Barnsley Hospice Appeal

# Barnsley Hospice

**Inspection report**

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Date of inspection visit: 28 April 2021 29 April 2021 4 May 2021
Date of publication: 28/07/2021

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 | Inadequate |
| Are services safe? | Inadequate |
| Are services effective? | Requires Improvement |
| Are services caring? | Good |
| Are services responsive to people's needs? | Inadequate |
| Are services well-led? | Inadequate |

# Summary of findings

## Overall summary

We inspected this service in response to intelligence that indicated a potential risk that the quality of care was not up to standard. We found numerous significant issues of concern and have placed the service in special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement, we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Early in the inspection process, we issued three warning notices relating to the safe care and treatment of patients, the service's capacity to safeguard patients from abuse and improper treatment, and the overall management of the service. We issue warning notices where the care a provider is responsible for falls short of what is legally required, tell the provider what was not right, and explain how long they have to comply with the regulations.

In addition, we issued the provider with 12 requirement notices and told the provider that it must take prompt action to comply with the regulations.

Our rating of this location went down. We rated it as inadequate because:

- Staff did not have training in key skills, did not understand how to protect patients from abuse, and did not manage safety well.
- The service did not always control infection risk well. Staff assessed risks to patients and acted on them but did not always keep good care records. They did not always manage medicines well. Records were not clear or complete.
- The service did not manage safety incidents well and did not learn lessons from them. When things went wrong staff did not apologise or give patients honest information or suitable support.
- Managers did not monitor the effectiveness of the service well and did not make sure staff were competent for their roles by providing support and development including making sure they understood their responsibilities under the Mental Capacity Act.
- The service did not plan care to meet the needs of local people, did not take account of patients' individual needs, and was not always inclusive. The service did not make it easy for people to give feedback.
- People could not always access the service when they needed it and had to wait for treatment.
- Leaders did not run services well using reliable information systems and did not support staff to develop their skills. Risks were not well managed, and performance was not measured effectively. Staff did not all feel respected, supported and valued. The service did not engage well with patients and the community to plan and manage services.

However:

- The service had enough staff to care for patients and keep them safe.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it.

# Summary of findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff were focused on the needs of patients receiving care and were clear about their roles and accountabilities.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| Hospice services for adults | Inadequate  | |

# 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 also provides day hospice services, bereavement and family support.

The hospice is registered as a charitable trust and also receives funding from the NHS. 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 2016. The hospice was rated good in all five domains, with no compliance actions or enforcement issued.

## How we carried out this inspection

Our inspection took place between 28 April and 4 May 2021, 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 five sets of medicines administration records, four sets of patient notes, staff and volunteer files. We spoke to two patients and their families, one volunteer and 10 members of clinical and non-clinical staff. We looked at compliments and complaints received by the service as well as patient feedback surveys.

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.

## Areas for improvement

Early in the inspection process, we issued three warning notices to the provider, setting out clearly areas in which it needed to improve. Additionally, we then placed the provider into special measures.

Action the service MUST take is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

**Action the service MUST take to improve**:

We told the service that it must take action to bring services into line with five legal requirements. This action related to one service.

- The hospice must ensure that incidents are properly reported and investigated, and that learning is embedded to prevent similar incidents occurring in the future. Regulation 12 (2) (b)
- The hospice must ensure that staff working with patients, including bank staff and volunteers, have the correct training and competencies to meet the needs of patients. Regulation 12 (2) (c)
- The hospice must store current, easily accessible records of its staff's competencies, skills and qualifications and ensure these are always up to date. Regulation 12 (2) (c)
- The hospice must ensure that all equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way. Regulation 12 (2)(e)

# Summary of this inspection

- The hospice must ensure that visiting policies are clear, appropriate, in line with current COVID-19 guidance, adhered to and understood by all staff. Regulation 12 (2) (h)
- The hospice must ensure that all staff and volunteers receive appropriate safeguarding adults and children training, at the correct level, and that this training meets intercollegiate guidance. Regulation 13 (2)
- The hospice must ensure that effective and robust systems are in place to support the management of governance, risk and performance. Regulation 17 (2) (a)
- The hospice must collect appropriate and timely information and develop key performance indicators so that leaders have an overview of the effectiveness of the service. Regulation 17 (2) (a)
- The hospice must monitor progress against plans to improve the quality and safety of services, including the hospice strategy. Regulation 17 (2) (a)
- The hospice must keep timely and relevant information about staff and ensure that this information is created, amended, stored and destroyed in line with current legislation and guidance. Regulation 17 (2) (d)
- The hospice must provide appropriate ongoing supervision and training to ensure staff can carry out the duties they are employed to perform. Regulation 18 (2) (a)
- The hospice must ensure duty of candour is consistently applied when reviewing and investigating complaints and incidents. Regulation 20 (1)

