

## Barnsley Hospice Appeal

# Barnsley Hospice

## Inspection report

104-106 Church Street  
Barnsley  
S75 2RL  
Tel: 01226244244  
www.barnsleyhospice.org

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

### Ratings

Overall rating for this location	Outstanding	
Are services safe?	Outstanding	
Are services effective?	Good	
Are services caring?	Outstanding	
Are services responsive to people's needs?	Good	
Are services well-led?	Outstanding	

# Summary of findings

## Overall summary

We carried out a comprehensive inspection of this service as part of a follow up, as the service had previously been inspected in April and May 2021 and January 2022 and was rated inadequate.

At the last inspection we found significant safety concerns and we imposed urgent conditions using our section 31 powers on the service's registration to drive improvement and ensure patients were safe. These conditions were specifically in relation to the clinical assessment review and risk identification of patients, admission assessment processes and COVID-19 management processes and policies. The application of conditions required the service to urgently complete a full review of all patient records to ensure appropriate documentation and risk management process were in place. We issue conditions where the care a service is responsible for, falls short of what is legally required, tell the service what was not right, and explain how long they have to comply with the regulations.

At this inspection we found the service had made significant improvements and had taken prompt action to comply with the regulations.

Our rating of this location improved. We rated it as outstanding because:

- People are protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.
- 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.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. They followed national guidance to gain patients' consent.
- People were truly respected and valued as individuals and are empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service
- 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.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- All staff were committed to continually learning and improving services.

However:

- The service should consider auditing 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms.
- The service did not provide leaflets in multiple languages.

# Summary of findings

## Our judgements about each of the main services

### Service

#### Hospice services for adults

### Rating

Outstanding



### Summary of each main service

- People are protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong. Staff had training on how to recognise and report abuse and they knew how to apply it.
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- 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.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. They followed national guidance to gain patients' consent.
- People were truly respected and valued as individuals and are empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service
- 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.
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# Summary of findings

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# Summary of findings

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# Summary of this inspection

## Background to Barnsley Hospice

Barnsley Hospice is operated by Barnsley Hospice Appeal. It provides hospice care for adults living in Barnsley and the surrounding area. The hospice has 10 inpatient beds, and provides day hospice services, bereavement and family support.

Barnsley Hospice Appeal is an independent charity and company limited by guarantee. The service is registered for diagnostic and screening procedures and treatment of disease, disorder or injury and has a registered manager in place to oversee this. CQC last inspected Barnsley Hospice in January 2022.

## How we carried out this inspection

The team inspecting the service comprised a CQC lead inspector, a CQC inspection manager, a team inspector and one specialist advisor with expertise in end of life care. The inspection was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Our inspection took place on the 15 and 16 November 2022 using our comprehensive inspection methodology. The inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We observed care and treatment, looked at 4 sets of medicines administration records, 4 sets of patient notes, 11 staff and volunteer files. We spoke with 21 members of clinical and non-clinical staff. We looked at compliments received by the service as well as patient feedback surveys. The service had not received any complaints since our last inspection.

You can find information about how we carry out our inspections on our website: <https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

## Outstanding practice

- Feedback from people who use the service and those who are close to them was continually positive about the way staff treated people. People said staff went the extra mile and their care and support exceeded their expectations.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who use the service, those close to them, and staff were strong, caring, respectful and supportive.
- Staff always empowered people who used the service to have a voice and to realise their potential. Staff showed determination and creativity to overcome obstacles to delivering care. People's individual preferences and needs were always reflected in how care is delivered.
- There was a compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care.
- Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired culture. Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond.
- There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans.
- Plans were consistently implemented and had a positive impact on quality and sustainability of services.
- Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process.

# Summary of this inspection

- There was a strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences.









## Areas for improvement

- The service should consider auditing 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms to ensure they are completed in line with best practice.
- The service should ensure that information is available in various languages suitable to the local community.

# Our findings






## Overview of ratings

Our ratings for this location are:

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



# Hospice services for adults

Safe	Outstanding 
Effective	Good 
Caring	Outstanding 
Responsive	Good 
Well-led	Outstanding 

## Are Hospice services for adults safe?

### Mandatory training

**People are protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things go wrong.**

At the last inspection we found that the service had taken steps to improve the internal mandatory training compliance. At this inspection we saw the service had greatly improved the internal mandatory training compliance and supported staff to complete the required elements. The service had moved training information to eLearning through Skills for Health, pulling the mandatory core skills list from Skills for Health including prevent training (Prevent is part of the government counter-terrorism strategy and aims to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism).

We reviewed the service's training spreadsheets and saw that staff were compliant with all mandatory training apart from moving and handling which was just under the target of 95% at 87% compliance. This amounted to 5 people not having completed their training. All 5 staff members were booked on training for December 2022 and January 2023.

At the last inspection we saw that clinical staff had not received training in relation to care of the deteriorating patient. At this inspection we found that all staff had been trained in the application of the national early warning score tool (NEWS). NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients. Managers implemented the tool in September 2022, and it had been evaluated weekly since then to ensure appropriate application of the tool.

Clinical staff had completed training on recognising and responding to patients with learning disabilities, autism and dementia needs.

The human resources (HR) team supported managers in monitoring mandatory training and alerted staff when training updates were required. All staff we spoke with told us that managers supported them with mandatory training needs and felt positive changes were taken to recognise staff training needs.



# Hospice services for adults

The service had an up to date equality, diversity and inclusion policy in place. All staff were required to complete equality, diversity and inclusion training through the e-learning for health learning platform.

## 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.**

The service had both adult and children safeguarding policies in place. The policies were in date and in line with national guidelines.

At the last inspection we saw not all staff were up to date with their training. At this inspection we saw that safeguarding training compliance had much improved and 100% of staff, including all registered nurses and medical staff had received safeguarding adults and safeguarding children training level 2. Safeguarding leads and the executive lead for safeguarding all had higher levels of training as determined by the intercollegiate guidelines.

The service employed a social worker who promoted safeguarding and supported staff when making and reviewing safeguarding referrals. We saw that the social worker held level 3 adults safeguarding training and was the nominated adult safeguarding lead for the service. The Lead Counsellor has level 3 training in safeguarding children and is the nominated safeguarding children lead for the service.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with were able to define safeguarding protocols and understood who to contact with safeguarding alerts when they had concerns.

Staff followed safe procedures for children visiting the ward. During the inspection we observed a planning meeting arranged to discuss a visitation of vulnerable children to the hospice to meet their relative. Representation of all staff levels and skill mix attended and discussed safety precautions, the children's needs, approach to their emotional support and actions to mitigate risk. The meeting was comprehensive and emphasised a multi-disciplinary approach to safeguarding vulnerable people.

Staff provided examples of safeguarding referrals that had been made just prior to the inspection and were able to explain how these safeguards were managed and investigated. We saw staff worked closely with external health care professionals to share safeguarding concerns including district nursing colleagues and social care organisations.

We reviewed adult and children safeguarding policies and saw that all volunteers (when in post) also received safeguarding training. At the time of the inspection volunteers were working in reception, fundraising and administration (although not in the inpatient unit) and these had all completed both adults and children safeguarding.

