with lone workers who provided the home-care service.

We checked four staff files and four volunteer files. All contained evidence of safe recruitment practices including current disclosure and barring checks and evidence of nursing qualifications where appropriate. No all contained copies of annual appraisals, although these were provided later by the hospice services manager.

## Multidisciplinary working

**All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.**

Staff worked across health care disciplines and with other agencies when required to care for patients. Home-care staff regularly liaised with specialist nurses, other charities, community nursing teams, Marie Curie and social care teams. Community nurses sometimes visited patients at the hospice if they needed to make assessments or provide treatment.

Nursing staff, family support and therapy staff worked together to provide the best experience possible for patients and their families.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression.

We saw staff working well together as part of a team to meet the individual needs of their patients.



# Hospice services for adults

There were many examples of multi-disciplinary working and nursing staff could describe how they were able to refer directly to allied health professionals and medical staff within the hospice and within acute and primary care settings.

Home-care staff talked about how they communicated with community nursing and other care providers to ensure patients received the best care possible.

Staff working in day-care received a morning handover every day. This was accompanied by a sheet giving details of patients and any specific needs or things for staff to consider when providing care.

The hospice held a multidisciplinary meeting to review neurological patients waiting to access services, however this was only scheduled to meet once a quarter and over the last year had only met twice due to diary constraints.

## Seven-day services

### Home-care services were available seven days a week to support timely patient care.

Home-care services were offered seven days a week and the managers had an on-call system to support staff if needed during out of hours periods.

## Health promotion

### Staff gave patients and families practical support and advice to live well.

The service had relevant information promoting healthy lifestyles and support.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. This support was extended to family, loved ones and carers.

## Consent and Mental Capacity Act

**Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, there was no formal documentation for staff to use to support them in making and documenting best interest decisions.**

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff asked for and documented consent for photos and information sharing.

Staff were aware of patients who had documented advanced decisions including do not attempt cardio-pulmonary resuscitation (DNACPR). Copies of DNACPR records were held at the front of patients notes and patients carried the original on their person.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Although new patients accessing the service usually had full mental capacity, staff recognised that patients could use the service over a long time and mental capacity could fluctuate.

Patients were asked for verbal consent for therapeutic interventions and this was usually documented at the start of a course of treatment.

Staff told us that if patients could not give consent, they would make decisions in their best interest, taking into account wishes and known daily activities or practices. However, there was no documentation available to support staff to do this.

Relevant staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

## Are hospice services for adults caring?

Good 

We rated caring as **good**.

## Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and

# Hospice services for adults

those close to them in a respectful and considerate way. We observed staff all had good communication skills and had a caring approach when interacting and engaging with patients.

Patients said staff treated them well and with kindness. The hospice took part in the Friends and Family Test and collated quarterly reports from the feedback. From October to December 2019 the response rate was 85% and 100% of respondents were extremely likely to recommend the service.

The hospice collected feedback from carers following the death of their loved one to evaluate the care they were given. From a survey sent to six patients who had received home-care from July to September 2019 four were returned. Feedback showed that staff always introduced themselves, they were knowledgeable about their patients and treated them with respect and dignity. Relatives had confidence in the staff providing care to their loved ones and relatives and patients had time to ask questions. Staff made an effort to meet patients' individual needs and wishes, treated relatives with courtesy and respected privacy.

Some examples of feedback from patients were; "Thank you for all the time you have given me, the patience you have shown me and above all the kindness." "Butterwick Hospice has helped me more than words can say physically, mentally, emotionally and they continue to do so". "The treatment I have had is second to none and they have gone out of their way, this includes all staff and helpers."

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs

Staff felt they were cared for by their colleagues and managers and that this helped them to provide good care to patients and families.

Staff told us how developing close relationships with patients and their families was important in delivering care. They felt rewarded that they were able to deliver a good standard of care and were able to honour patients' wishes at end of life.

We saw that staff were aware of and understood patients' interests and hobbies. They used this knowledge to inform conversations and social interactions that were warm and caring.

We saw that staff had good rapport with patients and relatives and listened, with genuine interest to how they had been over the period since their last contact. We saw that relationships were well- developed and caring and that patients were trusting of staff and able to disclose their concerns and fears.