**Action the service SHOULD take to improve:**

- The service should consider the implementation of a flexible staffing model that maximises the number of inpatients where possible.
- The service should consider a revision of the multiple systems used to store notes currently with a view to making this simpler and easier for staff to use and find the information they need.
- The service should complete a risk assessment to consider whether flumazenil should be kept as an emergency medicine.
- The service should update its medicines management competencies to ensure they reference current standards and best practice.
- The service should review its processes to track FP10 prescriptions to ensure losses would be captured.
- The service should ensure that the medicines reconciliation policy includes medicines reconciliation, and that this includes cover and continuity of service.
- The service should consider auditing when patients miss doses of their medicines and the reason for those omissions.
- The service should consider adopting a recognised tool for the prompt identification of the deteriorating patient.
- The service should consider reinstating link nurses for mental health and dementia.
- The service should review its safe use of bed rails policy, accompanying practice and procedures to ensure that it is clear that this is a restriction of liberty and prompt appropriate action.
- The service should consider a review of the complaints procedure and whether this is meeting the needs of complainants and their families.
- The service should ensure that it knows its local population, and consider developing links with underrepresented groups and key partners.
- The service should consider implementing an exclusion criteria or other method of being clear about which patients' needs would be best suited to a different caring environment.
- The service should provide a clear pathway for service users to access appropriate spiritual support in a timely way that meets their needs.

# Our findings

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Hospice services for adults | Inadequate | Requires Improvement | Good | Inadequate | Inadequate | Inadequate |
| Overall | Inadequate | Requires Improvement | Good | Inadequate | Inadequate | Inadequate |

Inadequate

# Hospice services for adults

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

## Are Hospice services for adults safe?

Inadequate

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

**Mandatory training**

**The service provided mandatory training in key skills to all staff but did not make sure everyone completed it.**

Nursing and medical staff did not always receive and keep up-to-date with their mandatory training. 69% of medical and 77% of nursing staff were up to date, while the remaining staff had lapsed training, which had the potential to affect patient care.

Clinical staff completed training on recognising and responding to patients with mental health needs and dementia, but did not receive mandatory training on autism or learning disabilities. Staff told us they felt that mandatory training was comprehensive, they had time to complete it, and their induction had met their needs.

**Safeguarding**

**Staff did not fully understand how to protect patients from abuse. Not all staff had the correct training on how to recognise and report abuse.**

Nursing and medical staff received training specific for their role on how to recognise and report abuse. However not all staff were up to date with their training. For example, a member of staff working in the IPU on the day of our visit had not received any safeguarding adults or children training since December 2017, a member of the executive team had not completed any safeguarding training since November 2016 and a member of the family support team had not completed any in the previous three years.

Only one member of hospice staff held a Level 3 Safeguarding qualification. This person was not the safeguarding lead. This was not in line with Royal College of Nursing Adult Safeguarding: Roles and Competencies for Healthcare Staff

guidance which states that a Level three qualification is appropriate for those staff engaging in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns (as appropriate to role). This was a risk to service users because no-one held higher level training above the level of a general practitioner with regular contact with service users.

Staff knew how to make a safeguarding referral and who to inform if they had any concerns. However, they could not give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

When we spoke to staff, they were not familiar with terms such as FGM (Female Genital Mutilation) or CSE (Child Sexual Exploitation). Best practice would be that staff are familiar with these terms, how they are used, and what to do if they have suspicions or concerns relating to them. Staff said they did not have regular safeguarding supervision. No safeguarding referrals had been made in the previous 12 months.

There was no chaperone policy in place, although staff explained that doctors would request a chaperone if they felt it was needed.

The hospice safeguarding adults and children policies did not contain information on key topics in safeguarding. For example, the safeguarding adults policy did not reference Deprivation of Liberty Safeguards (DoLS) or FGM. The safeguarding children policy did not reference CSE.

This was a risk to service users because the hospice had not ensured that staff at all levels, including those providing direct care, had the skills, training and competencies to recognise abuse and to take action to prevent the risk of abuse to service users.

**Cleanliness, infection control and hygiene**

**The service did not always control infection risk well. Equipment was not always visibly clean or stored correctly. However, staff used equipment and control measures to protect patients, themselves and others from infection.**

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 ensuite bathrooms. Hand wash and hand sanitisers were available throughout the ward and the hospice audited hand hygiene regularly.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Daily cleaning schedules were signed off and housekeeping staff had separate equipment for cleaning areas where there was a suspected or confirmed case of COVID-19.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff completed online 'donning and doffing' training and we saw that they knew how to use protective equipment correctly. Staff could describe how to deep clean rooms between patients. However, there was no infection control lead in place.

Staff did not obviously clean equipment after patient contact and did not label equipment to show when it was last cleaned. Staff had reported equipment storage and cleanliness as an ongoing concern. A store cupboard containing

walking aids and hoists was very untidy, with hoists obstructing doorways and walking aids stored on their sides. There were no labels on equipment, and one label dated 2019 stuck to the floor. This had been repeatedly raised with leaders as a risk to patients because there was a risk of the spread of infection through the unsafe and unclean storage of equipment.

**Environment and equipment**

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

Patients could reach call bells and staff responded quickly when called. We saw all call bells in reach, and patients told us that staff responded quickly when they needed assistance.

Staff carried out daily safety checks of specialist equipment. Syringe pumps, were regularly serviced and tested, and staff knew how to report any concerns with specialist equipment. Staff checked the inpatient unit resuscitation trolley regularly and all items were in date.

After death, service users stayed in their rooms. The service did not have any cooling blankets to keep bodies cool after death, and we were told they turned on the air conditioning. This was a risk as effectively controlling the temperature of a body using this method would be a challenge, and likely to be distressing to any families visiting their loved ones after their death.

