# St Clare's Hospice

## Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

## Ratings

| | |
|---|---|
| **Overall rating for this location** | **Inadequate** |
| Are services safe? | **Inadequate** |
| Are services effective? | **Inadequate** |
| Are services caring? | **Good** |
| Are services responsive? | **Inadequate** |
| Are services well-led? | **Inadequate** |

## Overall summary

St Clare's Hospice is a standalone hospice provider, which is a charitable incorporated organisation but receives over 40% funding by the local commissioning group. The hospice which had been in operation since 1987, is based in Jarrow and offers specialist palliative care for adults who live south of the Tyne. The health of people in South Tyneside is worse than the England average. Deprivation is higher than average and life expectancy for both men and women is lower than the England average. 2.9% (2011 census) of Jarrow's population is non-white British making Jarrow the least ethnically diverse major urban area in Tyneside. The service operates both day hospice and inpatient hospice services and provides palliative and end of life care for over 451 patients.

The inpatient unit is an eight-bed facility which provides respite and longer term care for adults with a life limiting illness including, chronic obstructive pulmonary disease, motor neurone disease, supranuclea palsy, heart failure

# Summary of findings

as well as cancer. The Hospice has a day care facility which caters for up to 15 patients per day Tuesday to Friday. In addition the hospice offers bereavement counselling and befriending services.

The hospice is situated in a single story building within the grounds of a local hospital. All rooms have wheelchair access with all inpatient rooms leading to a paved garden area.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 12 and 13 September.

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

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

**Services we rate**

Our rating of this service went down. We rated it as inadequate overall.

We found areas of practice that were inadequate in relation to St Clare's:

- We saw significant safety concerns in areas such as medicines management, risk identification and incident investigation and subsequent learning. Safety is not sufficient priority and we saw patient harm had occurred as a result of this.
- There is insufficient attention to safeguarding. Staff displayed limited safeguarding understanding and the interim safeguard lead was appointed to the role without agreement or knowledge of doing so.
- Staff were not supported with mandatory training and managers had no oversight of training needs required for the role.
- Patient records and assessments were incomplete and routine assessments were not completed for all patients, including those deemed to be high risk. Opportunities to prevent or minimise harm were missed.
- Patients care and treatment does not reflect current evidence based guidance, standards and practice.
- None of the nursing staff had received an appraisal in the 12 months leading to inspection.
- There is no formal process to monitor patient's outcomes of care and treatment and there was little appetite by managers to drive improvement.
- Patients receive care from staff that do not always have the skills or training that is needed through regular completion of mandatory training.
- Staff and teams work largely in isolation and do not seek support or input to actively improve services for patients.
- People are unable to access the care they need. Access and flow within the service was interrupted without due consideration for patients waiting for services.
- Complaints and concerns are not taken seriously and patients concerns and complaints do not lead to improvements in the quality of care.
- Staff do not understand the vision and values and the strategy is not underpinned by detailed realistic objectives and plans.
- The governance arrangements and their purposes are unclear. Financial and quality governance are not integrated to support decision making.
- Leaders do not have the necessary experience, knowledge, capacity, capability or integrity to lead effectively.
- Staff told us there was a culture of bullying and instances of conflict between individuals.
- There is minimal engagement with people who use the service, staff and public.
- There is minimal evidence of learning and reflective practice.

Following this inspection we undertook due process regarding the significant safety concerns and had begun the process to suspend related activities at the hospice. However following a discussion with the provider they chose to voluntarily suspended services. In addition, we told the provider that it must take some actions to comply with the regulations. We also issued the provider with five requirement notices that affected St Clare's Hospice. Details are at the end of the report.

**Ellen Armistead**

Deputy Chief Inspector of Hospitals (North)

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Hospices for adults** | **Inadequate**  | Hospices for adults was the only activity provided at this location.<br>The hospice had 8 inpatient rooms providing palliative and end of life care, including respite. At the time of our inspection four patients were accommodated. Day Hospice, bereavement and counselling services were also provided.<br>We rated this service as inadequate because we saw concerns across four of the five domains which impacted negatively on the ratings. |

# Summary of findings

## Contents

Inadequate

**Services we looked at**
Hospices for adults;

# Summary of this inspection

## Background to St Clare's Hospice

St Clare's is standalone hospice, funded in part by the local clinical commissioning group. The hospice primarily serves the community of South Tyneside. It also accepts patient referrals from outside this area.

The registered manager has been in post since 2011. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. Prior to inspection the provider informed us the registered manager was on unplanned leave and an interim manager was in post.

The provider also informed us prior to inspection that the hospice had voluntarily closed for three weeks in July 2018. This was due to a loss of doctors at the hospice and a number of concerns that the provider wished to rectify, for example staff would undergo a period of intensive training during this time and the hospice would undergo some refurbishments.

The Care Quality Commission carried out a comprehensive inspection of this service in January 2018, where it was rated 'requires improvement' overall. Following inspection the provider was asked to make a number of improvements and in addition, take specific action in relation to medicines management and governance. The provider was told to develop an action and improvement plan to include what they would do and by when, to improve these key questions.

We carried out an unannounced comprehensive inspection on the 12 and 13 September 2018. We reviewed the action plan during this inspection and found a significant number of issues had not been addressed.

## Our inspection team

During this inspection a team of two inspectors, an inspection manager and a specialist advisor spoke with nine staff, appraised five patient records, and reviewed relevant data including policies, procedures, reports and meeting minutes.

The inspection team was overseen by Head of Hospital Inspection Sarah Dronsfield.

## Information about St Clare's Hospice

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St Clare's Hospice provides both inpatient and day hospice services providing respite and longer term care for adults with an end stage disease including, chronic obstructive pulmonary disease, motor neurone disease, supranuclea palsy, heart failure as well as cancer.

The provider registered in 2011 to provide:

- Diagnostic and screening
- Treatment of disease disorder or injury

Staff are divided into inpatient and day hospice teams on a rota basis. Both of these facilities were open at the time of our inspection. The service does not provide care or support in the community.

St Clare's has a board of trustees and two sub-committees, clinical governance and finance. There is chief executive officer, registered manager, lead nurse for Lead Nurse for Quality and Safety and a day hospice sister.

# Summary of this inspection

The service has been inspected three times and the most recent inspection took place in January 2018. In addition to these services the provider provides counselling and befriending services. These are outside the scope of CQC registration and were therefore not inspected.

During the inspection we spoke to nine staff, including senior managers, registered nurses, health care assistants and ancillary staff. We also spoke to one trustee and two volunteers.

We spoke with five patients and relatives.

We observed care and treatment and looked at five patient care records and five medicines administration records as well as service performance data.

Activity (July 2017 to June 2018)

- In the reporting period July 2017 to June 2018 there were 451 patients receiving palliative care.
- The hospice provided care to 243 patients over 65 years old and 208 patients aged between 18 and 65.
- There were 170 admissions to inpatient beds.

St Clare's Hospice employed 15 registered nurses, 16 health care assistants and 174 volunteers.

In addition, the provider employed a pharmacy technician three days a week. The accountable officer for controlled drugs was the Chief Executive

Track record on safety (July 2017 to June 2018)

- No never events
- Three serious incidents

A 'never event' is a serious patient safety incident that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

As an independent provider, St Clare's Hospice is required to report serious incidents to CQC.

There were no incidents of confirmed hospital acquired infections.

There was one complaint in the reporting period and one immediately following inspection.

St Clare's Hospice does not provide any services that accredited by a national body.

There are no services provided at the hospice under service level agreements.

# Summary of this inspection

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

We always ask the following five questions of services.