Staff had implemented a new process for obtaining and storing information regarding DBS checks. All staff files reviewed had fully completed enhanced DBS checks and all results were appropriate for the roles being undertaken. The HR process staff followed, and the electronic system in use did not allow for any member of staff to be offered a start date without all documentation in place including a satisfactory DBS check, references or interview record.

We saw the services annual update for commissioners relating to their safeguarding standards. The report was comprehensive and robust, itemising all actions taken to ensure the service practiced in line with intercollegiate guidance.



# Hospice services for adults

## Cleanliness, infection control and hygiene

### **Staff used infection control measures when visiting patients on wards and transporting patients after death.**

We reviewed the service's infection, prevention and control (IPC) policies and procedures and we found them to be up to date and were in line with national guidance.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. The inpatient unit was bright and visibly clean. Patients each had separate rooms, with en-suite bathrooms. Hand washing facilities and hand sanitisers were available in patient rooms, throughout the ward, and the hospice as a whole.

At the last inspection we saw the service had conducted hand hygiene audits. We reviewed the results of the last audit completed for the period of October – December 2021 and saw that 80% of staff were compliant. The audit was due to be reviewed again in three months. However, at this inspection we found that a formal hand hygiene audit had not been completed since December 2021. Arrangements had been made with a local trust specialist infection prevention and control team to support with IPC. The agreement included; hand hygiene programme, annual IPC training programme, use of their audit tools (including hand hygiene, sharps and sluice audit), rapid improvement reviews, regular review and updated suite of IPC policies, fit testing and outbreak management. However, due to pressures at the local trust, this agreement had been delayed. Recent dates to deliver a hand hygiene ultraviolet lightbox to the hospice had been cancelled. All delays were due to pressures at the local trust during the COVID-19 pandemic and new dates were still to be confirmed at the time of the inspection. The hospice had appointed 2 IPC Champions. The local trust undertook hand hygiene audits in December 2022 following the inspection and outcomes showed 100% compliance.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. However, audits did not provide a compliance rate against a target and were completed using a tick box system with comments. However, audits had actions, so staff knew what was required to meet full compliance. The last IPC cleaning audit was undertaken in June 2022.

Housekeepers used detailed cleaning checklists, tailored with specific tasks for every shift. Staff signed and dated each task as it was completed and there were no gaps in the signing of any records. We saw a record of communications between housekeeping staff that showed where specific needs were required, such as deep cleaning of a vacated room. Room checks and spot checks were completed by the inpatient unit sister.

Staff followed infection control principles including the use of personal protective equipment (PPE). We reviewed the services guidance in relation to management of COVID-19 and saw the service had produced a 'patients, relatives immediate infection prevention and control checklist'. The checklist stated that doors should be closed where possible when managing possible cases of COVID-19. We saw additional cleaning arrangements had been introduced as a result of COVID-19 and we saw rooms actively cleaned in accordance with these enhanced protocols during our inspection visit.

The service had a COVID-19 action plan in place to enable early detection, investigation and management of a potential outbreak, and to enable the Local Authority and Public Health England to determine if there was an issue with infection prevention and control (IPC) and other factors that may be increasing the population's vulnerability or increasing the risk of cross-transmission.



# Hospice services for adults

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned using 'I am clean' stickers. We saw that equipment audits were completed but the audits did not provide a compliance rate against a target.

## Environment and equipment

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

The service had suitable facilities to meet the needs of patients' families. The design of the environment followed national guidance and patients were offered individual private rooms. The environment was light and bright with comfortable furniture and surroundings were pleasantly decorated with artwork. Additional electrical lighting was added to create a more welcoming environment. All rooms opened out into a patio garden. Patients could reach call bells and staff responded quickly when called.

All equipment was serviced and checked by the maintenance company and a service level agreement and schedule of works was kept up to date. The service had enough suitable equipment to help them to safely care for patients. Staff carried out daily safety checks of specialist equipment. Syringe pumps were serviced and tested, and staff knew how to report any concerns with specialist equipment. We reviewed the resuscitation trolley and saw that regular checks of the equipment were in place. All items were checked including emergency medication, sharps, blood glucose monitoring equipment, and clinical supplies, were in date.

The service hired furniture for use by patients with bariatric needs. Staff said they could request this within hours of a referral so that everything was provided and in place before the patient arrived.

Staff disposed of clinical waste safely. A service level agreement for safe disposal was in place. We saw the use of colour coded laundry bags and bin bags for the disposal of clinical waste. Clinical waste was also double bagged and stored externally in a locked cage.

There was a cooling blanket stored securely and records were kept of servicing and maintenance checks. However, staff told us the blanket was rarely used because local undertakers were very responsive and attended as soon as required. Staff knew where the blanket was stored and how it needed to be used and checked.

The CEO/Chief Nurse is a member of the Barnsley Place Partnership Delivery Group, Barnsley Place Committee and Partnership Board. The Director of Governance & Quality and the Director of Nursing are also members of the Integrated Health and Care Quality and Safety Committee Barnsley Place.

A health and safety handbook was provided to all staff during their induction. The booklet explained Barnsley Hospice's health and safety policy, rules and responsibilities, and gave practical guidance on how to look after themselves, and others, at work.

We saw that all chemicals were stored securely and appropriately in line with Control of Substances Hazardous to Health Regulations 2002.

## Assessing and responding to patient risk



# Hospice services for adults

## **Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.**

The last inspection found that staff used the Phase of illness and Karnofsky Performance Status score (validated for use in specialist palliative care) as measures to reflect changing care needs in palliative care patients. These are useful tools to guide care planning in palliative care patients but do not perform the same function as the National Early Warning Score (NEWS) tool which uses bedside observation measurements to identify patients experiencing acute deterioration and then informs a response in the immediate and short-term. At this inspection, we found that the National Early Warning Score (NEWS) tool was being applied appropriately, in addition to the Phase of Illness and Karnofsky Performance Status measures, to recognise and respond to the needs of a deteriorating patient.

Managers could organise additional support staff for patients with additional needs such as one to one care.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary information to keep patients safe. The daily safety huddle was held at 13:15 hours each day. A key element of the huddle was to provide daily assurance and mitigate risk in relation to safe staffing in accordance with patient acuity and dependency, skill mix and staff numbers. Patients identified as requiring enhanced care/observation were flagged to ensure appropriate measures were in place to support and maintain a safe environment.

Staff we spoke with knew about and how to deal with specific risk issues such as reporting sepsis, Venous thromboembolism (VTE), falls and pressure ulcers.

The service had undertaken a falls review in October 2022 and found an upward trend in reported falls incidents since July to September 2021 with an increase in July to September 2022. As a result of the findings the service implemented falls prevention measures including the monitoring of lying and standing baseline blood pressure recordings. Findings also showed that the compliance rates for completion of a falls assessment on admission were 95%. It was evidenced that 9 out of 11 (82%) high risk patients had a falls care plan completed on admission. However, 2 out of 11 (18%) high risk patients falls care plan appeared to have been commenced after the first fall. Five out of 20 (25%) patients had been seen by a physiotherapist prior to their first fall.

Following the falls review a number of actions were implemented through lessons learned processes. The service's prevention and management of falls policy was updated to highlight the need to complete falls assessments and the timescales for completion, the criteria and scoring system used to determine levels of risk was reviewed, and an assessment review timeline was established. Guidance was provided about when to seek input from the physiotherapist, the role of manual handling care plans, and consideration was given to the frequency of falls prevention training.