Staff disposed of clinical waste safely. Clinical waste was double bagged and stored externally in a locked cage. A service level agreement for safe disposal was in place.

**Assessing and responding to patient risk**

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

Staff did not use a nationally recognised tool to identify deteriorating patients. Staff took regular observations and told us that if patients were unwell, they would increase the frequency of these observations and call a doctor to review if they still had concerns. There was no policy or guidance for staff on when to escalate their concerns. This was a risk because there was no safeguard in place to ensure that specialist review took place consistently when needed.

Staff completed risk assessments for each patient on admission / arrival, using a tool to assess patients. Inpatient unit records included pressure sore and malnutrition assessments. However, they did not always review this regularly, including after any incident. A hospice falls audit identified that assessments of visual impairment and suitable footwear were not documented consistently and falls prevention measures were not always correctly documented. This meant there was an identified risk to service users where assessments had not been regularly updated, but no actions had been put in place to stop this happening again.

Shift changes and handovers included all necessary key information to keep patients safe. Staff met every morning and discussed each patient in detail, including their psychological needs. All staff working in the inpatient unit had access to patient records, a communications book and whiteboard where important updates were stored.

**Nurse staffing**

Inadequate

# Hospice services for adults

**The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.**

The service had enough nursing and support staff to keep patients safe. The number of nurses and healthcare assistants matched the planned numbers. Planned nurse staffing was three nurses during the day, two in the evening and two overnight. Planned Healthcare Assistant cover was two during the day, two in the evening and one overnight. This was being consistently met.

Managers did not calculate and review the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The hospice were using a recognised scoring system to identify patients' needs, but did not use this to directly inform or flex planned staffing, which was fixed. Staff told us they had plans to implement a dependency system but this was not yet in place. This fixed staffing model was a potential risk to service users as the hospice kept occupancy rates stable to fit staffing, despite evidence that some people were waiting a long time to access the service.

The service had an increased turnover rate in the last 12 months. The inpatient unit had undergone a restructuring exercise in mid-2020 which had led to several staff leaving the service and recruitment of new nursing staff. Plans were underway to fill any remaining vacancies and the hospice used its own part-time staff as bank staff in the interim to ensure continuity of care.

**Medical staffing**

**The service had enough medical 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 had enough medical staff to keep patients safe. The medical staff matched the planned number. The hospice directly employed their medical staff and had 2.2 full time equivalent posts. This included consultants, specialty doctors, a junior doctor and trainee doctors.

The service always had a consultant on call during evenings and weekends. During the day, there could be four or five doctors in the inpatient unit at any one time. There were no doctors onsite after 5pm on weekdays but a medical on call rota meant nursing staff could access specialist advice seven days a week.

**Records**

**Staff kept records of patients' care and treatment. Records were not clear or always complete, but were stored securely and available to all staff providing care.**

Patient notes were not always comprehensive and stored in several different systems and places. Nursing and medical notes were stored separately, some on paper, some electronically. Another set of notes stayed by the patient's bedside, and then a further folder containing a patient's spiritual and emotional preferences, and Do Not Attempt Cardiopulmonary Resuscitation DNACPR form, was kept in a third location. The most recent records action plan had identified a need to reduce the paperwork around handovers, create up to date relevant nursing assessments, and develop clear, person-centred care plans. These actions were not complete. The hospice's most recent records audit showed gaps in record keeping, for example, only 54% of patient chart entries, 47% of repositioning and 67% of skin assessments were signed. This meant that there was a risk to service users that records of their care did not contain everything necessary to keep them safe.

The hospice overview of a patient's 'do not resuscitate' status was to write 'for resuscitation' on a whiteboard, and to leave that section blank if a patient was not for resuscitation. This was a risk to patients as an omission in recording could incorrectly indicate a patient was not for resuscitation. DNACPR forms were stored at the front of patient's files. Three of four forms were correctly completed, the fourth, completed by a hospice doctor, did not provide adequate reasoning for the decision and did not indicate if the patient had been involved in the discussion.

Records were stored securely. Patient records were stored in the office in the inpatient unit, accessible only by staff. Staff completed care plans and made notes in patient records in this area, where they were confident they would not be overlooked.

**Medicines**

**The service did not always have systems and processes in place to safely administer and record medicines use.**

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were supplied by a community pharmacy and clinical oversight was provided by a pharmacist who visited three times a week from a local trust. Prescribing was clear, safe and appropriate to be able to respond to symptoms that patients may experience during their stay. Emergency medicines were available should they be required except for flumazenil, which is a medicine used to reverse the sedative effect of a commonly used medicine in palliative care. Staff completed medicine management competencies, however, the assessments referenced NMC standards which were withdrawn in January 2019.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. However, at discharge the patient was not given a comprehensive list of all the medicines that were being either taken by themselves or being administered to them. There could be up to 5 separate discharge documents with medicines recorded on them.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy except for FP10 prescriptions which were recorded at the point of issue, but the system did not allow staff to identify if any were missing.

