

Butterwick Limited

Butterwick Hospice

Inspection report

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

Ratings

Overall rating for this location

Inadequate



Are services safe?

Inadequate



Are services effective?

Inadequate



Are services caring?

Good



Are services responsive to people's needs?

Requires Improvement



Are services well-led?

Inadequate



Summary of findings

Overall summary

Butterwick Hospice is operated by Butterwick Limited. The hospice is purpose built; is fully accessible and has appropriate facilities for day care, therapies and family support. The hospice provides adult hospice services that includes palliative and neurological day care, family support services for adults, children and young people and a home care service for palliative and end of life patients. The hospice does not have inpatient beds. We inspected the service using our comprehensive inspection methodology. We carried out an unannounced inspection on 1 and 2 February 2022. During the inspection we visited the hospice's day care service at Bishop Auckland and one patient who was receiving care at their home.

Following this inspection, we served the provider a Warning Notice under Section 29 of the Health and Social Care Act 2008. The warning notice told the provider they were in breach of Regulation 17 and gave the provider a timescale to make improvements to achieve compliance. The principles we use when rating providers requires CQC to reflect enforcement action in our ratings. The warning notice identified concerns in the safe and well-led domain. This means that the warning notice we served has limited the rating for safe and well-led to inadequate.

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

- The service did not have effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.
- There was no clearly defined purpose of the Hospice at Home service provided at Bishop Auckland and staff were not suitably trained to deliver care in line with the purpose.
- Staff did not have appropriate policies and guidance to support them to deliver care in line with the service's purpose. There was no appropriate oversight of the service provided at Bishop Auckland to ensure staff were delivering care in line with the service's purpose.
- The service did not have an admissions policy, operational policy, service specification, standard operating procedure or similar document which would identify the remit of the service and identify whether the service was able to meet service users' needs.
- The service did not have a policy or procedure for staff to follow in situations where service users' risks had changed, or where a service user had deteriorated or become seriously unwell.
- Not all staff had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards; Loss and Bereavement; Palliative Care; Incident Reporting; or Lone working.
- Governance systems did not identify or monitor the quality of care provided and there was lack of oversight from senior leaders.

However:

- Staff demonstrated caring, compassionate interactions with patients and their families.
- The service had an open culture and staff felt confident to be able to raise and escalate concerns.
- Service users we spoke with spoke highly of staff and the care that they received.
- People could access the service when they needed it and did not have to wait too long for treatment.
- Patients and families using the service were very happy with the care they had received.

Summary of findings

Our judgements about each of the main services

Service

Hospice services for adults

Rating

Inadequate



Summary of each main service

Butterwick Hospice is operated by Butterwick Limited. The hospice is purpose built; is fully accessible and has appropriate facilities for day care, therapies and family support. The hospice provides adult hospice services that includes palliative and neurological day care, family support services for adults, children and young people and a home care service for palliative and end of life patients. The hospice does not have inpatient beds. We inspected the service using our comprehensive inspection methodology. We carried out an unannounced inspection on 1 and 2 February 2022. During the inspection we visited the hospice's day care service at Bishop Auckland and one patient who was receiving care at their home.

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

- The service did not have effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.
- There was no clearly defined purpose of the Hospice at Home service provided at Bishop Auckland and staff were not suitably trained to deliver care in line with the purpose.
- Staff did not have appropriate policies and guidance to support them to deliver care in line with the service's purpose. There was no appropriate oversight of the service provided at Bishop Auckland to ensure staff were delivering care in line with the service's purpose.

Summary of findings

- The service did not have an admissions policy, operational policy, service specification, standard operating procedure or similar document which would identify the remit of the service and identify whether the service was able to meet service users' needs.
- The service did not have a policy or procedure for staff to follow in situations where service users' risks had changed, or where a service user had deteriorated or become seriously unwell.
- Not all staff had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards; Loss and Bereavement; Palliative Care; Incident Reporting; or Lone working.
- Governance systems did not identify or monitor the quality of care provided and there was lack of oversight from senior leaders.