An evaluation of the roll out of the national early warning score (NEWS) tool had been completed at the time of the inspection. It was found that the education and ongoing service evaluation had supported a successful implementation. NEWS was observed to be embedded in practice, and the service evaluation had supported ongoing learning and reflection regarding its use and application.

## **Staffing**

**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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.**



# Hospice services for adults

The ward sister was responsible for ensuring the duty rota was prepared six weeks in advance, and that the rota was maintained to reflect staffing accurately. Night Duty, Bank Holidays and week-end shifts were planned and filled as a priority so that any shortfalls would occur during a weekday, since there was more staff available across the hospice during those times, and therefore a greater likelihood of cross-cover from other professionals.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. The service told us they were working closely with Hospice UK on a national tool that could be implemented in the future.

At the time of inspection, we saw that the service had enough medical, nursing and support staff to keep patients safe. The inpatient unit accommodated a maximum of 10 patients, and we saw the actual number of nurses and healthcare assistants matched the planned numbers.

In the event of staff shortages emerging, the Barnsley Hospice nurse bank were contacted to fill the gap. Consideration was given to re-distributing available nursing resource evenly across the working week which could result in split-shifts if necessary.

The service had enough medical staff to keep patients safe. The medical staff on duty matched the planned number for the number and acuity of patients. The hospice directly employed 3 part time consultants, 2 part time and 1 full time speciality doctor. At the time of inspection there was also 1 locum doctor and 2 regular bank doctors used to fill gaps in the on-call provision and provide weekday backfill for leave and absence. Some of the work of this medical team took place outside the hospice and within the specialist palliative care teams in the community and acute hospital NHS Trusts.

Managers could adjust staffing levels daily according to the needs of patients and would request additional healthcare assistants to support patients with one to one care or one to two supervision if this suited the needs of the patients. All staffing was planned and organised around patient needs rather than organisational, financial, or environmental requirements.

The service had reducing vacancy rates, reducing turnover rates, and low sickness rates.

Managers limited their use of bank and agency staff. All agency staff were familiar with the service. All bank and agency staff had a full induction and understood the service. The quality matron and chief nurse both worked clinically if and when necessary to support staff care for patients' safety.

## Records

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

The service had a records management policy which was reviewed in October 2022. As a result of the review, a new policy was created and awaiting imminent ratification at the time of the inspection.

At the last inspection we found that patient notes were not always comprehensive or up to date. We reviewed the records of 5 patients and saw documentation was not completed fully and in some areas, it was found not to have been completed at all.



# Hospice services for adults

At this inspection we reviewed 4 patient notes and found they were all comprehensive and completed contemporaneously. All records were personalised, and key risks and needs had been identified for each patient. Staff said that they could access records easily and in a timely manner. We observed that records were stored securely.

Record audit outcomes showed that in September 2022, 17 out of 17 sets of records were fully compliant. October 2022 audit outcomes showed that 12 out of 12 sets of records were fully compliant. Clinical record keeping audits conducted in October 2022 showed that records were completed to a good standard with most outcomes RAG (red, amber, green scoring) rated green. An action plan had been implemented to address those areas that had been RAG rated amber.

The electronic recording system for shared care records had been slow to roll out and implement. There had been 3 rounds of interviews for a project implementation manager and offers had been made but staff were not yet in post.

## Medicines

### **The service used systems and processes to safely prescribe, administer, record and store medicines.**

The service had a medicines management policy and found it to be comprehensive. This was actively under review and awaiting ratification at the time of the inspection. During the review, the service highlighted areas of change such as full review of all sections of the policy in line with current research and evidence-based practice. The service was reviewing roles and responsibilities of individuals, groups and committees were added and there had been an update on the remote prescribing and transcribing sections, patients' self-medicating and a symptomatic relief section added to the policy.

Staff followed systems and processes to prescribe and administer medicines safely and to check patients had the correct medicines. The hospice had a formal arrangement with a local trust who provided a pharmacy technician to visit each morning Monday to Friday to action requests for drugs ordering for individual patients and to stock medicines. A clinical pharmacist attended twice weekly as part of the multidisciplinary team (MDT) and attended the weekly MDT meetings for each patient review. Both in and outside of this meeting they advised on medication regimes, supported decision making regarding treatment, provided professional support in respect of medicines management more generally (including destruction of controlled drugs) and provided education for clinical staff. The pharmacist also undertook controlled drugs (CD) audits every 3 months and provided the results to the CD accountable officer; the director of governance and quality, the quality and risk manager and the quality improvement and patient safety group.

Staff reviewed each patient's medicines regularly, provided advice to patients and carers about their medicines and kept records up-to-date. Prescribing was clear, safe and appropriate in response to symptoms that patients experienced during their stay. When medicines were not administered, reasons were clearly recorded on the paper prescription chart. There was evidence of medicines being appropriately titrated to respond to patients' increasing symptoms.

The white board in the drug room provided a tool for clear and easy communication between clinical staff in respect of medication administration and checks for each patient, observations and storage of patients' own controlled drugs. This meant that if a staff member who was caring for a particular patient was suddenly not available, all other staff were able to view the board to see at a glance what time medication was last administered, what was next due and when and what observations had been completed or were required.

Staff stored and managed all medicines and prescribing documents safely. Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The service had



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introduced a system to check (medicine reconciliation) the medicines the patient was taking throughout their admission and a detailed reason was recorded for why a medicine had been stopped, started, or a change in dose. This allowed a detailed discharge letter to be produced, which gave a correct list of medicines to be sent to the patient's GP. We saw medicine reconciliation processes were much improved, since the last inspection.

We saw fridge temperatures were checked during each shift and documented. The fridge temperature acceptable range was printed on the recording documents with instructions to staff on what to do should temperatures not fit the required range. There was also a written policy available electronically to all staff.

We observed a 'safety huddle' and found information about patients' symptoms, medicine choices and non-pharmacological measures were discussed between all members of staff. Staff learned from safety alerts and incidents to improve practice.

Before discharge, a take home medicines list was completed by a doctor at least 48 hours in advance of the planned discharge to ensure the medicines would be available at the correct time. General Practitioners received a secure NHS email summary of the patient's current status and list of medicines from the hospice doctor on the day of discharge and a full discharge letter within three working days following the patient's discharge. The discharge letter was copied to all other medical professionals and palliative care teams involved in the patient's care. Where appropriate, the patient was discharged with a nursing summary to be passed onto the nursing team who would continue with the patient's care. The patient was also provided a full list of their medicines, which was explained either to them or their carers, and an emergency telephone contact sheet was provided.

Prescribers used antibiotics under advice of a microbiologist. The pharmacy support technician completed a monthly audit on storage, drugs and fridges.

Cabinets were metal and kept locked. Keys were held by the staff nurse and handed over to another nurse at the shift change. CDs were checked nightly. All 3 books checked were correct. CDs were also checked by the pharmacist monthly.

Medical gases were stored secured appropriately on the wall.

## Incidents

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

We reviewed the services incident reporting and management policy (including serious incidents) and found it to be up to date, comprehensive and in line with reporting guidelines. The policy was last reviewed in September 2022.