### Are services safe?

Inadequate

The service was previously rated requires improvement in safe and the provider had failed to improve in several areas. We found significant safety concerns across several areas which impacted negatively on the rating. We rated safe as inadequate because:

- The service did not have reliable systems and processes to manage staff training. Managers were unable to identify which mandatory training staff should undertake, and did not monitor when staff had completed training. This meant staff were not trained adequately to work safely within their role for example only 40% of nurses had completed basic life support training.
- The provider failed to recognise concerns, incidents or near misses. Action plans following incidents were incomplete, learning was not identified or shared. Staff were not always transparent when reporting concerns.
- Care premises were unsafe as patients were not protected from potential risks within the building.
- The provider took insufficient attention to safeguarding. Staff were not clear in relation to their responsibilities when reporting or investigating safeguard concerns.
- The provider did not follow best practice regarding the administration of medicines. We saw evidence of several medication errors, resulting in patient harm.
- Risk assessments were not completed consistently and patients deemed to be at high risk were not routinely re-assessed, resulting in patient harm.

### Are services effective?

Inadequate

The service was previously rated good in effective, however found significant concerns which impacted negatively on the rating.

We rated effective as inadequate because:

- The provider did not have processes in place to ensure care and treatment was delivered and monitored against evidenced based guidance and best national practice.
- There was limited monitoring of patient outcomes. Where patient care and treatment outcomes were monitored they were not consistently reviewed.
- Patient's nutritional needs were not consistently assessed and staff did not always accurately monitor and record the amount of food or fluids taken.

# Summary of this inspection

- None of the clinical staff received clinical competency supervision, to ensure staff delivered effective care.
- None of the nurses at St Clare's had received an appraisal within the 12 months leading up to inspection.
- A number of patients were currently being reviewed at the time of inspection. Staff were unclear which patients had given consent in relation to DNACPR.
- We saw low numbers of mental capacity assessments and no best interest assessments had been completed.

However,

- The service worked alongside colleagues at the local healthcare trust to support patient care and delivery.

## Are services caring?

Good

The service was previously rated good in caring. Feedback remained consistently positive.

We rated caring as good because:

- Staff cared for patients with compassion. Most of the feedback from patients and their relatives confirmed staff treated them well and with kindness.
- The service had received many thank you cards which showed patients and relatives felt staff treated them with compassion and care.
- Staff provided emotional support to patients and relatives to minimise their distress. The family bereavement support and counselling services offered ongoing emotional support was not time limited.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients told us they and their relatives had been involved in developing their care plan and we saw evidence of this in patient care records.
- Patients told us they felt involved in their care and recent changes to the décor at the hospice were felt to be positive.

However

- We were not assured staff had received the appropriate training in relation to dignified end of life care.

## Are services responsive?

Inadequate

The service was previously rated good in responsive, however, found significant concerns which impacted negatively on the rating:

We rated responsive as inadequate because:

# Summary of this inspection

- The service did not plan and provide services in a way which met the needs of local people. We did not see evidence of understanding of the needs of the local population.
- We saw limited engagement with patients and their families to shape and steer the design of the service.
- The service did not provide facilities to meet the cultural and spiritual needs of patients of different faiths and cultural backgrounds.
- Staff were unclear as to which translation services were available and how to use them.
- The provider was did not assess patients in a consistent manner. Care plans were generic and did not reflect the individual's needs. This is a repeated breach from the January 2018 inspection
- Patients were unable to access the care they needed at the right time due to the providers decision to stop admissions at the day hospice. In addition we saw interruption to the access and flow with patients coming to the hospice for many years without an agreed outcome.
- The provider did not have a robust system to capture and investigate complaints. Patients told us they had raised concerns but we did not see evidence of these issues and no actions taken or improvements made, as a result of them being raised.

However,

- Some areas within the hospice had been changed as a result of feedback from patients and carers, such as the colour of the walls.

## Are services well-led?

**Inadequate**

The service was previously rated requires improvement in well-led, however, found significant concerns which impacted negatively on the rating:

We rated well-led as inadequate because:

- Staff working within leadership roles at the hospice had not had the necessary training or support to perform the role effectively.
- The provider's strategy and vision was not embedded within the service and staff were unclear when asked to describe it.
- Morale was varied at the hospice. Some staff reported improvements in the atmosphere, whilst others told us there remained a bullying culture.
- We were not assured managers understood how to monitor and improve quality for the patients at the hospice.

# Summary of this inspection

Commissioning for quality and innovation (CQUIN) targets, in place to support improvement were not progressed in a timely manner and there was limited appetite to measure improvement.

- The post action improvement plan following the January 2018 inspection had not been completed. There were no definitive dates for completion or accountable owners recorded against the actions.
- The provider displayed a lack of understanding in relation to its clinical and professional responsibilities at all levels.
- Risks to the service were not recorded, investigated or monitored effectively. Specific risks were not always identified by the provider and managers displayed a lack of ownership when asked about risk management.
- The provider failed to learn following incidents and did not have a robust system in place to ensure incidents were managed effectively.
- We saw the board of trustees lacked oversight of operational concerns and we did not see any level of scrutiny applied to key clinical issues. For example medication errors.
- The provider did not have a robust system to record and investigate complaints
- Access and flow within the hospice was not fluid and we saw patients were prevented from being admitted due to a failing system, which was not responsive to the needs of the community.

However,

- The day hospice had developed educational wellbeing days, which had been received positively by the community.
- The provider was due to commence a number of reflection days to support staff following difficult experiences.

# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Hospices for adults | Inadequate | Inadequate | Good | Inadequate | Inadequate | Inadequate |
| Overall | Inadequate | Inadequate | Good | Inadequate | Inadequate | Inadequate |

Inadequate

# Hospices for adults

| | |
|---|---|
| Safe | Inadequate |
| Effective | Inadequate |
| Caring | Good |
| Responsive | Inadequate |
| Well-led | Inadequate |

## Are long term conditions safe?

Inadequate

Our rating of safe went down. We rated it as **inadequate**

### Mandatory training

- The provider did not have a policy or process to ensure mandatory training was completed by staff working at the hospice. During inspection we asked to review mandatory training compliance figures for all staff working at the hospice but there were no local records maintained to show this.
- Managers told us training was delivered largely through the local healthcare trust such as moving and handling and e-learning and by face to face training at the hospice.
- Following inspection, we requested mandatory data from the provider. We reviewed a spreadsheet received from the local healthcare trust, which showed members of the St Clare's Hospice clinical team and courses they had completed through the trust. We noted that five nurses working at St Clare's were not included within this spreadsheet. Managers at St Clare's had no oversight of completed training or knew which staff who needed specific training.
- Following inspection, the provider submitted a list of five areas of training, which they considered to be mandatory. This included information governance, safeguarding children level 2, safeguarding adult's level 2, medical devices and health and safety. Manual handling and cardio pulmonary resuscitation was provided in addition to these five.
- A senior manager told us non clinical staff, such as volunteers were not required to complete mandatory training. This meant volunteer staff would not be aware of key responsibilities such as reporting safeguarding alerts and identifying emergency situations such as deteriorating patients.
- Information submitted prior to inspection stated all volunteers received an induction. However, we did not see evidence of completed staff inductions.
- Managers told us manual handling and cardiopulmonary resuscitation (CPR) training was booked for staff, through the local healthcare trust and was due to be delivered between April 2018 to March 2019.

### Safeguarding

- The organisation had a 'vulnerable adults' policy which was produced in August 2018. The policy identified processes to raise safeguarding concerns internally and identified staff within the hospice whom had responsibility for investigating safeguards. The policy did not provide staff with guidance on how to escalate safeguarding alerts to the local authority and the provider stated they had never raised a safeguarding alert. St Clare's vulnerable adult's policy stated 'all staff will undertake a written training module in safeguarding every three years'. Managers did not have oversight of this and therefore were unable to corroborate if this training was completed.
- The provider did not have a policy in relation to safeguarding children.
- All staff told us they received training in safeguarding for children but the provider did not maintain records to show which staff had completed or required

safeguarding training. We reviewed the spreadsheet provided following inspection and saw 33% of nurses had undertaken safeguarding children level two training.