We saw a volunteer treating patients with compassion and kindness, taking the time to have long conversations with them and asking about their interests and their families. A volunteer told us that they felt a huge sense of achievement being able to take the time to speak to people and make them a drink, and that it could "make all the difference" to someone that day.

We observed care delivered in a patient's home. The care worker obtained verbal permission to re-position the patient and checked what else they could do to help them several times. The care worker and patient discussed the patient's interests, their shared taste in music and the patient's forthcoming plans.

## Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it

Staff undertook training on bereavement and loss and demonstrated empathy when having difficult conversations

Staff understood the emotional and social impact that a person's care, treatment or condition had on their well-being and on those close to them

# Hospice services for adults

A patient receiving care in their own home told us the team had been fantastic. They said they had felt well supported physically and emotionally by staff they described as excellent.

A patient attending neurological day-care explained that many of the patients knew each other very well having attended for several years, and that they were 'like family', as were the staff. Staff had a clear rapport with patients and patients told us that it was good to see the same staff as they felt they didn't have to repeat themselves.

One patient told us that the social aspect of day care was almost as important to them as all the other patients had similar experiences and they all supported each other. They told us "it is important to me psychologically to come here."

Staff received emotional support from other staff and managers through supervision, debriefings and general conversation and felt this enabled them to support patients better.

The family support team provided emotional support through; one to one counselling for adults and children, social groups for adults and a bereavement group for children.

Feedback from patients for the family support team was extremely positive and patients made comments such as "the counsellor was an amazing support, she was lovely and made me feel secure and counselling has given me the tools to improve my emotional health"

Hospice staff offered complementary therapy to patients and their families. This could be given in their own homes if necessary

## Understanding and involvement of patients and those close to them

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. They ensured a family centred approach and offered support services to families including children and young people.**

Staff made sure patients and those close to them understood their care and treatment

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions about their care

Staff supported patients to make informed decisions about their care

Patients gave positive feedback about the service.

Staff could give examples of how they used patient feedback to improve daily practice.

We saw staff who were very sensitive to patients' communication needs. They interacted with patients who found it difficult to communicate using appropriate language and enabling them to respond with non-verbal cues.

We saw staff interacting with family members as partners in care. They treated family members with respect and visibly valued their opinion and instructions as they were the people who knew the patient best.

We spoke to three patients attending neurological day-care. All confirmed that they had a good understanding of their condition and were able to make informed decisions. They told us that the physiotherapy they received was vital to their well-being and the complementary therapies additionally helped to lift their mood.

We observed a care worker supporting a patient in their own home. The patient's immediate relative was present and all three had a detailed discussion about how the patient had been feeling that day and any changes in their condition or treatment. The relative told us they felt entirely involved in their loved one's care.

Staff assessed the health needs of carers when a patient entered the service and signposted to other support services where necessary.

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



# Hospice services for adults

(for example, to feedback?)

Requires improvement 

We rated responsive as **requires improvement**.

## Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population

Facilities and premises were appropriate for the services being delivered

The service had systems to help care for patients in need of additional support or specialist intervention

The hospice had identified that there was a high incidence of neurological conditions and in particular; Multiple Sclerosis (MS) in the local population. As a result, the team worked with the NHS MS nurse specialist to provide a more tailored service for these patients. Two day-care places at each of the hospice's locations were ring-fenced for neurological patients and the hospice provided one neurological group session per week. Half of the hospice's patients had a non-cancer diagnosis.

The hospice was situated in an area that was predominantly populated by people identifying as White British. However, there were people from a range of other communities and ethnicities living in the hospice catchment area. We asked two members of staff providing clinical care, both confirmed they had never cared for someone identifying as being from a black or ethnic minority. One person told us they had worked for the hospice for over ten years and nobody fitting this description had used the hospice.

We asked leaders if they had done any work around hidden voices or barriers to using hospice services and were told this was not something that had been undertaken.

## Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

The nurse from the hospice visited patients at home to make an assessment of whether the hospice could meet their needs before accepting them as a day patient. This home visit also ensured the patient had enough information about the service to decide for themselves if the service could meet their needs and would be of benefit to them.