Staff knew what incidents to report and how to report them. We saw the service used an electronic database system for logging and monitoring incidents. Staff had received training for this system. Staff we spoke with knew what incidents to report and were able to articulate how they should be reported in line with the service's policy.

At the last inspection we saw that incidents were not always investigated thoroughly and were found to contain conflicting information. At this inspection we found that managers investigated incidents thoroughly. Patients and their families were involved in these investigations and staff said they received feedback from investigation of incidents.





# Hospice services for adults

The service had no never events on any areas. Staff told us that managers debriefed and supported them after any serious incident.

Managers and staff understood duty of candour and there was a duty of candour policy in place. Staff were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff met to discuss the feedback and look at improvements to patient care and there was evidence that changes had been made as a result of feedback.

## Are Hospice services for adults effective?

Good



### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.**

At the last inspection we found that the service did not hold a number of requested policies in relation to clinical assessment and review of patients receiving care at the hospice. At this inspection we found that a large number of policies had been implemented and reviewed in line with national guidance.

At the last inspection we found clinical practice was not audited or formally reviewed. At this inspection we observed that clinical practice was audited, and findings were positive. We were assured that the service's processes ensured staff followed national guidance and evidence-based practice.

The service had implemented a quality and patient safety dashboard which monitored medicines, pressure ulcers, falls, healthcare acquired infection, safeguarding, restrictive interventions and training figures.

We saw staff had undertaken psychological wellbeing assessments and we were informed that the GP would be notified of any concerns. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, and their relatives and carers.

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms are not yet being initiated in Barnsley place services. Barnsley Hospice is an active partner in the implementation group working across providers in Barnsley place to implement ReSPECT during 2023. This includes community, hospital and ambulance partners as well as the hospice. For Barnsley Hospice patients capturing individual choices and preferences was a key part of assessment and ongoing care. These choices and wishes were recorded in new patient assessments, and in the use of the My Care Plan document for dying patients (this document was used across Barnsley providers to support care in in the last days of life).

### Nutrition and hydration



# Hospice services for adults

**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, particularly those with specialist nutrition and hydration needs. Staff used a screening tool to monitor patients at risk of malnutrition. We saw this was appropriately completed in the care records of patients we looked at. Guidance was available to support staff with encouraging people with life-limiting illnesses to eat.

The hospice cooks spent time with patients listening and planning meals, snacks and drinks to suit their needs and wishes. Staff made meals at the request of patients and had space and creativity to provide any food the patient requested. Cooks worked together with speech and language therapists to provide tempting foods with specified textures such as purees or thickened drinks.

Staff told us they would offer dietary choices in accordance with patient's cultural or religious choices but patients receiving care at the time of inspection had not requested these options. There was a varied 3 week rolling menu in place which included light snacks available throughout the day.

A nutrition and hydration survey was given to patients during their admission to establish if they were given choice, enough access to food and drinks, and if they had received any help they may have required. The survey was used to improve catering services.

. At this inspection we saw that staff would refer to the GP if necessary, should the patient require additional input from an external source. More often for inpatients at Barnsley Hospice a direct referral was made to community Allied Health Professionals or doctors from other disciplines such as in the following examples: inpatient review by community Macmillan dietician, or Tissue Viability Nurse, outpatient or telephone review by oncologist or pain anaesthetist.

We observed that patients' fluid and nutrition charts were completed appropriately. In all four of the patient's fluid balance charts we reviewed, we saw staff recorded fluid measurements properly. Patients were weighed for dietary purposes and staff assessed weight loss or gain as part of their stay at the hospice.

We saw patients had water provided within reach and staff offered drinks to patients and their visitors throughout the day. Patients and their relatives were offered complementary afternoon teas, fruit bowls, smoothies, Christmas hampers including bespoke gifts, sparkling wine, and birthday treats.

## Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately.

Patients were asked how their pain levels were, following administration of analgesia and recorded the information as part of the integrated palliative outcome scale (IPOS) scoring system.



# Hospice services for adults

We reviewed the clinical assessment for all patients at the point of admission and we saw that assessments were recorded for risks associated with pain management.

Staff discussed pain management with the internal multi-disciplinary team, and we observed this as part of the MDT meeting that we attended during the inspection. We also observed patients were comfortable and at rest during our visit to the hospice.

Patients we spoke with advised that their pain was managed well. We reviewed information provided from the Integrated Palliative care Outcome Scale (IPOS) which was a patient-reported outcome questionnaire that aimed to capture the difference that healthcare makes for patients and families. One of the symptoms surveyed was pain and the survey showed that there was a 44% improvement in pain for patients from admission to discharge from July to September 2022.

## Patient outcomes

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

At the last inspection managers told us that audit activity was largely on hold due to the pandemic and the lack of some senior staff within the governance team. Leaders of the organisation told us that developments were in place to expand the audit plan and further improve quality outcome monitoring.

At this inspection we saw that managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The clinical audit programme and associated actions were delivered and monitored by the hospice quality improvement and patient safety (QIPS) group and information governance audits by the information governance group (IGG). The QIPS Group and IGG then reported directly into the governance and quality committee which was a board sub-committee with delegated authority of the board of trustees.

The governance and quality committee was chaired by a trustee of the board and attended by a minimum of 3 trustees at each meeting. The board of trustees and the governance and quality committee requested additional clinical audits out with those already on the annual audit plan based on triangulated data and intelligence received. Audits completed were positive, consistent and met expectations, such as national standards.

The service networked with 3 other hospices in the area to align audits and for the purposes of local benchmarking within the network. Managers and staff used the results to improve patients' outcomes and made sure staff understood information from the audits.

We saw the service submitted data relating to pressure ulcers, medication incidents and falls to Hospice UK and used this as a benchmark in which to monitor some patient outcomes and aid improvement.

The use of the national early warning score (NEWS) as a tool to aid in the recognition of the clinically deteriorating patient had been completed. Records showed NEWS was embedded in practice, and the service evaluation had supported ongoing learning and reflection regarding its use and application.

## Competent staff



# Hospice services for adults

**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. Managers gave all new staff a full induction tailored to their role before they started work. In addition to this, we saw the service had developed a trainee trustee appraisal booklet which had recently been implemented, to support new trustees joining the organisation.

The board report followed a template provided by NHS England that guided organisations through the key requirements for training compliance with regulations and key national guidance. It also provided a format to review these requirements, so that the service could demonstrate not only basic compliance but continued improvement over time.

The managers supported staff to develop through yearly, constructive appraisals of their work. At this inspection we saw managers had implemented both formal supervision and informal peer support discussions and staff were able to further discuss areas of clinical development during staff meetings and MDT sessions. Formal supervision sessions included reference to work performance and training development needs.

All doctors with a prescribed connection to the Hospice reported to a single responsible officer. Three of the current hospice doctors also worked in primary care and therefore their prescribed connection is with NHS England North (Yorkshire and the Humber) - South Yorkshire. The hospice supplied a yearly appraisal report for their hospice work. At Barnsley Hospice the Responsible Officer function had been outsourced to a local trust with regard to appraisal and revalidation processes and recommendations for revalidation, with some tasks delegated to the medical appraisal lead for the service. We reviewed the service level agreement (SLA) in place with the local trust and found it to be appropriate.