Staff followed current national practice/guidance to check patients had the correct medicines, although not all patients had this check (medicine reconciliation) carried out within 72 hours especially during March 2021 when only four of the 11 eligible patients received it within the specified timeframe. This was due to the pharmacist taking annual leave. The medicines management policy does not contain any reference to the responsibilities of the hospice to provide medicines reconciliation, who conducts this and planning for cover when the pharmacist is on leave.

Monitoring of the patients receiving medicines was in line with current guidance and in some circumstances for high risk drugs such as methadone, the hospice had put in place individual care plans to ensure that patients were monitored closely when doses were changed or new prescriptions were started. Doctors had conversations with patients to explain if unusual medicines were used and receive their consent and this was documented in the patients records. However there was no auditing of missed doses of medicines and the reasons for those omissions.

The destruction of Controlled Drugs should follow best practice guidance to minimise the risk of diversion and Controlled Drug Denature kits should be used appropriately.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Staff reported medication incidents and near misses appropriately. They were then reviewed and shared with pharmacy staff so the appropriate actions could be taken. There was evidence that actions had been completed.

**Incidents**

**The service did not manage patient safety incidents well. Staff did not always recognise and reported incidents and near misses. Managers did not investigate incidents and share lessons learned with the whole team and the wider service. When things went wrong, staff did not apologise or give patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Staff did not know what incidents to report and how to report them and did not report incidents and near misses in line with provider policy. The hospice had reported three serious incidents between January 2020 and March 2021. There had been a total of 164 incidents including 67 patient falls over this period. This had not been investigated until February 2021, and there was no action plan with named, dated actions around falls. No incidents above 'moderate' were reported in 2020/2021 despite a patient having sustained a fractured neck of femur following a fall and a second a dislocated shoulder and skin tear following a fall.

Staff told us they saw examples of falls which were dismissed as 'a unique set of circumstances' and not reported. A serious incident in 2020 was not correctly identified as such until three months later, leading to a delay in reporting to the commissioner. Incidents were logged on paper by staff when they occurred and passed to a different person to add to the electronic system. This was a risk to service users as it meant that there was the potential for delays or backlogs to occur.

Managers did not investigate incidents thoroughly. Patients and their families were not involved in these investigations. The hospice only investigated its serious incidents to a standard which had the potential to lessen the chance of recurrence. Other incidents were poorly investigated and there was little evidence of lessons learned. Recurring incidents, such as falls, were not prevented, nor the risk lessened, because staff did not fully investigate the causes of these, nor learn from them. This was not in line with hospice policy and posed a risk to patients that the same incidents could happen again.

Staff did not routinely receive feedback from investigation of incidents, both internal and external to the service. Staff did not know where and how incidents were discussed and were unclear how they would receive feedback. Leaders told us that incidents, such as medication incidents, would be discussed with those involved, which they were, but they were not then shared with the wider team. By not sharing wider learning from incidents, the hospice did not fully minimise the chances of something similar happening in future.

Staff did not understand the duty of candour. They were not open and transparent, and did not give patients and families a full explanation if and when things went wrong. The hospice had not correctly applied Duty of Candour legislation when responding to a notifiable patient safety incident in 2018 and had not apologised to the patient's family. Following a further notifiable incident in 2020, the hospice did not follow Duty of Candour legislation. They did not write to the patient or their family, and did not offer apologies or an explanation of what went wrong.

Inadequate

# Hospice services for adults

## Are Hospice services for adults effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

**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. Staff protected the rights of patients subject to the Mental Health Act 1983.**

Staff followed up-to-date policies to plan and deliver care according to best practice and national guidance. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Staff ensured that service users' care plans included symptom control, social and spiritual support, and psychological needs. Evidence of discussion with patients and relatives was recorded in care plans and discussed in handover meetings. Staff delivered care and treatment in line with care plans. Anticipatory medicines for distress, agitation, seizures and pain were prescribed and given in line with National Institute of Health and Care Excellence (NICE) guidelines.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. However, there was no link nurse for mental health. Previous mental health link nurses had left the organisation and a new link nurse had not been identified. This was a risk to service users as there was no identified nurse with a specific interest in mental health to disseminate knowledge and learning to their colleagues.

**Nutrition and hydration**

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

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. Service users told us they were happy with the food and drink they received and we saw that they had water provided within reach. Staff offered drinks to patients throughout the day and ice pops were provided for those with dry mouths. Visiting families were offered drinks.

Staff used a screening tool to monitor patients at risk of malnutrition. We saw this was appropriately completed in the care records of service users we looked at. Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Specialist support from staff such as dietitians could be arranged for service users who needed it through the local hospital trust. However, nursing staff had not received any training in topics such as dysphagia (difficulty swallowing) and how to assess this.

The hospice provided a full menu for breakfast, lunch and tea, including hot and cold food options, and staff told us that they could provide hot and cold snacks to service users outside regular mealtimes. However, there was no regular hot food option for vegetarians or vegans.

**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 checklist and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after requesting it.

Staff discussed patients' pain relief at every handover. Pain management was collaborative with doctors and nurses regularly discussing adjustments as needed. These were made without delay. Staff checked on patients and discussed their pain relief with them regularly.

Staff prescribed, administered and recorded pain relief accurately. They documented in patient notes when pain was present and adjusted medication accordingly.