The hospice was designed to meet the needs of patients; although primarily a day care centre the hospice was able to provide quiet rooms and a bed for patients who needed to rest during the day.

There were rooms available for the family support team to work with children and young people. These had been thoughtfully furnished with decoration, toys and activities for children of varying ages. The rooms for children and young people were away from the adult day centre area and staff told us children, young people and families were escorted to these areas from the reception area.

Family support and counselling was tailored to individuals and family needs and staff were flexible with the hours they worked. Services were delivered in community or school settings, at the hospice or in the home and could be delivered in the evenings to accommodate the needs of others.

The team used tools developed specifically for children to measure emotional pain and also to evaluate the service they received.

Staff told us how they made adjustments to ensure privacy for the patient was maintained when delivering a session at home. For example, they told us of occasions when they had delivered support at home and taken a support worker with them to care for children and young people, so they were able to work with a parent. On other occasions a support worker had been needed to care for a sick adult while the counsellor worked with another member of the family.

# Hospice services for adults

All staff had attended a 'Dementia friends' session during 2019 to help them consider the needs of people suffering with dementia.

The service did not have information leaflets available in alternative languages however managers said they would source these as and when needed. The hospice did not have any current patients whose first language was not English.

Managers told us that staff, patients, loved ones and carers could get help from interpreters or signers when needed.

Although the hospice did not have any patients with a wide range of protected characteristics, staff and managers described individualised care to all their patients and did not believe there were barriers to patients accessing their services. The hospice services manager had recognised that the hospice needed to consider ways in which it could improve its marketing to ensure equal access to all groups.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff told us that if a patient being cared for at home expressed a wish to die in a hospice setting, the home care team would refer this to the district nursing team, who could arrange a transfer to one of three local hospices.

The service offered complementary therapies to patients in their own home and in day care. This offer was extended to wider family members and not just to the patient. Family support services also provided services to people in their own homes where needed.

The hospice had recently ceased provision of transport by hospice volunteers and this was now provided by an external company.

The hospice provided a chapel for prayer and quiet reflection. Iconography was Christian and non-removable. There were a number of other quiet rooms and interview rooms that could be used by other faiths, however the hospice did not have any items such as texts or prayer mats for use by patients or their families for other religions.

The hospice's service level agreement for the provision of chaplaincy services was only for the provision of Christian chaplains, however leaders told us they did have contact details for other faith leaders if required.

Staff told us about celebration days they had held in response to national events or for patients' interest examples given were a St Patrick's day celebration, Easter and Christmas celebrations and a ladies' world cup day.

Staff told that one of the things they liked most about working at the hospice was that they were able to provide patient led, person centred care. Activities were organised around patients' interests and included things such as bingo, Thai chi, quizzes and themed days like beach days.

## Access and flow

**People could access most of the services when they needed it and received the right care in a timely way. Patients could access the specialist palliative care service when they needed it. However, managers did not monitor waiting times for neurological day care services and patients could have extended waits before being able to access this service.**

Referral to the hospice services could be made by any healthcare professional and referral criteria were in place. For the home-care service patients had to be receiving care from a community nursing team and the community nursing service needed to be aware of the referral.

Referrals into the complementary therapy service could be made by any healthcare professional but treatment would not commence until the patient's general practitioner had given their approval.

Referral criteria for the family support service were clear and staff had a seven-day standard for referral to first contact and courtesy calls were to be made if a client had not been seen by five weeks. The hospice did not provide data to show how many patients waited more than five weeks, actual length of waits or longest waits.

Referrals to the home care service were submitted on paper by other health professionals. People were not able to self-refer. These were then prioritised by the care co-ordinator based on urgency. District nurses spoke at least weekly to the care co-ordinator about the needs and changes in the condition of those receiving the service, and this was incorporated into visit planning.

# Hospice services for adults

There were a number of performance targets regarding access and flow that were reported to commissioners every quarter; for the day care service from October to December 2019 100% of patients were contacted within five working days of referral; for the hospice at home service preferred place of care was achieved in 100% of cases and the family support and bereavement service contacted patients within seven days of referral occurred for 92% and 90% of patients in the last two quarters.