There was an up to date policy in place for responding to concerns about doctors. There was also a revalidation oversight group which met four monthly to discuss the delivery of appraisal and revalidation processes and overall direction in terms of performance. Consideration was also given to the delivery of the improvements to revalidation based on the recommendations from the Taking Revalidation Forward [TRF] report.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The service offered staff a number of additional training opportunities, which further supported staff clinical training skills including time out days for ward sister, controlled drugs accountable officer training, grief and loss training, medical gas and interpretation of blood results training. The service provided medical trainee placements and the ratio of medical staff to trainees was above the national requirement.

During the inspection we saw that all staff had received an appropriate disclosure and barring (DBS) check. We saw the service had strengthened and improved policies and processes. We reviewed 11 staff files and saw that appropriate checks were now in place and the services' policy had been updated to meet with national guidance. We saw professional registration checks were now in place to include Nursing Midwifery Council (NMC) and the General Medical Council (GMC). The service had taken steps to improve the organisation and general housekeeping of staff files so that key information could be easily accessed and identified. We saw files were comprehensive.



# Hospice services for adults

We saw that there was 61.9% appraisal compliance on a rolling programme for staff appraisal. Compliance figures were low due to recent recruitment. Leader of the service held this information electronically and knew how many weeks it had been since the staff members last appraisal. Staff were notified in advance of their appraisal to allow time to prepare.

## Multi-Disciplinary Working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff worked together to ensure patient information was shared. A number of meetings such as patient's safety and safeguarding meetings were held to ensure key information was known to all staff.

We saw that MDT discussions included symptom control, safeguarding, escalation plans, falls risk, diet risk, skin risk, DNACPR choices and NEWS outcomes. Discussion also covered approaches to family inclusion and patient involvement. We observed that symptom control discussions included patient feedback.

Staff worked across health care disciplines and with other agencies when required to care for patients and sought information from national organisations such as Hospice UK. Evidence showed that when required, the service would link with physiotherapists and speech and language practitioners. Patients cared for on the inpatient unit who showed signs of mental ill health were assessed by the inpatient unit (IPU) team. If medical input such as prescribing of antidepressants was needed it was done on the IPU. Referral to the hospice counselling team is considered as appropriate, and if advice is needed by a psychiatrist this would be sought in liaison with local mental health services. Clients of the hospice counselling service may be referred back to their GP for mental health assessments where indicated.

We were informed that the social worker provided support and advice to patients and those close to them. This included (but was not limited to) advice and support in getting wills written; benefits; power of attorney etc.

## Health promotion

**Staff gave patients practical support to help them live well until they died.**

The service displayed paper versions of information leaflets and relevant information promoting healthy lifestyles and support in patient areas. However, all information was in English at the time of the inspection.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle for example nicotine patches for people trying to stop smoking.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.**



## Hospice services for adults

At the last inspection we saw that staff did not always gain consent from patients for their care and treatment in line with legislation and guidance. At this inspection we found that staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff made sure patients consented to treatment based on all the information available and clearly recorded their decision. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

We reviewed the service Mental Capacity Act and Deprivation of Liberty Safeguards: including Consent policy and found it to be up to date and in line with national guidelines. Staff could describe and knew how to access the policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Training compliance was 100% for all staff.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Managers monitored the use of the Mental Capacity Act and Deprivation of Liberty Safeguards and made sure staff knew how to complete forms appropriately. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Staff were able to describe the best interest decision making processes and how they would be applied. We reviewed 4 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms within the patient records were up to date, fully completed and stored securely. Patient records were stored in the office in the inpatient unit, accessible only to staff. However, we found that DNACPR forms were not audited in line with good practice.

## Are Hospice services for adults caring?



### Compassionate care

**People are truly respected and valued as individuals and are empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service**

Staff were empowered to treat patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. This was a significant improvement from findings at the last inspection. Staff regularly took time to interact with patients and those close to them, in a respectful and considerate way.

The environment on the inpatient unit was quiet and calming and we saw patients were relaxed during our inspection. Staff were observed completing visual checks whilst patients were at rest and assistance was offered in between the patients using the call bell.

All patients were cared for in private individual rooms and we saw staff-maintained patients' dignity and privacy whilst assisting with personal care needs and during sensitive conversations.



# Hospice services for adults

The service actively sought feedback from patients and those who used the service. Feedback from people who used the service and those who were close to them was continually positive about the way staff treated people. People thought that staff went the extra mile and their care and support exceeded their expectations. We saw feedback which said “I cannot forget what the staff did for my late wife in the last few days of her life, so kind and caring and also the way they looked after family members too”

We reviewed recent feedback questionnaire summaries and saw that 100% of patients said their privacy and dignity was respected and staff were polite and treated them with courtesy. We saw thankyou cards displayed around the ward area which reflected this.

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people’s dignity. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.

Staff recognised and respected the totality of people’s needs. They always took people’s personal, cultural, social and religious needs into account, and found innovative ways to meet them such as preferred food options, chaplaincy support and creative ideas to adapt social gatherings when patients were too unwell to go on outings.

The hospice catering team brought in their own china tea sets for patients and families to use. They took great care and pride in providing food and drink to help families celebrate events. Staff had an electronic wish list for specialist catering equipment such as afternoon tea stands and ice buckets to provide memorable and high quality experiences for patients and families. The catering team also provided afternoon teas and buffet style food for special occasions for patients and those close to them. These had been very well received and were arranged with involvement of the whole of the hospice team.

Therapists at The Orangery supported people living with a range of conditions including cancer, respiratory disease, heart disease and neurological conditions such as Parkinson’s disease and motor neurone disease (MND). They helped people cope with the physical, psychological and emotional demands of their condition and live their lives as well as possible as their illness progressed.

The Orangery was a safe and tranquil space within Barnsley Hospice which opened on to a restful, sensory garden and had facilities for refreshments, and free parking. Every patient referred to the Orangery by a healthcare professional had their needs assessed through a simple process over the phone to design an individual package of wellbeing support was designed to suit them. The hospice provided complementary therapies and a series of short programmes to help patients cope with their illness and develop effective self-help techniques to manage symptoms.

We were told about patient stories which included when a patient on the inpatient unit wanted to be able to celebrate their wedding anniversary. A suggestion was made to hold a movie night in The Orangery. The patient chose a film, non-alcoholic drinks, popcorn and choc ices for the intermission. The staff ensured that the evening ended with “twinkly lights” on the patio as requested by the patient. Staff also created a movie poster which the couple had framed.

## Emotional support

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



# Hospice services for adults

Staff gave patients and those close to them help, emotional support and advice when they needed it. People's emotional and social needs were seen as being as important as their physical needs. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

The hospice counsellors were specialists in providing bereavement counselling and support for those experiencing grief after someone dies from a life-limiting progressive illness like cancer, a chronic heart or lung condition, motor neurone disease or Parkinson's disease. They provided both pre- and post- bereavement support, which was deemed especially important for children. The team were experienced in helping children aged 5 to 18 work through their grief and the feelings and thoughts they had relating to their loss. The service also worked with local schools when children required support.

Since the last inspection, chaplaincy support had been recruited and visited the hospice 2 days per week. A team of 3 part-time chaplains shared this role and could provide support to staff and patients of all faiths. As well as the spiritual support offered through the external 'chaplaincy and listening service', they also provided the hospice with an out of hours service if needed.