**Patient outcomes**

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

Managers and staff carried out a programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits. The hospice shared a clinical effectiveness and audit programme for 2021/2022. In the previous year, due to COVID-19, it had not been possible to complete all planned audits. Contract monitoring with the local clinical commissioning group was being completed regularly and included monitoring of 'softer' patient outcomes such as reduction in patient anxiety and dignity and self worth. The hospice was participating in a Hospice UK benchmarking trial with a clinical governance overview dashboard showing incidents, complaints, policies, notifications, drug alerts, infection control and safeguarding. It was not clear from this document what targets had been set and how these were monitored. During 2020-2021, a total of 81% of patients died in their preferred place of death. This was above the 75% target set by the hospice.

**Competent staff**

**The service did not make sure staff were competent for their roles. Managers did not regularly appraise staff's work performance appropriately or hold supervision meetings with them to provide support and development.**

Managers did not properly check that staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff received a disclosure and barring (DBS) check when they joined the hospice. Although staff received a DBS check when they joined the service, policy did not cover rechecking these. A total of 23 staff had no up to date DBS on record for the past 10 years.

Managers did not support staff to develop through yearly, constructive appraisals of their work. Five staff files relating to a variety of clinical and non-clinical roles contained no evidence of a recent appraisal (within the last year). Managers did not have one to one meetings formally set up for all staff.

Managers gave new staff a full induction tailored to their role before they started work. New starters reported feeling well supported, and, where they had requested reasonable adjustments to enable them to fulfil their role, these had been provided. Clinical staff were able to work outside planned staffing numbers when they first started.

Staff files were disorganised and contained incorrect information. Sensitive confidential information had been misfiled in the wrong person's folder. Staff files did not meet the requirements set out in of the Health and Social Care Act. They did not contain information to show staff had all the necessary checks to ensure safe recruitment to keep patient safe.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. There was a designated note taker, and minutes were stored centrally so staff could find them easily.

Managers did not give staff the time and opportunity to develop their skills and knowledge. Nursing staff told the service in their exit interviews that a main reason for leaving was because they had become deskilled and did not feel that they were supported to keep their skills and knowledge up to date. Nurses at the service worked closely with a large doctor team who completed many of the jobs a nurse could also do. This had not been discussed at board level or recorded as a risk.

Managers did not always identify poor staff performance promptly and support staff to improve. Where mistakes had been made, senior staff had observed staff to check they were safe, but then hadn't worked with staff to provide longer term support underpinned by an agreed action plan, or identified any longer term learning needs.

Managers did not safely recruit volunteers to support patients in the service. Two volunteer recruitment files contained no evidence of a current DBS, a third contained a DBS dated 2003. Emergency contact details had not been updated and there was no proof of identity in volunteer files.

**Multidisciplinary 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. Multidisciplinary meetings were held once a week, and daily handovers were attended by doctors, nursing staff, health care assistants, therapy and administration staff, working together to share information. Nursing staff and doctors reported good working relationships and felt well supported and part of a team.

Staff worked with other agencies when required to care for patients, but said they could be doing more in this area. There was limited outreach and joint working with local GPs, care and nursing homes.

**Health promotion**

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

The service had relevant information promoting healthy lifestyles and support. Day hospice services were being delivered remotely due to the COVID-19 pandemic, but this included a new pilot 'companionship, openness, planning and exercise' programme supported by a physiotherapist, registered nurse and complementary therapist. Topics covered included sleep hygiene, anxiety management and planning for the future. Participants stated "I have a reason to get up and get ready", and "This has given me something to look forward to."

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff referred patients to local social prescribing services and stop smoking services. Leaflets covering topics such as smoking cessation were on display in communal areas.

**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. However, staff had not kept their skills and knowledge up to date.**

Nursing and medical staff received but did not keep up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Doctors regularly assessed the mental capacity of patients. Of the nine doctors employed by the hospice, four had not completed any Mental Capacity Act (MCA) training in the past three years. This was not compliant with the hospice's own training requirements. The author of the hospice's safe use of bed rails policy (a form of restraint) had not completed any MCA or deprivation of liberty training since 2017.

We would have expected to see anyone regularly conducting a mental capacity assessment or with oversight or authorship of policies to be up to date with their MCA training. This was a risk to patients because decisions about their capacity was being made by staff who had not kept their skills up to date.

The hospice safe use of bed rails policy and the accompanying electronic form did not prompt staff to consider whether a person's liberty was being restricted nor prompt the submission of a DOLs application.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff checked that patients were ready for care and treatment and accepting of this. When people asked for a rest before resuming treatment, this was respected and a sign was put on the person's door to alert other members of the team.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff clearly recorded consent in the patients' records. Patients entering the hospice did not routinely receive an assessment of their capacity, but where there were concerns, this was conducted, usually by a doctor, and clearly documented in their notes.

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. Staff contacted the local authority Deprivation of Liberty Safeguards team for advice and support where needed.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. Deprivation of Liberty Safeguard applications were completed electronically. These were countersigned by the registered manager and were completed appropriately. However there was no regular audit of these.

Inadequate

# Hospice services for adults

## Are Hospice services for adults caring?

Good

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

**Compassionate care**

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. People's buzzers were answered promptly and nursing staff and healthcare assistants prioritised responding to patients, breaking off from other tasks to assist patients when buzzers were pressed.