Day care place occupancy was also monitored for each of the day care centres. We could see that this fluctuated and at Bishop Auckland this ranged between 80 and 93% from July to September 2019. For the same period occupancy was 73 to 100% at Weardale, 106 and 135% at the Richardson and 84 to 95% at Sedgfield.

From July to September 2019 the palliative home care team delivered 2,597 hours of respite care

From July to September 2019 the family support service had 67 referral and 185 people accessed the service.

From July to September 2019 the neurological day care service delivered sessions to 153 people with 122 accessing physiotherapy and 117 accessing aromatherapy.

Hospice managers could not tell us how many patients were waiting to access the neurological day service or how long they had waited. Managers did not monitor waiting times for neurological day-care services and one patient told us they had waited 'a couple of years to access the service'. Managers told us the neurological day service provided by the hospice at its Bishop Auckland site was heavily oversubscribed.

There was no clear rationale regarding some patients accessing a rolling programme while other patients had long waits. It was unclear what the rationale was for the length of time between patients being on and off the programme. The hospice managers told us patients sometimes waited longer than usual in-between therapy, to enable new patients to access the service. However, this had not been systematically reviewed or monitored to establish consistent waiting times, either for the patients on the programme or those waiting to access it.

The hospice had set up a multi-disciplinary team meeting to review waiting patients to see if they needed to access services earlier, however this was led by the MS nurse and

only met every six months. Other neurological specialists did not receive an invite, leading to the possibility that people with a non-MS diagnosis could potentially wait for much longer before they could access the service.

Staff supported patients when they were referred or transferred between services. Staff were able to give examples of how they had supported patients and or family members when they had suffered a medical or mental health crisis.

A care co-ordinator organised all home visits. Visits for the weekend were scheduled on Friday, so it was not possible to organise a weekend visit at short notice. However, as the care co-ordinator held an emergency phone, they were able to re-prioritise staff at weekends if a patient had passed away.

The home care service had identified the team could provide 8000 hours of patient care per year and they monitored performance against this. The team told us that if they were unable to fulfil a visit, they would ask colleagues at another home care organisation if they would be able to pick this up.

The hospice had recently taken the decision to stop providing a transport service for its patients. This had been communicated directly with each patient using the service and alternative methods of transport had been discussed. The hospice had worked with a charity to provide some transport and had signposted patients to other patient transport services such as those provided through GP surgeries or other voluntary agencies. Staff had identified that patients would benefit from a leaflet to give clear information on how to access transport, but they had not done this yet.

The family support team provided services to children and young people and their families, staff told they provided interventions for children as young as six years. For younger children the service provided guidance, information and signposting to parents to help them access more appropriate services.

The services accepted referrals from members of the hospice team, other healthcare professionals, teachers and they would also accept self-referral. Family support services were provided at the hospice, in schools and community groups and in the home.

# Hospice services for adults

The team also provided teaching sessions to other professionals. For example, they had run a session regarding loss and grief with a group of teachers to help them understand and support children in school, who had been bereaved.

From 1 April 2018 to 31 January 2019 the family support service had seen 261 individuals, 105 of these were children. They had provided 1,369 counselling sessions (984 for adults and 385 for children and young people). They had held 250 adult support groups and 123 groups for children and young people)

The family support team used a needs-based waiting list for their services and the clinical lead told us the waiting list for counselling was 14-16 weeks.

## Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.**

Patients, relatives and carers knew how to complain or raise concerns

The service clearly displayed information about how to raise a concern in patient areas.

Managers investigated complaints and identified themes

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

The hospice had not received any complaints in the previous twelve months. We checked the last two complaints which dated back to 2017. One was partially upheld and related to concerns by a patient about not feeling welcome at a group they attended, and the second was a complaint about staff behaviour. Neither complaint file was complete, with copies of all documents missing in the first instance, and a copy of the final letter missing from the second. Although the second complaint was a personnel matter that would have been dealt with confidentially there was no evidence in the file to say how or if this was addressed

Managers shared feedback from complaints with staff and learning was used to improve the service

## Are hospice services for adults well-led?

Requires improvement 

We rated well-led as **requires improvement**.