We observed that the service leaders held inter faith weeks and shared cultural information. At the time of inspection, the cultural beliefs and requirements of the Hindu faith were shared through the staff newsletter. Religion, spirituality and existential issues were often brought into the counselling sessions and clients had the opportunity to explore these issues.

Bespoke experience sessions for patients and those close to them were arranged by the whole staff team. Experiences included, for example, providing a paddling pool filled with children's play sand so that the patient could feel the sand between their toes one last time, and trips out of the hospice with family and friends. We found that it was not unusual for family pets to visit or for a local farmer to bring a pony to the hospice for patients to spend time with. We were also informed of a patient and their family being assisted to the seaside.

The Orangery support and wellbeing service was launched in December 2021 to offer a package of wellbeing support for people living with active and progressive life limiting illnesses which could not be cured.

Staff chatted to every patient referred to the inpatient unit and to the Orangery and assessed their needs to design an individual package of wellbeing support to suit them. Staff also offered advice and support services online, over the telephone and in person.

Complementary therapies and a series of short programmes were available with group work facilitated to help patients cope with their illness and develop effective self-help techniques to manage symptoms and challenges in their own way, for example, the COPE programme offered education and support on symptom management for fatigue, breathlessness, anxiety and sleep problems.

## **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.**

People who use services and those close to them were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person. Staff always empowered people who used





## Hospice services for adults

the service to have a voice about their care and treatment and to realise their potential by encouraging small daily achievements. They showed determination and creativity to overcome obstacles to delivering care and people's individual preferences and needs were always reflected in how care was delivered, for example, each room in the inpatient unit had a message mood board to help the patients express what their mood was at any time. The boards were also used by visitors to leave messages for patients on any particular requests.

We were informed about the admission process to the inpatient unit and heard how family members were involved in the admission and assessment process. We saw electronic care records stating that both medical and nursing staff had spoken with families regarding changes in care needs and clinical needs.

We saw that the service had introduced 'This little box' which was a complimentary box offered to all patients to promote positivity, wellbeing and self-care. These boxes contained items such as a book, music, breathing technique guides and information. The introduction of these boxes had received recent positive feedback.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff supported patients to make informed decisions about their care.

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

### Are Hospice services for adults responsive?

Good



#### Service delivery to meet the needs of the 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.**

The hospice was well connected locally. The chief nurse had encouraged the executive team and clinicians to network with peers locally. The hospice belonged to the Barnsley-wide palliative care network. This included strategic networking and less formal networking with the aim of identifying the sharing of good practice.

The chief nurse met with council members as an opportunity to discuss the service and how constituents could access hospice services – the aim was for all local communities to know about Barnsley Hospice. A meeting was planned with the executive lead from community nursing services to plan and deliver a more joined up service. The hospice had since strengthened links with the local NHS trusts and GP surgeries, and within the community at the local library and football club.

At the last inspection we saw the numbers of non-white British patients remained low and there were no established links in which the services could demonstrate it was addressing the needs of the wider ethnic community. At this inspection we saw that the service had undertaken a project to establish gaps in coverage of the service to the Barnsley population. A comparative analysis of deprivation levels in the Barnsley borough, against admission levels to services



# Hospice services for adults

were undertaken by the service. The outcomes highlighted that areas close to Barnsley Hospice had a higher admission rate than parts that were further away. It was thought that this was due to a higher awareness of the existence of the service among professionals located closer to the hospice, with shorter travel distances, and the fact that the area surrounding the hospice had lower deprivation levels when compared to areas with similar population density.

As a result of findings, an awareness campaign was commissioned in order to attract more referrals to the service. Occupancy levels were currently slightly below the national average for hospices the same size. The campaign aimed at increasing the number of referrals received and inequality of admission rates would decrease.

We saw that the service had systems to help care for patients in need of additional support or specialist assistance for example one to one care.

## Meeting people's individual needs

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

At the last inspection we saw that staff did not always make sure patients living with mental health conditions, learning disabilities and dementia, received the necessary care to meet all their needs. There was no learning disabilities or dementia link nurse in post.

At this inspection we found that staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff used 'This is me' documents and patient passports. There were additional provisions made for patients diagnosed with dementia or learning disability. The inpatient unit had new visual signage and staff had completed mandatory training in dementia, learning disabilities and autism. The service told us that a staff nurse had been identified as a dementia champion for the inpatient unit and had one day per month protected time to progress the agenda. The dementia champion had also completed a diploma in dementia.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to communication aids to help patients become partners in their care and treatment. Managers made sure staff, and patients, loved ones and carers could get help from interpreters when needed. There was access to a telephone translation service, but no written material, nor any posters or signs on display, to let families or patients know that this service was available.

At the last inspection we saw that the service did not have clear visiting protocols and we told the service it must ensure one was in place ensuring they were clear, appropriate, in line with current COVID-19 guidance, adhered to and understood by all staff. At this inspection we saw the service had developed clear visiting protocols which were developed in accordance with the patient's physical and emotional needs.

We heard that a patient's spiritual needs were explored during the admission process and during their stay and were recorded both electronically (on the initial assessment document) and on the daily handover form. The hospice also had good links with the leaders at the local church who supported with the annual "light up a life" services held in December. Spiritual needs were regularly discussed at the weekly MDT meeting and any required actions implemented to support patient needs.



# Hospice services for adults

Patients and their families and carers received ongoing emotional support from all members of the multi-disciplinary team during their stay on the inpatient unit and any “special events” happening during their stay could be celebrated as they wished.

We were informed about a patient who had suffered a stroke leading to blindness. The patient was unable to identify the nurse call button as a result of the visual impairment and she did not know braille. A complementary therapist applied a different texture to the button so the patient could feel which button to press. We saw that staff also used picture communication sheets for patients who were unable to write or use electronic tablets.

The hospice counselling team tailored their services to match specific points in the annual calendar such as national grief week and reached out to bereaved fathers.

## Access and flow

**Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.**

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Managers monitored that patient moves between services were kept to a minimum. The service did not move patients unless there was a clear medical reason or in their best interest. Staff did not move patients between areas at night.

Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs and supported patients when they were referred or transferred between services.

At the last inspection, the service did not have detailed eligibility criteria for admissions or a defined ceiling of care. At this inspection we saw that the service had detailed eligibility criteria for admissions, and a defined ceiling of care embedded in practice. The staff stated that they aimed to provide prompt access to the Inpatient Unit (IPU) for those with an advanced life-limiting illness, and their families, who had complex needs or needs persisting in spite of input from the team currently caring for them. These needs could be physical, psychological, spiritual, existential, or social, and were often a combination of them all.

The referrals were discussed directly after the ward handover and all the clinical staff present at handover (medics, nurses and AHP’s) were then involved in the discussion about the referrals including the Ward Sister and Palliative Medicine Consultant. Information received on a referral form was considered as per guidance reflecting this policy and documented on a proforma. In the case of obvious or urgent need, discussions took place outside of the morning team meeting in an MDT discussion involving a senior nurse and doctor. Staff told us they reviewed admissions on an individual basis and could articulate when an admission should be declined.