Patients said staff treated them well and with kindness. Patients described caring staff who listened to their needs and checked on them regularly. A patient told us staff took the time to find out what their likes and dislikes were. Feedback and thank you cards were on display and echoed the sentiments expressed by patients that staff had provided compassionate care. After a patient's death, a candle was lit on the inpatient unit so that staff were especially mindful of their behaviours and that of other patients and visitors.

Staff followed policy to keep patient care and treatment confidential. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff delivered care in individual side rooms and privacy screens were used where needed to maintain people's dignity. They worked to accommodate patient preferences and needs, such as moving patients with more regular visitors to larger rooms to accommodate visits. Staff were observed assisting a patient gathering clothes and discussing their preferences and choices about what they would like to wear that day.

**Emotional support**

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. 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. Family and bereavement support services were working virtually rather than face to face due to the COVID-19 pandemic, The hospice supplied pairs of knitted love hearts, one to the patient, one to their family, to promote a feeling of connection during the COVID-19 period. Staff celebrated birthdays, Easter and Christmas with patients. A bereavement course facilitated by the hospice counsellor was planned for April 2021, covering topics such as grief, loss, empathy and non-verbal communication. A visit to the seaside for a patient and their family was facilitated in partnership with another local organisation. The hospice sent new daycare patients a 'this little box' to encourage positive self care and improved mental and physical wellbeing. Families accessing bereavement counselling commented that "it was just what I needed at the time" and "the counselling has been beneficial and helpful."

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

Inadequate

# Hospice services for adults

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. Staff supported patients to make informed decisions about their care. Patients told us that they were involved in all decision making and planning, and that their family were kept fully informed. They knew what the next steps and plans were for their care and treatment.

Patients and their families could give feedback on the service and their treatment. Patients gave positive feedback about the service. Results of the most recent survey (2019) showed that 100% of patients reported they were very satisfied with their comfort and the way their dignity was respected. However there were only nine respondents to the survey.

Staff supported patients to make advanced decisions about their care. The hospice's new COPE programme, due to start imminently, provided an opportunity for all new day care patients to learn about advance care planning, how this worked, and what options they had for their care. Care records for patients in the inpatient unit showed evidence of family input into plans and decision making where appropriate.

However, there was no clear oversight of the implementation of the visiting policy in the IPU. During our visit, we noted that the inpatient unit was busy with visitors, including families with children. Hospice staff and the executive team had raised concerns in the executive team meeting and clinical meeting around the numbers of visitors and staff understanding of the policy. Staff were unable to clearly describe the visiting system and we did not see a maximum visitor number in place. Visitors were not asked to complete a lateral flow test prior to their visit. This was a risk to service users because staff were not taking reasonable action to prevent the spread of COVID-19 infection to service users.

## Are Hospice services for adults responsive?

Inadequate

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

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

**The service did not plan and provide care in a way that met the needs of local people and the communities served. There was limited work with others in the wider system and local organisations to plan care.**

Managers did not plan and organise services so they met the needs of the local population. For example, four percent of the local population of the Barnsley area identified as non-white British. Leaders were not aware of this figure, as the hospice had not treated anyone identifying as non-white British in recent years with one potential exception. Leaders had not identified this as an issue. The hospice had links with the local hospital trust, but did not promote their services in GP surgeries or community places of worship or congregation, and had limited contact with nursing and care homes.

When questioned, staff did not recognise the term 'protected characteristics'. Upon further prompting, staff could provide very limited examples. No work had been done on ensuring equality of access for people with protected characteristics. A resource folder, containing material such as caring for LGBTQ service users and people who are homeless or temporarily housed had not been updated since 2018. Staff working clinically did not know where to find the folder.

Facilities and premises were appropriate for the services being delivered. The inpatient unit had been recently refurbished and was bright and visibly clean. All patients had their own individual rooms with en-suite facilities, and many rooms had access to the garden outside. Rooms were wheelchair accessible. There were no facilities for bariatric patients as staff explained that previously available equipment had been condemned and not replaced, however, they were able to access equipment from the local community equipment store.

The service had systems to help care for patients in need of additional support or specialist intervention. The hospice could access the local hospital trust when specialist intervention was required. There were no service level agreements in place to support this.

**Meeting people's individual needs**

**The service was not always inclusive and did not always take account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**

Staff 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. The inpatient unit was not designed to meet the needs of patients living with dementia. Floors and walls were not sufficiently contrasting in colour and there was no visual signage. The hospice did not have an exclusion policy, stating that every case was judged individually. However, evidence from a previous serious incident showed that this had led to staff providing care to a patient they had found challenging to manage, culminating in a serious incident. Since this incident, the hospice had provided additional training to staff, but had not implemented any criteria around admissions. This was a risk to patients because there was no clarity around which patients it would not be best placed to support.

Staff explained that the hospice had not done any work to support teenagers transitioning from children's services to adult. They had supported one 18 year old who had trialled their services as an inpatient and had not returned. Staff did not know why and there had been no learning from this.