- Within the same spreadsheet we also saw that 26% of the nurses had completed Safeguarding Adults level two training, which included mental capacity and deprivation of liberty training.
- We were not assured staff were clear in relation to their roles and responsibilities around safeguarding and if all safeguarding alerts were raised when required. Staff were not always clear about who the safeguarding lead was and one member of staff told us they had never seen the safeguarding policy and would not know what to do.
- During inspection we saw five volunteers working within the building. We saw volunteers brought food and drink to patients and direct patient support was sometimes unsupervised. Staff told us that these volunteers were not required to have disclosure and barring checks (DBS), however, the provider had not completed risk assessments to mitigate this. All staff providing direct unsupervised care or treatment were required to have these checks in place. This meant there was a potential risk to patients and visiting children as neither the DBS or risk assessment had been completed.
- The interim registered manager told us they were not aware they were the safeguarding lead during the period in which they held responsibility and therefore did not understand their responsibilities at St Clare's. In addition, the Chief Executive told us there were gaps in her knowledge in relation to safeguarding, despite being included with the vulnerable adults policy and the responsible manager in the absence of the clinical nurse manager. We saw the interim manager had not received any additional safeguarding training or support in order to support understanding of the role.
- Following inspection the registered manager told us they had completed additional Safeguarding adults level 3 training but we were not provided with certification.

**Cleanliness, infection control and hygiene**

- The provider stated they followed the local healthcare trusts cleanliness and infection control policy and therefore had not developed service specific guidance for staff to follow.
- There were no instruction or guidance developed by the provider on how to manage patients with a communicable illness and therefore a risk patient would not be managed in accordance with national guidance and best practice.
- We asked for all environmental audits which the provider had completed since last inspection in January 2018. We were provided with a single sheet of paper with the heading 'Infection Prevention and Control audit carried out at St Clare's Hospice 13/08/2018'. It stated:
  - Staff members within St Clare's followed the local healthcare trusts policies and procedures. They are currently in the process of updating the hard copies of the policies, but all are readily available on the intranet.
  - There is no audit of infection control practice undertaken. Minimum recommendation would be to carry out monthly audits of hand hygiene, use of personal protective equipment, peripheral venous cannula insertion and ongoing care and urinary catheter insertion and ongoing care.
  - Induction and training of all staff is accessed from the local healthcare trust. All staff members have completed infection prevention control training whilst the hospice has been closed.
- We reviewed the training spreadsheet sent by the provider following inspection and saw 47% of nursing staff had completed infection prevention and control training level one and 7% had completed level two.

**Environment and equipment**

- The hospice is situated in a single storey building with adequate car parking facilities, including disabled spaces.
- All visitors enter the building through a main door into reception, which was unlocked. A receptionist was available during certain times of the day, which presented the risk of unauthorised access into the building.
- We saw the environment was clean and bright and domestic staff were actively cleaning in and around the patient rooms.
- All staff we spoke with told us they have adequate stock of equipment and were easily able to obtain new stock as required.

- We checked the emergency equipment in the unit. We saw two resuscitation boxes which were checked and in date and an anaphylaxis box which was also in date and had tamper proof seals in place.
- We saw connecting doors between St Clare's and the former vacant Primrose Hill Hospital were open and the area was unsecured and could be accessed from St Clare's. We saw several of the bedrooms within the vacant building contained items such as disused beds, paint, dressing's trolleys, chemicals, old electrical and extremely hazardous items such as rat poison, needles and cleaning chemicals. The provider had not completed a risk assessment or made appropriate arrangements to secure this environment.
- Therefore we are not assured the safety of the patients and visitors at St Clare's was considered and requested the provider take immediate steps to remove and secure items found within this part of the building. The provider removed all items marked St Clare's and secured all items which could not be moved to locked bedrooms, on the day of inspection. We also viewed arrangements with the local healthcare trust which included the removal of all other items found. An action plan was also sighted, which included the addition of security measures to the connecting door into Primrose Hill Hospital. Control measures were to be added in October 2018.

**Assessing and responding to patient risk**

- The provider told us there was no policy to guide staff as to the frequency of clinical assessments and re-assessments.
- Staff told us if they had any concerns in relation to patient deterioration they would call 999 and notify St Clare's doctors of the deterioration.
- We reviewed the training spreadsheet and saw only 40% of clinical staff had completed basic life support training.
- Following patient admission nurses told us risk assessments were carried out. However, we found continual re-assessments were not taking place consistently. This meant staff were unable to identify and respond appropriately to the changing risks of patients including deterioration, health or wellbeing changes.
- We reviewed four files specific to patients who had suffered a fall whilst at St Clare's. We saw patients were not reviewed in accordance with the providers falls policy. This included two patients deemed to be at high risk. One of these patients sustained a further fall resulting in harm.
- We saw the provider had a 'Falls Management and Prevention' policy but this was due to be reviewed in October 2017 and had not been completed.
- We found only one audit conducted by the provider to gain assurance that patient records were being completed appropriately. This provided only a basic review of patient files and scored 100% compliance.
- We saw one patient self-administered their own medicines and had been assessed to do so by staff.
- We were not assured the provider had sufficient process in place to protect the needs of patients and ensure risks to patients were identified, managed and mitigated.

**Nurse staffing**

- The registered manager who was also a registered nurse was supported by the day hospice sister.
- The provider told us there were 25 registered nurses including bank staff and managers working at St Clare's.
- In addition a new post (Lead Nurse for Quality and Safety) was recruited in May 2018.
- The numbers of patient admissions varied and day hospice patient numbers fluctuated. Staff numbers were flexed to accommodate this
- The registered manager and day services manager were also registered nurses.
- We saw ten of the registered nurses who hold substantive posts at the acute trust are bank Staff.
- The provider told us the Safe Staffing Tool in accordance with The National Institute for Health and Care Excellence (NICE) is used to ensure the correct numbers of staff with the right skill mix are on duty. We reviewed staffing numbers for August and saw staffing numbers were provided in accordance with the Safe Staffing Tool.
- We saw sickness rates within the nursing staff was high at 37%. We asked clinical managers what actions had been taken to address this but we were not provided with any information.

**Medical staffing**

- Prior to inspection the provider told us there had been some difficulties ensuring medical cover for the hospice.

The provider took the decision to suspend services in July 2018 until appropriate cover could be found. During the inspection we saw there was a new full time doctor employed at St Clare's.

- There was also an informal agreement with another local hospice for out of hours and weekends for advice from a second on call consultant.
- Staff we spoke with recognised medical staffing had been a challenge but felt past issues had been resolved.
- We saw there was no medical director within the organisation but the palliative consultant from the local healthcare trust visited several times a week, to provide clinical support and advice.
- St Clare's also provided IT equipment for a consultant to run an out patient's clinics should they wish to see community patients at the hospice.

**Records**

- Patient records were in paper format and contained initial basic patient information such as date of birth, next of kin, and allergies. In addition patients were assessed in accordance with the twelve activities of daily living (Roper, Logan, Tierny 1996). Generic care plans were then completed, depending on the needs of the patient assessed.
- Staff told us there a number of assessments were completed for all patients at St Clare's. These were baseline nursing assessments, patient information sheets, NHS continuing health care tool, patient promise, care plans, risk assessments, care of the dying documents, advanced care plans and accountability tools. Medicines records were maintained in addition to this.
- We reviewed four additional sets of patient records and saw documents such as assessments were incomplete or missing.
- Staff told us they were unsure when patient records and assessments should be completed or re-assessed and the provider had not developed guidance in relation to this.
- We reviewed a documentation audit the provider had undertaken in in July 2018, which looked at nursing documentation only. The audit looked at 10 random patients and checked to see if all documentation was completed correctly. This included care plans. The audit scored an average of 100%.