Planned admissions took place between 9am and 5pm Monday to Friday, due the medical staff availability on site. Staff told us that if there was a specific need to admit outside of these times, they would try to accommodate it, such as an urgent need or emergency. This could include admissions at weekends.

Occupancy levels fluctuated and the hospice had not been to full capacity since our last inspection. This was due to in part the COVID-19 pandemic and patients choosing to receive care at home. The service recognised that individuals from ethnic minority groups had fewer options to access bereavement support services and had taken steps to offer this. We were told that the hospice staff made a weekly call to offer beds to local hospitals and the community.



# Hospice services for adults

## 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. The service included patients in the investigation of their complaint.**

We reviewed the service's policy on compliments, concerns and complaints. We found the policy was up to date, detailed and fit for purpose. We also reviewed the service's up to date duty of candour policy and found it to be in line with national guidelines.

Patients, relatives and carers knew how to complain and raise concerns and the service clearly displayed information on the complaints process in patient areas.

Staff understood the policy on complaints and knew how to handle them. We saw a complaints leaflet was available for patients and their families. Staff knew how to acknowledge complaints and were keen to resolve any issues that were brought to their attention quickly. We were informed that patients received feedback from managers after the investigation into their complaint.

We reviewed the latest feedback submitted to the service and saw that results were generally positive. We saw 23 responses were received from 23 questionnaires issued to patients July to September 2021. We observed that 87% of patients felt fully informed regarding their care and 87% involved in their choices regarding their care. The survey found that 91% of patients would recommend to friends or family should the need arise.

The service received zero formal complaints and 2 informal complaints in July to September 2022. One concern from a patient related to an external door banging multiple times in early morning when staff entered and left the building. The maintenance team very quickly fitted a soft closure fitting to reduce the noise of the door when it closed to resolve the issue. The second complaint related to a member of the public who was upset regarding correspondence which had accidentally been sent to a family member who was deceased.

In July to September 2022 41 compliments were received by the service.

## Are Hospice services for adults well-led?



### Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**

The hospice was overseen by a board of trustees led by a chair person. The hospice executive team was led by the chief executive whom was also the registered manager and chief nurse. Since the last inspection a number of senior posts had been filled and the revised organisational structure included: director of governance & quality, director of human resources & organisational development, head of income generation, quality and risk manager, corporate administration manager and a facilities manager. In addition, there was a governance officer, HR advisor, and volunteer co-ordinator. All roles were embedded at the time of the inspection.



# Hospice services for adults

There was compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver sustainable care. The nursing leadership comprised of chief nurse (combined with CEO role), quality matron and ward sister.

The chief executive demonstrated knowledge of the demographics of the local area and had commenced plans to reach ethnic minority groups living in the region through the development of the quality improvement project (QIP). The project aimed to explore access to inpatient services at the service from ethnic minorities in the local area.

Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired culture. Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond.

We spoke with the chair of trustees who told us the board had undergone 'a refocus on mindset' with a priority to invest in staff to enable an increase in capacity. Trustees were encouraged and expected to cast a critical eye and provide the necessary challenge when it was needed. We saw new trustees had been recruited and trustees brought a diverse range of skills due to their different cultural and professional backgrounds.

## Vision and Strategy

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

The strategy and supporting objectives and plans were stretching, and challenging, while remaining achievable. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership.

There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans. Plans were consistently implemented and had a positive impact on quality and sustainability of services.

The service had a vision to be the first choice for patients, referrer's and customers for all services, to provide more services to more people and to be regarded as one of the best hospices in England. The values of the service were to provide comfort, care and dignity for patients. We saw staff display these values during our inspection.

At the last inspection the service told us that they would be reviewing the current strategy as part of future board and trustee meetings. At this inspection we saw that the hospice board of trustees and the executive leadership team had identified 4 strategic objectives with associated activities and milestones to achieve. The strategic objectives were incorporated into the board assurance framework (BAF) and reported to the board of trustees a minimum of 3 times per year. It was recognised that the strategy aligned to the Care Quality Commission single assessment framework, the ambitions for National Palliative Care and End of Life Partnership and the NHS England Palliative and End of Life Care Statutory Guidance for Integrated Care Boards.

We reviewed the action plan from the last inspection and saw that strategic and service objectives had been developed for each aspect of the service, for example, inpatient unit, training and human resources. The plan covered all services provided by the hospice and how it intended to expand or develop each service. All leaders were involved in the development of these strategic objectives and felt able to contribute to the future developments of the hospice provision.



# Hospice services for adults

We saw evidence of strategy development involving the community such as regular dialogue with regional stakeholders to ensure the service met the needs of the wider community. The action plan emphasised engagement with stakeholder and partner forums to identify and work on shared agendas and priorities, including exploring opportunities to partner with others, particularly those who support people who were described as under-served.

## Culture

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

All staff described leaders as open and approachable and acknowledged the passion dedication and hard work demonstrated by the executive team and senior management to deliver change and improvement. Leaders had an inspiring shared purpose and strove to deliver and motivate staff to succeed. There were high levels of satisfaction across all staff.

All staff we spoke with were positive about the extensive changes implemented at the hospice and were able to describe the positive changes that had taken place. Nurses and doctors were keen to share the positive improvements and emphasise the benefits to patients and those accessing the service. Leaders of the service were open and transparent about the challenges addressed to make improvements and continued to articulate ambitious plans for the future.

Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively support this process.

Staff told us they had confidence in policies and processes introduced by the executive team and felt fully involved in decision making and the HR team told us they felt involved in the development of continuous improvement projects and strategies.

The service had a whistleblowing policy in place and staff knew how to share concerns. The hospice were implementing a freedom to speak up (FTSU) policy which was in draft at the time of inspection. A FTSU guardian had been appointed along with 4 FTSU champions. Computer screensavers were deployed to raise awareness of speaking up, as well as newsletters promoting freedom to speak up month.

Staff told us they welcomed the changes to the appraisal and training processes.

Staff wellbeing days had been held which acknowledged the difficulties staff had faced due to the pandemic.

## Governance

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

During the inspections we found that governance processes were in place to ensure patients were safe from risk of harm or potential harm. Leaders of the service had established processes to collect, review and improve data and manage risk. Two sub-board committees had been established, one for Governance & Quality and one for Finance & Resources. In addition, four governance groups had been established to review quality and patient safety, information governance and human resources and facilities.



# Hospice services for adults

At the last inspection we found that there was no dedicated governance resource within the organisation. At this inspection we saw that a Director of Governance & Quality had been appointed and that governance arrangements were proactively reviewed and reflected best practice. A systematic approach was taken to working with other organisations to improve care outcomes.

We reviewed 3 sets of combined board of trustee minutes and found the meetings well attended, the agenda was comprehensive, and discussion was detailed, for example, items discussed included a patient story, the BAF, management accounts, and the risk register, to name a few.

The service had a policy tracker which listed all policies held by the service, the date created, date of review, the responsible officer, the status (red, amber, green (RAG) rated) and tracking notes. We saw that out of the 96 policies in place, 77 were in date; 2 were in progress and on target; 12 were in progress but behind target; and 5 were new policies which were yet to be started.

We saw evidence of shared learning through leadership briefings, team briefings and staff forum notes. Day to day learning was observed during the morning rounds and safety huddles. All learning was shared with the board of trustees and evidenced in the meeting minutes.