There was no provision in place for the spiritual welfare of service users and their families. A previous service level agreement ended prior to March 2020 and there had been no specific spiritual provision since then. A local church across the road had been approached to provide ad-hoc support when needed and staff told us that they would request a person's own faith leader when requested specifically by them. This lack of planned resource meant that there was no regular onsite or offsite spiritual support, which was a risk as patients' holistic needs were not being met.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters when needed. The service did not have information leaflets available in languages spoken by the patients and local community. There was access to a telephone translation service, but no written material, nor any posters or signs on display to let families or service users know that this service was available.

Inadequate

# Hospice services for adults

**Access and flow**

**Patients could not access the service when they needed it. Waiting times from referral to achievement of preferred place of care and death were not in line with good practice.**

Managers did not act upon waiting times and did not always make sure patients could access services when needed. Patients waited to use the service, even when the hospice was not full. Staff decided which patients were admitted and when on a case by case basis at the hospice daily meeting. Over the last two quarters, the hospice had achieved 85% and 73% bed occupancy in the inpatient unit. The hospice had not been over 90% full since our last inspection. Even though the hospice was not full, and less patients were being referred than prior to the COVID-19 pandemic, patients waited to access the inpatient unit for an average of 4 days between October 2020 and March 2021. During this time, one patient waited 27 days to access the service. Prior to the COVID-19 pandemic, longest waits were still 8-10 days. For the last three quarters, only half of patients were admitted the same day or within one day of referral. This was a risk to patients as they were waiting longer than necessary to use the service.

The hospice did not admit patients after 5pm or overnight. This was not in line with the hospice 'Admission to and Discharge from Barnsley Hospice In-Patient Unit policy' which stated that admissions could be accepted following agreement with the doctor on duty and nurse in charge. However, staff confirmed that this did not happen.

Day care services were suspended from meeting physically due to the COVID-19 pandemic, however data showed that there was no emphasis on discharge from daycare prior to this. Some patients had accessed the service over a long period of time, and the hospice could not offer day care places to everyone newly referred that month.

Managers and staff worked to make sure that they started discharge planning as early as possible. Managers monitored patient transfers. In the previous two quarters, the hospice had supported 79% and 86% of patients respectively to achieve their preferred place of death.

**Learning from complaints and concerns**

**People could give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them. The service included patients in the investigation of their complaint but did not provide resolution for patients and their families.**

Patients, relatives and carers knew how to complain or raise concerns, however the service did not clearly display information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff explained how they would receive a complaint and how they would attempt to resolve these quickly and informally where possible. However, the policy directed unsatisfied complainants to CQC, who do not investigate individual complaints.

Managers investigated complaints and identified themes. Copies of the last three complaints received by the hospice showed that none of the complainants felt the hospice had resolved their concerns and all remained very dissatisfied with both the original issue they had raised, and the way in which their concerns had been addressed. It was not clear from minutes of board and clinical governance meetings if anything further had been done to attempt to further resolve this.

Inadequate

# Hospice services for adults

## Are Hospice services for adults well-led?

Inadequate

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

**Leadership**

**Leaders had some of the right skills and abilities to run the service. They did not always fully understand and manage the priorities and issues the service faced. They were not all 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 the chair. The hospice executive team (HET) comprised the chief executive, deputy chief executive and patient services director. Nursing leadership had been recently restructured with two new inpatient unit leaders in place. The chief executive and patient services directors were also registered nurses.

Leaders demonstrated little knowledge of the demographics of the local area and had not reached out to local community and faith leaders, GPs or local care homes to develop working relationships. They had some understanding of the challenges to quality and sustainability faced by the service but there were few examples of leaders demonstrably improving quality or sustainability in board or subcommittee meeting minutes.

The hospice had recently recruited new trustees to the board after longstanding members had stepped down. Trustees did not all regularly attend meetings. There was little or no documented scrutiny of meetings by non-executive board members. Trustees and executive leaders recognised that there was not enough challenge from the board to the HET. Trustee recruitment files did not meet requirements. This was a risk to patients because the service could not be assured that all proper checks had been made and risks mitigated to safely recruit trustees and protect patients from harm.

Staff told us that not all members of the HET had been approachable and visible, not just throughout the COVID-19 period but prior to this, however the patient services director had spent some time working clinically in the inpatient unit during the previous year, which had been appreciated by staff.

**Vision and strategy**

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, but this had not been developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.**

The hospice had a clearly stated vision, and had developed a one year strategic plan, developed with a short timescale in order to respond to the changing shape of services in 2020. Strategic objectives had been revisited, but remained unchanged from the previous version as it was felt they were still relevant. Staff, patients and wider stakeholders were not consulted in the refresh of the hospice strategic objectives. The document referenced feedback from patients, families and colleagues, and key documents, but did not say what was used or how. There had been no engagement

with the wider local population during the development of the current strategy. Leaders talked about objectives being communicated to staff and service users, but not developed with. Local statistics used in the strategy document had not been updated since the 2016 iteration. Achievement against objectives was monitored by the executive team on a monthly basis.