However:

- Staff demonstrated caring, compassionate interactions with patients and their families.
- The service had an open culture and staff felt confident to be able to raise and escalate concerns.
- Service users we spoke with spoke highly of staff and the care that they received.
- People could access the service when they needed it and did not have to wait too long for treatment.
- Patients and families using the service were very happy with the care they had received.

Summary of findings

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Summary of this inspection

Background to Butterwick Hospice

Butterwick Hospice is operated by Butterwick Limited. The hospice opened in 1984 and is an independent hospice in Bishop Auckland, County Durham. The hospice primarily serves the communities of the Durham Dales, Easington and Sedgefield clinical commissioning group areas.

Butterwick hospice provides adult hospice services which includes; palliative day care services, physiotherapy and complementary therapies. It also provides a palliative home care team which predominantly provides an overnight service. A family support work team provides support and counselling to those bereaved or affected by a life limiting illness. The family support work team provides services to adults and children and young adults in the wider family. The complimentary therapies provision extends to patients with a life limiting diagnosis and carers.

The hospice has a registered manager in post and is registered to provide the following regulated activities; Diagnostic and screening procedures and Treatment of disease, disorder or injury.

The hospice was inspected using the hospitals framework. CQC last inspection in March 2020 rated the service requires improvement and the provider was issued with three requirement notices.

Early in the inspection process, we issued a warning notice relating to good governance. We issue warning notices when the care falls short of what is legally required, we tell the provider what was not right and explain how long they have to comply with the regulations.

How we carried out this inspection

Our inspection took place between 1 February and 2 February 2022, using our comprehensive inspection methodology. The inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We observed care and treatment and looked at ten sets of patient notes. We spoke to three patients and their families, five members of clinical and non-clinical staff. We looked at compliments and complaints received by the service and reviewed other information and data provided by the hospice to make our judgement.

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

Action the service **MUST** take is necessary to comply with its legal obligations. Action a service **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:

- The provider must assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. **Regulation 17 (2)(a)**

Summary of this inspection

- The provider must 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 the carrying on of the regulated activity. **Regulation 17(2)(b).**
- The provider must ensure staff have access to a policy and process to support the identification, assessment, management and escalation of service users' risks. **Regulation 17 (2)(b)**
- The provider must ensure that patients have their individual needs assessed and that care planning is personalised to meet their individual needs. This must include the assessment of mental capacity and cognitive impairment assessments and emotional needs. **Regulation 9(1)(a)(b)(c)**
- The provider must have enough suitably qualified, competent, skilled and experienced persons deployed to comply with the fundamental standards **Regulation 18(1)**
- The provider must ensure that staff received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform **Regulation 18 (2) (a)**

Action the service SHOULD take to improve:

We told the service that it should take action 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.

- The service should consider how it could promote its services to minority groups to ensure its services are accessible to diverse groups.
- The provider should review its audit programme to ensure it can demonstrate achievement of safe standards and how it can use this information to make improvements over time.
- The service should consider implementing an exclusion criteria or other method of being clear about which patients' they accept into the service.






Our findings

Overview of ratings

Our ratings for this location are:

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

Hospice services for adults

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

Are Hospice services for adults safe?

Inadequate 

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

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

Mandatory training

The service did not provide mandatory training in key skills to all staff and did not make sure everyone completed it.

Staff said they received a full induction when they started work at the hospice.

Training figures were 100% for safeguarding and equality and diversity training for day care and the palliative home care team (PHCT).

The mandatory training was not comprehensive and did not meet the needs of patients and staff.

Day care staff were not all up to date with essential training, only 20% of the staff had completed all modules of required training.