The clinical audit programme and associated actions were delivered and monitored by the hospice quality improvement and patient safety (QIPS) group and information governance audits by the information governance group (IGG). The QIPS Group and IGG then reported directly into the governance and quality committee which was a board sub-committee with delegated authority of the board of trustees. The governance and quality committee was chaired by a trustee of the board and attended by a minimum of 3 trustees at each meeting. The Board of Trustees and the governance and quality committee can also (and do) request additional clinical audits out with those already on the annual audit plan based on triangulated data and intelligence received. For example, falls data identified Barnsley Hospice as an outlier when benchmarked against national Hospice UK data. A thematic review of falls had been undertaken and reported to QIPS Group on 2 November 2022 and was on agenda for the next governance and quality committee on 6 December 2022.

There was a comprehensive year-round audit plan in place that covered clinical audit, record audit, medicines reconciliation audit, preferred place of death, audit of controlled drugs, safeguarding, tissue viability, oral care to name a few. There were 24 tasks audited throughout the year, on a biannual, quarterly or monthly basis.

## Management of risk, issues and performance

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**

There was a demonstrated commitment to best practice performance and risk management systems and processes. The organisation reviewed how they function and ensured that staff at all levels had the skills and knowledge to use those systems and processes effectively. Problems were identified and addressed quickly and openly.



# Hospice services for adults

Leaders of the service understood risk and could identify organisational or clinical risks. The service had an up to date risk management policy in place to enable individuals and the hospice to deal competently with all key risks, thereby providing more confidence that personal and organisational objectives would be achieved and that statutory and regulatory requirements placed upon the hospice were met. This was supported by a dynamic risk register, which was a live document, reviewed regularly and updated as new risks were identified, changed, grew or receded.

The service had developed comprehensive policies to manage major incident, disaster recovery and business continuity policies. The plan set out the roles of those who may be involved in managing an interruption event, and the subsequent business continuity and recovery phases.

The service admission criteria highlighted that the services aimed to provide prompt access to patients in need of their support.

We reviewed quality improvement and patient safety group meeting minutes and found that the meetings were well attended, were quorate, and that comprehensive discussion was held relating to the quality and safety dashboard, and audit outcomes.

Benchmarking against similar organisations was embedded with the introduction of data submission to Hospice UK. The data submitted aided improvement and ensured the service could align with the national targets.

We observed a patient safety meeting which was held during the inspection. We saw incidents were reviewed through the electronic system and the meeting was attended by different members of the hospice team. Lessons learned and improvement ideas were shared across all disciplines.

An external company had undertaken a fire safety assessment and had provided a report for the service. Recommendations from the report had been undertaken within the timeframe required. The service had a fire evacuation standard operating procedure which was in draft at the time of the inspection. Fire evacuation drills were undertaken in October and November 2022 and deemed to be very successful.

## Information Management

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

We observed a patient safety meeting and safeguarding review meeting which was fully implemented and embedded. The patient safety meeting we observed demonstrated a good understanding by the service regarding the identification of themes and trends to enable them to mitigate further recurrence of incidents.

The service had recruited a data analyst to review themes and trends from audits and incidents. The analyst was able to scrutinise figures and undertake a deep dive as required, through an electronic system.

We saw that the hospice was moving from paper based staff rotas to e-rostering including shifts, holidays and all other types of leave. In addition, the system would produce electronic time sheets for payroll purposes which was intended to make the rostering process much easier for all. The electronic system also provided enhanced data and intelligence to support pay roll, future planning and triangulation with other data to measure quality indicators such as comparison such as staffing against falls prevention activities.





# Hospice services for adults

The service had systematically reviewed all policies and procedures. We saw action plans in place to ensure change was implemented post policy review.

## Engagement

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

We saw the service sought feedback using questionnaires which were managed by the individual services such as bereavement, counselling and inpatient units. We reviewed feedback and saw that it was positive.

The first staff forum took place in December 2021. This monthly meeting was open for any employee or volunteer of the hospice to attend to share ideas, concerns and suggestions, and ensure their voice was heard.

The hospice was working to open up recruitment to a wider audience including those who may not have thought about a career in specialist palliative and end of life care before. To support this, the hospice ran recruitment open days to encourage people to come and see what they provided and to talk to some of the hospice team about their roles and why they found it so rewarding.

The service held staff away days and a team building event. This was said to be an opportunity for all staff to spend time together to learn about each other and the different roles at the hospice. It also aimed to share ideas for growth and development of the hospice and to support each other in the quality improvement journey across all the services and activities. Output from the group work was used to inform a review of hospice strategic objectives. The day was facilitated by an external company and was split into 2 half days so that all staff could attend without disruption to services. The day finished with an evening social event (meal and a quiz) for all to attend who wanted to.

There was a staff health and wellbeing service with an employee assistance programme in place in addition to standard occupational health services provided to all hospice staff through a local hospital trust. This provided staff with free resources and access to a confidential helpline and fast track counselling sessions.

We were informed by the senior leadership team that they were extremely grateful for the wonderful contribution of volunteers, some of whom had volunteered with the hospice for over 20 years. To say thank you and to celebrate this, the service held a Volunteer Celebration event in July 2022. The outputs of this event were being used in the development of a new Volunteer Strategy and Handbook.

The service had implemented 'time to connect'. The group supported people who had ended their one to one counselling and would like to attend a group. It was an informal drop in group that met monthly in Barnsley town centre library. The hospice worked in partnership with Barnsley libraries in their innovation to be a "death positive" library. The group first met in October 2022. The vision was to extend the group to the borough of Barnsley, especially the communities that were described as "hard to reach" or "under-served". Plans were underway to reach out to minority groups such as LGBTQ+ and men.

In November 2022, the local football club formally announced Barnsley Hospice as their front-of-shirt sponsor until the New Year. The club took this opportunity to support the hospice in raising awareness of their services, and how people could access them. Three patients currently using the hospice's support and wellbeing service were involved in an awareness campaign and their videos had been viewed on the hospice social media almost 5,000 times.



# Hospice services for adults

As part of Hospice UK's 'Hospice Care Week' campaign, representatives of Barnsley Hospice ran awareness stands across the Barnsley borough. Two central locations were chosen, the shopping centre and indoor market.

## Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. Since the last inspection there had been a significant change to the executive team, senior leadership team and board of trustees.

There was a fully embedded and systematic approach to improvement, which made consistent use of a recognised improvement methodology. Improvement was seen as the way to deal with performance and for the organisation to learn. Improvement methods and skills were available and used across the service, and staff were empowered to lead and deliver change. During the inspection we observed a significant improvement in patient safety, the effectiveness of the service, the staff approach to delivering care, how responsive the service was and the overall impact of the new leadership.

At the last inspection we found significant safety concerns and we imposed urgent conditions using our section 31 powers on the service's registration to drive improvement and ensure patients were safe. At this inspection we found that all areas of concern had been addressed, new practices embedded, and robust ambitions documented for the future.

The service outlined several areas of improvement and a significant change in staff culture was a major step in the transformation of the service.

We saw examples of learning from incidents and complaints and were assured that shared learning occurred on a frequent basis. We saw drive and ambition within the executive, leadership and staff teams to continually learn and improve the service.