**Medicines**

- We found repeated concerns following the inspection in January 2018 and patients were not fully protected against the risks associated with medicines.
- During the inspection on 12 and 13 September we reviewed the providers previous post inspection improvement plan in relation to the above medicines concerns. We saw the provider took action in relation to the use of off license medicines and patient files we reviewed showed patients were involved in discussions regarding their use.
- We also saw storage of medicines had improved and a service level agreement was in place through the local healthcare trust to provide a pharmacy technician three days per week to support with the general management of medicines within the hospice.
- However, there was no service specific medicines management policy. Staff told us they referred to the local health care trusts policy.
- The registered manager and clinical lead for quality told us hospice staff followed the local healthcare trusts policy.
- We were told all nurses had completed online medicines management training provided by the local healthcare trust. Information provided following our inspection showed 47% of nursing staff had completed the medicines optimise training. In addition none of the registered nurses working at St Clare's had undergone a clinical competency observation.
- We reviewed nine medication incidents that had occurred since last the last inspection in January 2018. These incidents varied and included a patient whom was without necessary analgesia for a significant amount of time, as the syringe driver was not checked when required, missed doses of anti-convulsants, missed doses of controlled medicines and Morphine Sulphate prescribed orally, but was given as an injection.
- We saw only one incident form suggesting one medication error in relation to the Morphine Sulphate incident. However a member of staff disclosed this error had occurred on five separate occasions. We did not see incident forms relating to these additional incidents and therefore these incidents were not investigated or escalated appropriately.

- We spoke with the pharmacy technician in relation to medicines incidents and the learning may have occurred following these events. The pharmacy technician was not aware of these incidents as they had not been shared.
- We saw a medication audit had been completed by the pharmacy technician in June 2018. We asked the clinical lead what actions had been taken following this audit but the clinical lead told us they had not read the audit.
- Therefore, we were not assured the management of medicines at St Clare's was safe and these significant concerns were raised with the provider at the time of inspection.

**Incidents**

- We saw the provider had developed an 'Adverse event (incident reporting)' policy dated August 2018. The policy provided guidance on when to report incidents, application of duty of candour, learning following incidents and supporting staff post incidents.
- Staff told us they knew how to report incidents. However, when asked for more information on this, staff could not recall the last incident. Staff told us incidents were discussed at staff meetings.
- The provider reported three serious incidents to us prior to the inspection. We reviewed these incidents and saw the incident form did not provide all of the necessary details such as the name of the staff involved, how incidents had been managed and how lessons learnt and actions taken had been shared.
- Following inspection we reviewed the report dated 1 April 2018 to 30 June 2018 and saw one of the serious incidents was included. The report stated this incident was to be discussed at the next clinical governance meeting. We reviewed the action log for the clinical governance meeting but did not see any evidence of this incident discussed or reviewed.
- We saw within the adverse event (incident reporting) policy, a quarterly report outlining all incidents was prepared by the clinical lead nurse and discussed at the Clinical Governance meeting.
- In addition the serious incidents, we also reviewed an incident relating to aggressive behaviour within the hospice. We did not see evidence of any action taken such as support to the staff or additional training to deal with challenging situations, such as conflict resolution training.
- Staff had not received training in the management of incidents.
- The interim registered manager told us they were not aware of their responsibilities in relation to notifiable incidents such as those to be sent to CQC and those specific to the reporting of injuries, diseases and dangerous occurrences regulations (RIDDOR).
- Therefore we are not assured the provider has a robust process in place to effectively manage incidents within the hospice.

**Safety Thermometer (or equivalent)**

- The provider reported no never events as these are attributed to NHS patients.
- The provider had developed 'Red Flags' which were noted in the event of a serious concern or incident. The provider states 'The Red Flags are monitored on a weekly basis and have started to be reported to the Clinical Governance Committee. This gives the opportunity to look at and evaluate where there have been staffing shortfalls and omissions in patient's care, the reasons for this and what the impact has been for the In-Patient Unit, discussing possible solutions to resolve any issues'.
- Following inspection we requested data regarding the red flags for example how successful they have been and what has been learnt following their implementation. We saw some incidents were identified with a red flag but these patients were not reviewed in accordance with the provider's guidance.
- The provider was not actively monitoring pressure ulcers or urinary tract infections.

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

Inadequate

Our rating of effective went down. We rated it as **inadequate.**

**Evidence-based care and treatment**

- There was no evidence to ensure nurses delivered care and treatment in line with legislation, standards and evidence based practice such as NICE guidance or other expert professional bodies.

- A Lead Nurse for Quality and Safety had been appointed in July 2018. This new role was developed to improve the clinical audit processes within the hospice and to ensure policies and protocols were in line with best practice and national guidance.
- The same nurse told us five policies had been reviewed since the last inspection in January 2018. Policies were selected and prioritised for review by the clinical governance team. We saw infection control, privacy and dignity, vulnerable adults, risk management, cardiopulmonary resuscitation policies had been reviewed. The provider did not have a formal plan of those policies which required review.
- Staff told us they provided 'holistic care' for the patients. A senior manager told us the interim registered manager had visited several local hospices in the area and had reached out to external networks to gather information on best practice care planning, specific to end of life care. This was supported by the trustees at the hospice following concerns from the last inspection in January 2018, which raised concerns that care plans were not personalised.
- We saw within the data the provider submitted prior to inspection '100% staff trained and competency assessed in nursing practice, assessing holistic needs'. We asked the registered manager and Lead Nurse for Quality and Safety to describe the new documentation being used following these visits and what model of care staff were using. Neither of the managers were able to clarify what the new documentation was and how practice was reviewed in line with best practice and national guidance.
- We reviewed five patient files and saw nurses no longer used core care plans and had moved to generic care plans which were completed according to symptom or illness. For example, oral health care or catheter care. However none of the care plans were individualised or holistic. Two nurses we spoke with did not know what a personalised care plan was.
- In addition we reviewed a patient file which included 'Care of the dying patient documentation'. Several sections were not complete such as spirituality care plan, communication care plan and general assessment.
- Therefore we are not assured the provider delivers care and treatment holistically and does not recognise patients as individuals.

**Nutrition and hydration**

- The provider was not meeting patients nutritional and hydration needs.
- The provider did not have any guidance for staff in relation to which assessments should be completed and therefore it was not clear which patients should have had an assessment in place.
- Within the five patient files we reviewed four files did not have a nutritional assessment.
- In addition we saw two fluid balance charts in use for two patients. However, we saw gaps in the recordings and intake of diet and fluids for these patients.
- We reviewed the latest patient satisfaction survey which scored between 4 and 5. Five being the highest satisfaction score, however we spoke to three patients in relation to food and they told us 'It could be better' and 'more choices needed'.

**Pain relief**

- The provider was not managing the pain needs of patients effectively at the hospice.
- Staff told us they assessed and monitored patients regularly to see if they were in pain and gave additional pain relief to ease pain. In addition, pain care plans were completed for those patients experiencing symptoms. However, We reviewed five patient files and saw two patients did not have a pain care plan but were receiving analgesics and two patients had pain care plans which were incomplete.
- Records specific to pain management were raised as a concern following the last inspection in 2018.
- We reviewed nine medications errors which had occurred since the last inspection in January 2018 and saw on three separate occasions patients did not have analgesia as prescribed. Two of these occasions were missed doses and the third was due to the syringe driver not checked for several hours.
- Patients were prescribed anticipatory medicines for pain relief and end of life care as required and in line with NICE guidelines but we were not assured patients were given medication in a timely manner.

**Patient outcomes**

- The provider did not have a defined approach to monitoring and benchmarking the quality of its services and outcomes for patients.