### Leadership

**Leaders did not fully understand and manage the priorities and issues the service faced. A lack of a leadership structure at local level with unclear responsibilities and links into the clinical services of the other locations had led to issues such as disjointed policies, a lack of a robust audit programme and ineffective management of waiting lists. However, managers were visible and approachable in the service for patients and staff. They supported staff to develop their clinical skills.**

The Butterwick hospice was led by a director of patient care who was also responsible for two other hospice locations. A hospice services manager led the team at this site. The individual services were led by a home-care coordinator, two lead nurses and the family support lead practitioner.

The hospice services manager told us they had been able to access training to help them with their role and they had been supported in developing their role.

Responsibilities of the lead nurses were not always clear, and they were sometimes unsure as to whether they should / could make changes in their area. They were also not clear about their role in supporting appraisals and supervision for the staff who reported to them daily.

This lack of clarity had contributed to the differences in practice between sites and services. For example, we saw differences in documentation and differences in administration and transcribing of medicines.

The service leads did not receive management supervision and there was not a forum for lead nurses / practitioners to get together to discuss clinical issues. This was likely to have contributed to multiple policies and procedures fitting the needs of one clinical service but not those of another.

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Local managers liked to be visible to staff and patients and staff described their leaders and line managers as supportive and caring. They gave examples of when managers had supported them with the death of a patient and with balancing caring commitments at home.

Local leaders were proud to work at the hospice and were proud of their staff and volunteers and their commitment to providing high quality patient care.

Staff told us they were very happy with their local leaders, and the visibility / approachability of the director of patient care. However, they commented that they rarely saw the chief executive or board members at the Bishop Auckland site. One member of staff told us they would be happier if executive leads spent more time meeting patients and speaking to staff, so they had a good understanding of the services they led.

Volunteer staff told us they felt isolated from senior leaders of the organisation and staff at the Stockton site which they felt was due to the complementary therapy manager post becoming vacant.

## Vision and strategy

**The hospice had a strategic five-year plan for 2019-2024 which outlined its priorities and the enabling actions required.**

The hospice had a mission statement “to improve the quality of life for those who have a life limiting illness, and their families, and to offer positive support for every challenge they may encounter during their illness. To see death as part of life’s journey.”

The hospice team wished to provide compassionate, dignified care and support where it was needed the most. The strategy expressed the values of care, compassion, dignity, support and community.

Priorities were defined as having the right workforce; the right environment for patients; volunteers and staff, to ensure openness and transparency; to have the resources and capacity to meet demand with the central aim of providing the best quality of care and quality of life for patients.

Each strategic priority was underpinned by enabling actions.

## Culture

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

Staff described the culture as open and told us they would have no fear about raising concerns. Staff had confidence in their managers and leaders said they would be able to approach them if they had anything they wanted to discuss. There was a clear sense of teamwork across day hospice staff and everyone spoke very highly of their colleagues.

Staff told us of concerns and ideas for improvements they had raised with managers. Senior nursing staff felt they were able to make changes and develop practice in their own area of responsibility. However, this had led to some inconsistencies in practice.

Examples of concerns staff had raised included policies and processes regarding administration of medicines and the quality of risk assessments. These concerns had been reviewed and managers had agreed that improvements needed to be made. Work was ongoing to make the changes needed.

Managers needed to ensure they consulted with clinical staff in all areas regarding any updates to clinical policies and procedures to ensure the needs of all services were incorporated.

## Governance

**Leaders did not have effective governance processes, throughout the service. Not all staff at all levels were clear about their roles and accountabilities. Clinical leads did not have regular opportunities to meet, discuss issues, propose improvements and learn from the performance of the service.**

There was a defined governance and committee structure in place for senior managers within the organisation. However, clinical leads did not receive management supervision or have a forum where they could meet to discuss clinical or practical service issues,



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propose improvements and learn from performance of the service. This had led to teams adopting different practices in different settings and policies or procedures which met the needs of one service but not another.

There was a regular manager meeting, but this was not always attended by a representative from day care or outreach services and reports or updates from those services were not always included in the minutes from the meetings.

There had not been any local staff meetings at the hospice for several months until they were reinstated on 5 March 2020. The minutes indicated there was good engagement with staff and there had been the opportunity for staff to raise concerns or propose ideas in relation to cost savings or efficiencies. It did not appear that the outreach services had been represented at the meeting.