**Culture**

**Staff did not all feel respected, supported and valued. They were focused on the needs of patients receiving care. The service did not always promote equality and diversity in daily work, but provided some opportunities for career development. The service did not have an open culture where patients, their families and staff could raise concerns without fear.**

Everyone, from staff working in the inpatient unit, to leaders and trustees told us that they felt that the culture of the organisation had improved, but it had been a very difficult year. During the COVID-19 pandemic, the hospice had undertaken a difficult restructure of staffing in the inpatient unit. This had led to resignations, whistleblowing to CQC and low morale in remaining staff. Staff who had experienced these changes first-hand felt they were poorly timed, badly managed, and they were not kept fully informed by leaders what was happening or why. Leaders accepted that they had underestimated the strength of feeling this produced.

The service had a whistleblowing policy in place and staff knew how to share concerns. A general email for staff to raise concerns went directly to HR. The hospice did not have a freedom to speak up guardian or similar post. There were no 'thank you' or other staff recognition awards.

The equality and diversity of staff and volunteers was not always respected. Not all staff files contained information about their protected characteristics and this was not present in volunteer files. However, reasonable adjustments, when requested by staff, had been successfully implemented.

**Governance**

**Leaders did not operate effective governance processes, throughout the service and with partner organisations.**

Minutes of the Board showed no evidence that clinical topics were regularly discussed. We saw in three sets of board minutes that there was no discussion of the quality of care provided to service users, there was no hospice patient care dashboard presented to the board, nor was there any wider discussion around the information committees fed into the board. The Clinical Governance committee minutes were noted with no further comment or challenge.

Evidence from board papers and well led interviews showed a lack of challenge from the board to the executive team. For example, in board papers dated 2 December 2020 it was noted that trustees would be expected to be more challenging and ask more questions. This did not demonstrate best practice which would be for a regular assessment of the quality of care provided to be discussed at board and comprehensive minutes of this discussion and any challenge to be recorded. We were not assured that the board were aware of, or had any oversight of, issues directly affecting clinical care as there were no clinical risks on the corporate risk register, and those interviewed confirmed this.

This was a risk to service users because the lack of effective scrutiny and challenge at board level demonstrated the service does not have effective systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services.

**Managing risks, issues and performance**

**Leaders and teams did not use systems to manage performance effectively. They did not identify and escalate relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**

There were at least five groups reporting into the Clinical Governance Committee, reporting in turn to the board. Additionally, and separately, the HET met every two weeks. Topics such as medicines management or infection control could therefore be discussed in at least three different meetings, none of which had a formal mechanism for escalating to the clinical governance meeting or board.

Minutes of the Infection Control Meeting of 6 October 2020 stated “a question was asked as to meeting content crossing over such as medicines management and nutrition meetings etc. Could these meetings be amalgamated into one meeting as most attendees are the same across most of the meetings?”

This was a risk to patients because competing and overlapping meetings with no clear escalation structure had the potential for significant risks to be missed, not escalated appropriately or not actioned in a timely way.

There were few clinical risks on the corporate risk register which did not reflect the breadth of issues identified on inspection. None related to the quality and oversight of care provided. Issues such as the increased number of patient falls were not recorded as a risk, so the board and executive team did not have oversight of or ownership of them.

The hospice had business continuity plans in place. In the event of a site specific major incident, there were plans in place to maintain critical services to patients.

**Managing information**

**The service collected limited data and did not always have the capacity to analyse this well.**

There was no dedicated governance resource within the organisation, and overall responsibility for good governance sat mainly with two people. Further individuals contributed, for example, by having oversight of incident reporting. There was limited audit of the quality of data being used to inform leaders. There was no system in place to check the grading of incidents and whether this was being applied correctly. The hospice had 67 falls, increasing throughout 2020, yet this had not been flagged up as an issue by the governance team nor investigated until February 2021.

A member of the governance team kept a spreadsheet of policies and we noted that all policies we saw were in date. We were told by leaders that HET reviewed and revised policies. The Safeguarding Adults policy had not been revised to include key terms. We could not find any quality assurance system for the checking of HET’s policy renewal work in the information provided by the hospice. This was a risk to patients as policies were found to be incomplete and therefore not fit for purpose.

Inadequate

# Hospice services for adults

All staff received information governance training as part of their mandatory induction. The hospice did not always follow its own information governance procedures.

**Engagement**

**Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. There was some collaboration with partner organisations to help improve services for patients, although this was limited.**

Individual services, for example, bereavement support and the inpatient unit, collected patient feedback using questionnaires. There was no regular review or discussion of these reports at board or subcommittee level. Patient stories were taken to board for consideration.

The most recent survey of service users in the inpatient unit was conducted in July 2020 and showed that most people were happy with the services provided. Counselling services received positive feedback from those using services. However, it was not clear from the feedback gathered how this was directly used to improve services for people and their families. There was no regular staff engagement mechanism and no regular opportunities for staff to meet to provide feedback.

Leaders recognised when challenged that people with protected characteristics were poorly represented in the hospice's literature, website and documentation and that they had not engaged with community equality groups.

**Learning, continuous improvement and innovation**

Staff were able to provide limited examples of learning and improving services.

The service had developed links and working relationships with other hospices and had begun to share practice, however, due to capacity, leaders had not attended meetings as regularly as they would have liked.

The inpatient unit restructure and COVID-19 pandemic meant that there had been little focus on continuous improvement and innovation in the past 12 months. However, the hospice was taking part in a new Hospice UK dashboard development project, and staff spoke of other plans they had to improve in future.