- Managers told us quality was measured through discussion at the clinical governance committee meetings, but as there were no minutes from these meetings, only action logs, it was difficult to identify consistent themes.
- Following the last inspection in January 2018, concerns were raised regarding the lack of clinical audit and the provider was asked to make some improvements.
- We reviewed the clinical audit programme, which had been recently developed and saw a programme of clinical audits were planned to commence in October 2018.
- The provider told us a number of audits had been completed since the last inspection. These included a drugs, infection control, catheter and diabetes audit. We reviewed the infection control audit but saw it was not an audit but a statement outlining 'There is no audit of infection control practice undertaken' and described current operational practice.
- We reviewed the diabetes audit which selected five random diabetic patients. We saw the audit scored 100% compliance.
- We reviewed the catheter care audit which selected five random patients and saw 100% scores across the majority of areas. 20% scoring was noted regarding catheter blockage recording and the use of bladder washouts. Actions for improvement were highlighted at the end of the report but we did not see evidence of audit outcomes discussed at the clinical governance meetings.
- We spoke with the interim registered manager who told us a piece of work had been completed last year, which specifically looked at the improvement of day hospice services, as part of the 'Living Better' programme. A CQUIN was in place to support this.
- The interim registered manager told us this work had been supported by the board of trustees to develop networks outside of the hospice and establish best practice. The feedback and recommendations following these visits was still in consideration at the time of inspection and we saw no information had been submitted to local commissioners in relation to this CQUIN during this financial year.
- The provider maintained links with South Tyneside Palliative Care Strategic Alliance & Hospices NE Collaboration.
- In addition, we saw a CQUIN was in place in relation to patient's wellbeing and safe staffing. A system of 'red flags' had been developed which alerted the provider to consider any incidents which may have occurred due to a lack of staffing.
- Patients and their relatives completed the 'Friends and Family' survey. We reviewed the latest survey undertaken in quarter four 2017- 2018 which saw 144 responses. 128 respondents said they were extremely likely to recommend St Clare's to their friends and family.

**Competent staff**

- The provider did not have a process in place to ensure all staff had received role specific training competency to enable them to perform their role.
- Nurses told us they were provided with re-validation support specific to their registration but we did not see evidence of any formal clinical observational supervision.
- We asked the registered manager if they had any form of clinical supervision or support. We were told one of the doctors used to provide this support but often it was not recorded. This doctor no longer worked at the hospice.
- The provider did not have a training and development policy and there was not an agreed list of mandatory training, aligned to job role and responsibilities.
- We saw no evidence of competency review for nurses required to undertake additional clinical skills such as cannulation, or taking bloods.
- None of the nurses had received supervision to confirm competency in relation to administration of medicines.
- The interim registered manager told us there was no handover given when asked to act as the registered manager and was not aware what the responsibilities of the role included.
- The pharmacy technician told us there had been no clinical handover of issues regarding medicines management and had not been provided with information regarding key policies such as safeguarding and fire safety within the building.
- We did not see any formal induction for agency or bank staff at the time of inspection.
- None of the 167 volunteers had completed mandatory training.
- Data submitted by the provider showed none of the nursing staff had received an appraisal in the last 12

months. Data also showed five HCA's had received an appraisal. We reviewed a completed appraisal and saw it was basic and did not include staff development objectives and outcomes.

**Multidisciplinary working**

- Doctors at the hospital worked alongside colleagues at the local healthcare trust, to enable co-ordinated care to the patients at St Clare's Hospice. A palliative consultant visited the hospice several times a week to support onsite doctors.
- A pharmacy technician supported St Clare's three days each week with medicines management at the hospice.
- A physiotherapist was also employed at the hospice but had been absent for several months leading up to inspection. Patients requiring physiotherapy were referred to the local healthcare trust in a timely manner.
- We saw limited evidence of multi-disciplinary communication discussions. Staff told us they would liaise with the local healthcare trust and on site doctors but we did not see evidence of structured patient review meetings.
- The Hospice was part of the Hospice UK network and NE Hospice Collaborative.
- The hospice physician noted a monthly palliative teaching group and afternoon teaching classes to share best practice were available at the local healthcare trust.
- Staff gave examples of multi-disciplinary working where patients were being assessed by occupational therapists to identify the suitability of patient's returning home.
- Staff worked closely with Macmillan cancer support services to ensure appropriate referrals were made to the hospice.
- Patients with complex dietary needs received referrals to dieticians at the local healthcare trust who would travel to the hospice for assessments.

**Seven-day services**

- The inpatient unit provided care and treatment across seven days. The day hospice operated Tuesday to Friday (10am to 3pm) at the time of inspection.

**Health promotion**

- The Hospice offered complimentary therapies as part of the day hospice and drop in services. Therapies were funded by the hospice and offered massage, aromatherapy and relaxation benefits for patients.

**Consent and Mental Capacity Act**

- Staff within the hospice acknowledged they sought consent from patients before providing care and treatment.
- We saw written consent within the patients files we reviewed.
- Staff told us they had never carried out a best interest decision and we saw mental capacity assessed in only one file we reviewed.
- The day hospice was reassessing patients at the time of inspection and this included reviewing patients notes for decisions regarding do not attempt cardiopulmonary resuscitation (DNACPR). At the time of inspection staff were unaware which patients had made this decision.

## Are long term conditions caring?

Good

Our rating of caring stayed the same.We rated it as **good.**

**Compassionate care**

- We spoke with five patients during our inspection. Feedback from patients confirmed staff treated them well and with kindness. In the day unit patients were referred to guests.
- We saw a memorial tree on the wall in the entrance to the hospice. This was a wall mounted display of a tree with remembrance names on the leaves of the tree. This was a way to recognise and remember those, no longer at the hospice.
- The hospice received 170 compliments between July 2017 and July 2018. Many of these were letters and cards sent to the hospice from friends, patients and family members. Some of the comments on these cards included: "Thank you for my respite. I appreciate what your staff have done for me. I will be thinking of you always. It has changed my lifestyle" another stated "A heartfelt thank you for your kindness and consideration to make her (mother) end of life experience as comfortable as possible. You treated her with dignity and respect. This helped make the sad time a little more bearable for her loved ones". One patient in an interview noted she "can't fault the hospice" and another patient noted staff are "top notch".

- We saw staff protected patients' privacy and dignity when providing care and treatment and patients confirmed this. Patients told us staff treated them with dignity and respect when carrying out personal care and they felt comfortable with staff delivering this. We saw staff closed the doors to patients' rooms when carrying out care and treatment and knocked before entering.
- The provider completed satisfaction surveys which included all in patient and day hospice patients. We reviewed the quarter 4 survey for 2017-2018 and saw 10 surveys were completed. Overall, the majority of patients felt satisfied with the care and felt respected and treated with privacy and dignity.
- Staff demonstrated knowledge of how to manage care after death sensitively. This included an understanding of last offices and training in the verification of death. Staff described informing patients about death certification, bereavement services and funeral directors in a compassionate manner.

**Emotional support**

- We saw staff were positive and attentive to the needs of patients at the hospice.
- We saw the provider held a bereavement counselling support service, based at two sites. Referrals are received from healthcare professionals, based in in the surrounding area and clients are able to self-refer. Group supervision counselling sessions is provided by 16 members of the counselling team.
- In addition to this, befriending services are offered by the same group of counsellors.
- Following inspection we received a complaint from a family member who told us staff had demonstrated insensitivity to the family's emotional needs. We were told that loud laughter would be heard from staff when the family were visited their very ill family member.

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

- Patients we spoke with felt they were involved in their care.
- Following the last inspection in January 2018, we raised concerns with the provider that medicines which were used off licence had not been fully discussed with patients. We saw during this inspection discussions were recorded and patients were fully involved in medicines decision making.
- Patients told us the food could be better and that the lack of choice was sometimes an issue. However most patients told us that they were satisfied.
- Patients told us the environmental feel of the hospice had greatly improved. This was because of the inclusion of plants and sofas in the lounge area.