There were gaps in systems and processes to support managers and leaders in maintaining effective governance and oversight. For example, the local hospice manager could not directly access; Disclosure and barring service (DBS) checks, registration or training information. However, Butterwick Ltd was working with partner organisations to help them modernise and implement new systems to address this.

There was no monitoring or oversight of patient waiting lists and there was no consistent assessment of any risk to patients who waited for long periods to access neurological day services or family support.

Although the service had recently introduced a system for ensuring all their employed staff had up to date registration, DBS, mandatory training and appraisals, this was not in place for staff not directly employed, such as physiotherapists who were employed by an NHS trust.

Clinical leads were not all clear about their roles and responsibilities.

Managers told us the new governance structure had been implemented during 2019 but this was not fully embedded. It had been intended that there would be certain agenda items discussed at all meetings to ensure a flow of information from service to board. However, we noted that incidents and complaints were not on the agenda for staff or manager meetings, but activity, staffing, policies and contract updates were.

The hospice produced a 'Quality Account' each year' with priorities and objectives but there did not appear to be an action plan or recorded meeting minutes that indicated whether the priority objectives had been met.

Although there was a system in place for reviewing and prioritising the re-writing of out of date policies, this was new and there was still a lot of work to do with bringing all policies and procedures up to date. Managers needed to ensure clinical staff were consulted with updated policies to make sure they met needs of all clinical areas.

## Managing risks, issues, performance and managing information

**Leaders and teams did not have robust systems to manage all risks and performance effectively. They identified risks and issues but did not always document identified actions to reduce their impact. Risks were not always escalated to a risk register for oversight and monitoring of actions.**

Although the hospice used agreed targets to monitor performance it did not produce comparative data over time. This meant the management team could not monitor its own performance over time, using appropriate control limits.

There were gaps in performance data, for example waiting times to access neurological day services was not monitored. This meant some patients could wait months or years to access the service while others accessed a roll on roll off service. The gaps in information meant there was limited data and a lack of knowledge which could have been used to improve access to the service.

Clinical leads were not clear about their role in managing risks, issues and performance which meant some risks were not identified or escalated appropriately.

Not all risks we identified or known to staff were recorded on the organisation's risk register. For example, the issues with handwash basins and other recommendations from infection control audits were not on the risk register despite being recommended at the annual audit for the last three years. This meant there was no monitoring of mitigations or any chance of the issues being escalated for action /allocation of funding to correct.

There was also some confusion in clinical areas regarding risk assessments. Although there was a process of

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assessing risks locally, the risks we saw documented, were in the main, clinical risks. Mitigations were around general management of those risks, for example patients with a tracheostomy, or exposure to bodily fluids.

Environmental / equipment risk assessments such as storage of oxygen or child safety were not documented. For example, although oxygen was stored safely and securely it was not evident that a formal risk assessment had been completed around this. Therefore, we could not be assured that staff were aware of the risks associated with the storage and use of oxygen.

Managers were clear about their biggest risks and identified these as funding, staffing and meeting standards.

Staff received training regarding confidentiality, information governance and data protection. The registered manager was the Caldicott lead for the hospice. A Caldicott lead is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

The hospice services manager identified a need for the services to be able to develop or access IT systems for patient records and for performance information. The hospice was looking for ways in which electronic systems could be developed.

## Engagement

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

Staff were clearly engaged with the organisation and what it stood for, they told us that managers were supportive, and communication was good. Staff and managers told us about weekly team briefs, service updates, staff supervision and a monthly information exchange. The chief executive or another senior manager personally delivered the information exchange at the different hospice sites.

Staff were given opportunities to propose; ideas for cost efficiencies, fundraising ideas and to make other suggestions. Suggestion boxes were available for staff to use.

However, there was no formal staff survey in place or any formal staff recognition or awards. Other than long service, where a volunteer had been in post for ten years and received an addition to their name badge, there were no staff or volunteer annual awards or thank you card system.

Managers told us that they were making a concerted effort to improve staff recognition and had introduced recognising and naming staff noted for examples of good practice at the regular information exchange.