## Are long term conditions responsive to people's needs?

(for example, to feedback?)

Inadequate

Our rating of responsive went down.We rated it as **inadequate.**

**Service delivery to meet the needs of local people**

- The hospice is funded in part by the local health commissioning team and the service specification was agreed with commissioning health colleagues, through communication and contract review.
- Patients were usually referred through their GP or local hospital but patients and families are also able to self-refer.
- The unit was situated within a single storey leased building with car parking and disability access.
- There was an open reception area, and patients were escorted straight to the unit. We saw reception staff available most of the time but the main entrance was unlocked resulting in some unsupervised access time into the hospice.
- The unit was wheelchair accessible. There was a disabled access toilet on the main corridor.
- We saw information leaflets in reception and across both the in-patient and day hospice unit. The hospice was not proactive in meeting the needs of people from different cultural and ethnic backgrounds, as we did not see any patient information leaflets that accommodated languages other than English. Staff told us they encourage individuality for example and gave examples of occasions when support was offered to Sikh families.
- A therapy room was available, which was supported by a two-day contract with volunteers from Coping with Cancer and funded therapists.

- The provider held male only therapy days because male patients had voiced their preference to have therapies together.
- A new adult changing room for day care patients had been built with the incorporation of a ceiling track hoist. We found this was currently not being used due to the lack of dependant patients.

**Meeting people's individual needs**

- The service did not take account of patients' individual needs. We saw care plans were not person-centred. A preferred priorities of care proforma was being used, however this did not achieve a sufficient assessment level of individual needs and the proforma was not present in several patient notes. On one occasion a nurse was unable to identify and describe the necessary level of detail needed to achieve individualised care plans.
- Several day care patients reported the meals offered at the hospice were not good enough. They meals were supplied by a local healthcare trust. These meals incorporated the trusts meal protocols rather than adopting specific hospice based requirements. The menu was rotated every four weeks; soft and pureed options were available. Patients reported the quantity of the food was "ok" but the choice was limited. Patients expressed the need for greater choice.
- The hospice had a small chapel which was light and airy. The room was Christian focused with no other areas for prayer or worship within the building. One patient noted the chaplain provided group services only and did not offer one to one time with patients and their families. There was no evidence that the hospice had support for people from other faiths.
- Several staff we spoke to were unaware of how to access translation services for patients' who did not speak English. However, some staff noted they would use services provided by the local foundation trust.
- A spacious kitchen provided light refreshments for friends and relatives, including hot drinks and toast. Use of a fridge, ice machine and microwave was also available.
- Facilities were available for families wishing to stay overnight. A guest room for families and relatives was available. This was small and contained a single bed with an en-suite toilet and shower room.
- Throughout the hospice we saw walls were blank with no pictures or art on display. We were told plans were in place to commission wall art which would be rotated periodically.
- The conservatory was an area primarily for patients, and was also the only area in which children could play. However, we saw it being used by staff to hold meetings, which meant the availability for patients, would be reduced from time to time.
- There was no designated quiet room available and the conservatory was used for this purpose. Staff, including the Chief Executive, told us the hospice suffered from a lack of space especially in relation to quiet areas and storage. However, the hospice had made new 'cosy' areas for patients with small sofa's and soft lighting.
- There were information leaflets on the wall of the hospice published by the 'We Are Macmillan cancer support'. There were many different publications including "Understanding Brain Tumours" and "Understanding Mesothelioma". The quantities of these leaflets were very low in some instances with many leaflet holders being empty and several only had one booklet available. All booklets were only available in English with no other languages accommodated.
- Patients with special dietary needs told us that their needs were not always met in relation to sufficient information being shared with them concerning meals on social trips which resulted in them not attending. We were also told that meal choices were often substituted with a meal that they did not choose and consequently may not enjoy.
- All inpatient rooms had a lockable medicine cupboard and if patients self-medicated, they would have access to the keys.
- Leaflets available for relatives including pensions and funeral arrangements. Staff told us they would get in touch with funeral directors and ask them to contact the family to discuss specific needs.
- We saw inpatient rooms had en-suite facilities together with sliding patio doors to external garden patio areas. Two rooms offered ceiling hoists to enable patients to go straight to the bathroom and toilet.

**Access and flow**

- The hospice welcomed patients with life limiting illness. We saw the day hospice was not admitting patients, at the time of inspection. Staff told us this was because

they were implementing a new therapeutic care model approach. We were not provided with an explanation as to why this would prevent current admissions and address the current patient waiting list of 12 weeks.

- In addition, we found patient flow into the day hospice was limited by long term patients, some of whom had been attending the day hospice facility for many years. One patient told us that access to day hospice was maintained by continued minimal interventions including paracetamol dosage changes.
- There was no urgent pathway into inpatient services. Patients were prioritised according to their need with patients being transferred from hospitals taking priority. Staff told us they could admit within 40 minutes if required.
- One family member told us staff had agreed an urgent admission in the morning but then told the family the patent could not come in the afternoon. The family were not provided with a clear explanation why the admission was cancelled.
- Due to staff sickness there was no on-site physiotherapy service provided by the hospice. Previously, there had been a 4-day weekly provision. We saw referrals were being made to local healthcare trusts and community health services.
- The lymphedema service at the hospice had ceased due to funding and recruitment problems. Patients were required to travel to other services in the area.
- The Activity Coordinator role was vacant at the time of inspection, which meant that a full range of patient activities were no longer being offered. A Health Care Assistant was providing basic activities such as stretching exercises. We were told that patients would have liked to do more activities, but the activity room was very small and especially so, for wheelchair users. Patients said that there were insufficient numbers of staff to support these activities.
- Day care patient services were provided Tuesday to Friday. On Monday's the Living Better Programme was held. Here patients could learn about nutrition, sleep, relaxation, financial matters and complementary therapies. The Living Better Programme sessions ceased in April 2018 but the day hospice manager told us there were plans to re-start the sessions.

**Learning from complaints and concerns**

- We reviewed the complaints policy and saw it was relevant, up-to-date and outlined the complaints process and steps patients could take if unhappy with the outcome of a complaint. However, we saw the service did not record investigation of complaints which meant they could not identify lessons learnt and findings were not shared with staff.
- The service reported one complaint during the 12 months between July 2017 and July 2018 and this was managed under the informal complaints procedure. This highlighted poor communication between a staff member and a patient's family. When reviewing the complaints folder and the Clinical Governance Committee action log for 2017 to 2018, we saw there was no evidence of processes being put in place for lessons learned.
- We were told that a letter had been written by a patient to the Chief Executive to complain about the lack of continued provision of the large hospice ambulance, which used to facilitate large day care outings. We reviewed the complaints file but did not see evidence of the complaint or a response.
- Staff told us in most cases patients would raise concerns and complaints verbally to them and they would in most cases be dealt with there and then. However, there was no formal monitoring of these complaints.
- We did not see complaints information on display in the hospice. There were no posters or booklets available for patients and relatives to inform them how to make a complaint.
- Complaints information was found within the inpatients information pack. This consisted of a small paragraph which described raising any issues with the sister or nurse in charge, however did not include how to escalate concerns to external bodies.
- The registered manager told us discharge questionnaires and surveys were used to gain feedback about the service. Trends identified were related to the food choices available.
- Patients told us if they wanted to make a complaint they would do so by discussing it with the nurse or sister and would be confident to do so if necessary.
- Staff told us if they received a complaint they would raise with their line manager. However, were unable to describe how these complaints would be monitored as verbal complaints were not written down. Staff were unable to describe how lessons would be learned.

## Are long term conditions well-led?

Inadequate

Our rating of well led went down.We rated it as **inadequate.**

**Leadership**

- Leaders within the inpatient unit did not have the necessary skills to lead effectively. None of the staff in leadership positions within hospice had received training to enable them to perform their roles. Staff working as managers had not received any additional management training and interim managers had not been given a handover to enable them to fully appreciate and understand the role.
- Leaders in the senior leadership team did not understand how assurance was gained regarding quality and safety and how process drove improvement. The chief executive told us clinical governance meetings provided an opportunity to discuss quality and safety risk but did not understand the internal challenges and requirements to audit current practice and learn from past risks.
- We saw an improvement plan which was developed following the last inspection in January 2018. There were 16 issues within the plan, each of which required completion in order to support improvement within the hospice. We reviewed the plan and saw only six were marked as completed.
- Following the last inspection a number of requirements were made. One of which was to review clinical policies and procedures. We saw only four policies had been reviewed since the last inspection. We spoke with the Lead Nurse for Quality and Safety and asked how the reviewing of policies was prioritised. We were told there was no particular order but those reviewed were agreed at the clinical governance meetings.
- We reviewed the risk register for the service and saw two separate risk registers. One relating to clinical governance and one to the finance committee. Only two risks were identified on the clinical governance committee which were reputational risk and business continuity in physio and rehabilitation. The finance committee risk register showed four risks. Three risks showed actions which were due to be reviewed in October 2018 and one risk showed an action which should have been reviewed in August but was not completed. This was in relation to adequate insurance.
- Managers told us trustees were very supportive and were visible and approachable. However, the relationship between the senior leadership team and the trustees was ineffective. The provider told us that a Trustee chaired all of the clinical governance meetings but these meetings were regularly cancelled and we saw no evidence of challenge regarding this or requests for information from the managers. We saw there were no clear lines of accountability within the hospice and it was unclear if trustees applied any level of scrutiny to any of the concerns raised at the hospice.
- We spoke with the registered manager regarding the improvement plan, training of staff, risk register and policies. We were told that as they had only recently returned back to work they would not be able to answer questions, as they weren't sure what was going on.
- We spoke with the Lead Nurse for Quality and Safety regarding the same issues and we were told it would be best to speak to the interim manager, as they had been dealing with those issues.
- We spoke with the interim manager who spoke passionately about the service but advised no handover had been given for the role of interim manager and had not fully understood the responsibilities of the role.
- We saw in the entrance of St Clare's there was a notice board displaying the names of the trustees.
- Some staff told us they were not sure who to contact outside of office hours. We saw within a memo dated 1 March 2018, the Chief Exceptive acknowledged the lack of clarify around on-call provision.

**Vision and strategy**

- Staff within the hospice were unclear as to what the vision and strategy of the service was.
- We were provided with two versions of the strategy. One provided prior to inspection and another during inspection. Senior managers appeared uncertain as to which version was current.
- We saw within a memo from the Chief Executive that the vision was described at St Clare's as 'Good care, good death, good memories'.

**Culture**

- Responses from staff we spoke with were mixed. Some staff with told us morale seemed better following the re-opening of the hospice in July 2018. Several staff told us some members of the team had left and the atmosphere felt different.
- Other staff told us they felt unsupported by the management and ideas were not listened to. They had to support each other to get by.
- Two members of staff spoke about a bullying culture within the hospice. They told us some action had been taken but were not clear when asked if bullying was a still an issue.
- The Chief Executive told us there had been an issue with bullying previously but this had been resolved.
- We saw a memo dated 1 March 2018 which was sent to all clinical staff from the Chief Executive. The memo outlined a number issues described as headaches. The memo stated 'The team passion has been lost since the 'good staff' left, team morale has significantly changed in the last 5 years.

**Governance**

- We were not assured senior managers understood how quality was measured at St Clare's Hospice. The provider had not developed any processes or systems in which to monitor quality and outcomes for patients at the hospice. The Chief Exceptive told us there were gaps in their knowledge, in relation to clinical processes.
- We were not assured the trustees were actively involved in quality assurance. We did not see any evidence of discussion with or scrutiny by the trustees in relation to the post CQC improvement plan for St Clare's or the ongoing risks identified above.
- We reviewed minutes from the recent clinical governance committee meetings. We saw there were no minutes or details of discussions purely action points. We reviewed the action log dated 2018 to 2019 and saw out of the 25 actions there were nine showing an empty status, five showing as outstanding and three showed complete.
- The provider demonstrated an over dependency of the local healthcare trust to deliver staff training. None of the managers we spoke with were able to clearly identify which staff had completed specific training and where there were gaps. There was no baseline to identify clear role specific training to assure competency.
- The chief executive made a decision to close the hospice for a period of three weeks to improve the level of medical cover within the hospice and to ensure all staff were trained in relation to care planning and medicines management.
- We saw not all staff had received this training and individualised care planning was still not in place for patients despite this period of focus.

**Managing Risk, issues and performance**

- We saw the provider had developed a 'Risk Management' policy. This provided staff with a definition of risk and how risk was scored according to its impact and severity.
- We reviewed both the clinical and financial risk registers and found the clinical register was not fit for purpose. We saw clear gaps within the operational governance structures such as clinical audit activity, lack of a medicines management's policy, high staff sickness, lack of clinical competency supervisions, access to Primrose Hill site, unlocked main entrance door and medication incidents but these were not considered as risks and therefore not included within the risk register.
- We were not assured managers understood risk within the service. For example, audits did not appear to be shared with the wider team, action plans following audits showed no completion dates and we saw no evidence of learning following incidents.
- Work to improve day hospice services commenced in July 2016 and the day hospice sister was supported in its development through a one day release arrangement. This time was used to review other local day hospice services and to prepare a paper for improvement. We reviewed this paper dated April 2017 and saw an outline under each of the local services. The paper however did not show what recommendations were to be made and what St Clare's aims were following this work. Some services which were in place at time had since ceased such as the lymph oedema services.
- We saw two CQUIN's in place. One of which to development day services and the other in relation to safer staffing. We saw no information had been submitted to local commissioners in relation to these CQUIN's during this financial year. Commissioners told us review meetings were regularly cancelled by the provider.

**Managing Information**

- The provider is required to submit statutory notifications to regulatory bodies following specific events. We saw statutory notifications were made in relation to expected deaths and the change in registered manager.

**Engagement**

- The provider held a number of carers support meetings. We requested minutes from these meetings but none were provided.
- The provider used surveys to gain feedback from patients who used the service. Feedback was generally positive but we saw some comments such as staff were asked to speak slower, and food was not always great.
- Staff told us the views and comments of patients and visitors were included as part of the recent refurbishment of St Clare's. Bedroom clocks were removed from the walls in response to feedback.
- Patients and their relatives completed the 'Friends and Family' survey. We reviewed the latest survey undertaken in quarter four 2017 to 2018 which saw 144 responses. 128 respondents said they were extremely likely to recommend St Clare's to their friends and family.
- The provider told us they planned to hold 'reflection' sessions for staff to openly discuss difficult or challenging situations. We did not see evidence of any meetings had taken place at the time of inspection.