Managers and staff welcomed feedback from service users and their families. The hospice services manager made themselves available to patients to hear their feedback on the services they received.

The service collected patient, relative and other service user feedback through surveys, formal and informal evaluations of services and by collating correspondence and thankyou cards.

The hospice had identified from a local joint needs assessment that there was a high incidence of neurological conditions and in particular; MS in the local population. As a result, the hospice team had worked with commissioners, the MS society and the NHS MS nurse specialist to provide and tailor a service for these patients.

## Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services.**

Managers and staff were open to service improvement and wanted to develop their services to provide the best possible care.

# Outstanding practice and areas for improvement

## Outstanding practice

The family support team had worked extremely hard to provide an accessible service for families with children, who had suffered a bereavement. Staff were extremely responsive and tailored their approach to meet the

individual needs of children, young people and their families to ensure they could access the service. They could access the service at home, at the hospice, in schools and community groups.

## Areas for improvement

### Action the provider **MUST** take to improve

- The provider must ensure that risks to patients are identified, assessed and monitored consistently throughout the hospice, and that assessments and care plans are updated regularly. Patient records must be kept up to date. Regulation 12 and 17.
- The provider must ensure that health and safety risks to staff and patients are identified, assessed and documented consistently throughout the hospice, and that they are escalated appropriately so they can be reviewed, and appropriate mitigating actions can be taken. Regulation 12.
- The provider must ensure there are policies, systems and processes in place to ensure the safe and consistent management of medicines across all hospice settings. To include; transcribing, administration, recording and storage medicines. Regulation 12.
- The provider must take prompt action to ensure staff and managers are clear about their responsibilities under 'duty of candour' to ensure they meet regulation standards and ensure regulatory requirements are reflected in policies and processes. Regulation 20.
- The provider must continue its work to bring policies and procedures in line with current guidance and best practice. To include a review of documentation to support staff making and documenting best interest decisions. Regulation 17.

- The provider must monitor waiting times for all aspects of its services to inform potential service improvements. Regulation 17.

### Action the provider **SHOULD** take to improve

- The provider should consider how it could promote its services to minority groups to ensure its services are accessible to diverse groups. Regulation 10.
- The provider should review how it collects patient outcome data how this information can be used to improve services and patient care.
- The provider should review its audit programme to ensure it can demonstrate achievement of safe standards and how it can use this information to make improvements over time.
- The provider should explore how staff in the home-care setting can be supported to assist patients who need help with administration of pain-relieving medicine.
- The provider should ensure staff at all levels are clear about their roles and responsibilities to support a robust governance, performance and improvement framework and that they are given the opportunity to meet, discuss issues, propose improvements and learn from the performance of the service.



## 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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>The hospice did not always assess the risks to the health and safety of service users and did not always mitigate identified risks.</p> <p>Risks to patients were not identified, assessed and monitored consistently throughout the hospice. Assessments and care plans were not updated regularly, and patient records were not always up to date</p> <p>The hospice did not always ensure the premises were safe to use for their intended purpose. Not all health and safety risks to staff and patients were identified, assessed and documented consistently throughout the hospice. This meant they were not always escalated, reviewed and mitigated appropriately.</p> <p>The hospice did not ensure the proper and safe management of medicines. The provider did not have robust policies, systems and processes in place to ensure the safe and consistent management of medicines across all hospice settings.</p>
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>The hospice did not have effective systems or processes to assess, monitor and improve the quality and safety of the services provided.</p> <p>Many of the hospice policies and procedures were out of date or unfit for purpose.</p>

This section is primarily information for the provider

## Requirement notices

The hospice did not monitor the length of time patients waited for services or consider the impact this may have on service users.

The hospice did not have effective systems or processes to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. This meant risks were not always identified and documented so they could be reviewed, and mitigations put in place.

The hospice did not maintain securely an accurate, complete and contemporaneous record in respect of each service user.

Patient records were not always complete or hold up to date information.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

Staff and managers were not clear about their responsibilities under 'duty of candour' to ensure they meet regulation standards. Regulatory requirements were not reflected in hospice policies and processes.

This section is primarily information for the provider

## Enforcement actions

### Action we have told the provider to take

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