**Learning, continuous improvement and innovation**

- We found no clear learning process or systems to drive improvement at St Clare's Hospice.
- The provider maintained links with South Tyneside Palliative Care Strategic Alliance & Hospices NE Hospice Collaboration. We asked for examples of practice which has been reviewed or implemented following these meetings but these were not provided.
- The provider had organised a number of wellbeing days for patients and their families. We saw these educational sessions were organised by the day hospice sister and had received positive feedback from families. These sessions were last held in April 2018 and there were plans to re-start them again later in the year.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

- The provider must ensure medicines are managed in line with national guidance (NICE 2016) and produce a medicines management policy which is service specific.
- The provider must ensure safeguarding processes are developed to ensure all staff fully understand how to report, investigate and learn from safeguarding alerts. In addition, all staff must receive training in line with Intercollegiate guidance (2018)
- The provider must develop robust incident management processes, to ensure all incidents are reported, investigated and lessons learnt following incidents are shared.
- The provider must ensure that risks to patients are identified, assessed and monitored consistently and that action plans in assessments and care plans are updated and contain enough detail to enable staff to reduce those risks effectively. This includes environmental risk.
- The provider must ensure care plans are individualised and person centred and reflect the needs and choices of each patient as an individual.
- The provider must ensure an accurate record is maintained of the amount of fluids given and taken by all patients.
- The provider must ensure all staff have the necessary skills and training to enable them to be competent in their role.
- The provider must ensure all staff receive an appraisal every year.
- The provider must ensure all staff receive clinical competency supervision to ensure staff are providing care and treatment in line with national guidance and best practice.
- The provider must improve the complaints processes, so that patients understand how to make a compliant and staff investigate and learn following complaints.
- The provider must improve governance processes to drive improvement. This includes the implementation of clinical auditing, review of all policies to ensure staff provide care and treatment in line with national guidance and best practice.
- The provider must ensure all staff providing direct unsupervised care or treatment have completed disclosure and barring checks.
- The provider must ensure patients from different religious or cultural backgrounds have all their needs met and provide translation services when needed.

On the basis of this inspection, the Chief Inspector of Hospitals has recommended that the provider suspend services. However, the provider chose to voluntarily suspend services.

### Action the provider SHOULD take to improve

The provider should ensure that all patients are given enough support and opportunity to be fully involved in the planning of their own care.

- The provider should review all DNACPR processes, to establish consent and ensure all staff are aware of those patients whom have a DNACPR in place.
- The provider should strengthen mental capacity and best interest processes and ensure they are completed consistently.
- The provider should review and access and flow within the hospice to ensure patients access care and treatment at the right time.
- The provider should review the on call arrangements for the hospice and ensure there is clarity in regard to which managers are on call.
- The provider should develop workable plans to turn their vision and strategy into action.
- The provider should discuss all clinical risks with trustees to demonstrate sufficient scrutiny is applied to all concerns.
- The provider should clearly identify timely actions and clear lines of accountability, following clinical governance meetings.
- The provider should review the culture within the hospice and identify positive processes to improve current concerns. Specifically in relation to bullying.
- The provider should investigate and carry out further analysis to understand the reasons for high staff sickness.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>9. - (1) The care and treatment of service users must—<br><br>(a) be appropriate,<br><br>(b) meet their needs, and<br><br>(c) reflect their preferences.<br><br>• (2) But paragraph (1) does not apply to the extent that the provision of care or treatment would result in a breach of regulation 11.<br><br>(3) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—<br><br>(a) carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user;<br><br>(b) designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met;<br><br>(c) enabling and supporting relevant persons to understand the care or treatment choices available to the service user and to discuss, with a<br><br>competent health care professional or other competent person, the balance of risks and benefits involved in any particular course of treatment;<br><br>(d) enabling and supporting relevant persons to make, or participate in making, decisions relating to the service user's care or treatment to the<br><br>maximum extent possible;<br><br>(e) providing opportunities for relevant persons to manage the service user's care or treatment; |

This section is primarily information for the provider

# Requirement notices

(f) involving relevant persons in decisions relating to the way in which the regulated activity is carried on in so far as it relates to the service user's

care or treatment;

(g) providing relevant persons with the information they would reasonably need for the purposes of sub-paragraphs (c) to (f);

(h) making reasonable adjustments to enable the service user to receive their care or treatment;

(i) where meeting a service user's nutritional and hydration needs, having regard to the service user's well-being.

**How the regulation was not being met**

**-** Care plans were generic and did not reflect the persons individual needs.

| Regulated activity | Regulation |
| --- | --- |
| Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>12.—(1) Care and treatment must be provided in a safe way for service users.<br>(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—<br>(a) assessing the risks to the health and safety of service users of receiving the care or treatment;<br>(b) doing all that is reasonably practicable to mitigate any such risks;<br>(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; |

This section is primarily information for the provider

# Requirement notices

**How the regulation was not being met**

- The provider did not have a policy or process to ensure staff received appropriate training.
- Premises were not risk assessed in order to protect patients and staff from the potential of harm or injury.
- We saw patient risk assessments, which were incomplete or had not been reviewed. Examples of this included falls and moving and handling assessments.
- The provider did not have a policy or process for the management of medicines, which was service specific.
- We saw examples of medication errors which had not been investigated or escalated and had resulted in patient harm.
- The providers incident management process was not was fit for purpose as incidents were not investigated and lessons learnt were not recorded or shared with staff.

| Regulated activity | Regulation |
| --- | --- |
| Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>13.—(1) Service users must be protected from abuse and improper treatment in accordance with this regulation.<br><br>(2) Systems and processes must be established and operated effectively to prevent abuse of service users.<br><br>(3) Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.<br><br>**How the regulation was not being met** |

This section is primarily information for the provider

# Requirement notices

- Staff told us they did not understand their responsibilities in relation to safeguarding. This included the interim registered manager and Chief Executive.
- The provider did not record when what level of safeguarding training staff had completed or when refresher training was required.
- There was no evidence the safeguarding vulnerable children training, despite children regularly visiting the hospice.
- The provider did not have an internal system for making safeguarding referrals.
- There was no policy or process to recheck staff that had undergone initial disclosure and barring checks. This resulted in staff not being checked for several years.

| Regulated activity | Regulation |
| --- | --- |
| Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>18.—(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.<br><br>(2) Persons employed by the service provider in the provision of a regulated activity must—<br><br>(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the<br><br>duties they are employed to perform,<br><br>(b) be enabled where appropriate to obtain further qualifications. |

**How the regulation was not being met**

- None of the clinical staff had received a clinical competency review.
- None of the nurses had received an appraisal in the last 12 months.

This section is primarily information for the provider

# Requirement notices

- The interim registered manager had not been provided with training or guidance in order to carry out the role safely.
- There was no training matrix or other method of monitoring and documenting that all relevant training had been undertaken and updated in a timely fashion.

| Regulated activity | Regulation |
| --- | --- |
| Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>17.—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.<br><br>(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—<br><br>(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of<br><br>the experience of service users in receiving those services);<br><br>(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from<br><br>the carrying on of the regulated activity;<br><br>(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and<br><br>treatment provided to the service user and of decisions taken in relation to the care and treatment provided;<br><br>(d) maintain securely such other records as are necessary to be kept in relation to—<br><br>(i) persons employed in the carrying on of the regulated activity, and<br><br>(ii) the management of the regulated activity; |

This section is primarily information for the provider

# Requirement notices

(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the

purposes of continually evaluating and improving such services;

(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

**How the regulation was not being met**

- We were not assured that leaders of the service understood how quality was measured within the service and we did not see a drive towards improvement.
- We saw limited audit activity within the service and no actions or sharing of information following audits which had been completed.
- Governance processes were not in place to monitor and improve services for patients.
- The improvement / action plan following the last inspection in January 2018 was incomplete.
- Some policies and procedures had been transferred from other providers and were not service specific or therefore not fit for purpose.
- We did not see any evidence of clinical review against national guidance and senior managers were not assured that care and treatment was carried out in accordance with best practice.
- Staffing sickness levels were high and morale was variable.
- The provider lacked oversight of staff training and was not sure what training staff had received.
- We saw that processes in place to manage complaints were not robust as actions following a complaint could not be evidenced at the time of inspection.
- Clinical governance discussions were not clear and there was no professional scrutiny from trustees.

This section is primarily information for the provider

# Requirement notices

- Statutory notifications were not submitted by the provider in accordance with the requirements of registration