Staff had not completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Staff in the PHCT had not received training for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The failure to provide this training meant that the service could not be assured staff had the training required to deliver care with consent or to identify and respond to concerns related to service users' mental capacity

None of the staff had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards; Loss and Bereavement; Palliative Care; Incident Reporting; or Lone working. Our review of records found examples where staff were required to deliver palliative care, lone work, and engage with families following bereavement.

Hospice services for adults

The failure to provide training in the Mental Capacity Act and Deprivation of Liberty Safeguards meant that the service could not be assured staff had the training required to deliver care with consent or to identify and respond to concerns related to service users' mental capacity. The failure to provide training in incident reporting meant that the service could not be assured staff had the training required appropriately identify and report incidents.

Managers said they monitored mandatory training using a training matrix and alerted staff when they needed to update their training. However, the training matrix showed there were gaps in staff training, expired staff training and some completed training that was not updated on the training matrix, so it was unclear how this was being effectively monitored.

Staff in the day care service had not received training in incident reporting. This meant that the service could not be assured staff had the training required appropriately identify and report incidents.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise abuse but did not know how to report it.

The service had a safeguarding policy that was in date and ratified by the trustees. The policy was in accordance with published inter-collegiate guidance on adult safeguarding, (first edition: August 2018).

All staff and volunteers had received a Disclosure and Barring Service (DBS) check at the correct level for their role.

All staff received training at an appropriate level for their role on how to recognise abuse. Staff we spoke with told us they had received safeguarding training and the director of care who was the safeguarding lead for adults was trained to level four.

Staff gave examples of types of abuse and how they would pass concerns on to their senior at local level who would then escalate to the registered manager or chief executive. However, staff we spoke with did not know how to make a referral themselves.

During the inspection we did not see safeguarding or local authority information in public areas. However, after the inspection we were told that this is displayed in the main entrance.

Staff did not receive safeguarding supervisions. After the inspection the service identified it as a gap in their process and said that they would start these supervisions.

The service had an up to date chaperone policy, it stated that training was done as part of the MCA and DoLS training. However only 60% of day care staff had completed this.

Cleanliness, infection control and hygiene

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

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

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Hospice services for adults

Staff followed infection control principles including the use of personal protective equipment (PPE).

We observed staff adhering to being bare below the elbow, hand washing and using hand sanitiser.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Hand washing posters were displayed around the hospice.

Cleaning cupboards onsite were secure and hazardous cleaning substances were stored securely inside.

Cleaning audits sent to us after the inspection showed good compliance with audits and evidence of actions undertaken to address any issues.

Uniform and hand washing audits were completed regularly with 100% compliance found on the audits.

An infection control audit was undertaken annually by an external infection control and prevention matron, as part of a service level agreement. The next audit was due to take place in March 2022.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. However, staff were not trained to use some of the equipment that was available to them.

The layout of the service meant that it was suitable for people with accessibility needs. All facilities were ground level with wide corridors, double doors and accessible toilets.

Car parking was ample and free to patients and their guests. All visitors entered the building through a main door into the ground floor reception, there was a buzzer system in use for entry and exit.

We checked the emergency equipment in the unit. A first aid box was routinely checked by

staff. However, the equipment it contained was not suitable for the level of first aid staff were to deliver. For example, the kit included suction equipment that staff were not trained to use.

Staff had a mixed understanding of what the suction equipment was to be used for. One staff member told us they would use it for patients who had a tracheostomy, another member of staff told it is never used.

Staff carried out daily checks of specialist equipment.

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

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

PAT testing and equipment servicing was up to date for all equipment we looked at.

Fire exit signs were clearly displayed, and the fire evacuation route was free from obstruction.

Hospice services for adults

The service had an in-date fire alarm maintenance certificate and fire extinguisher inspection certificate. Servicing of fire alarms had been completed in January 2022.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. However, risk assessments did not consider patients who were deteriorating and in the last days or hours of their life.

Healthcare workers providing care to patients in their own homes worked alone. They had an electronic lone worker system linked to a central call centre which provided extra security by logging workers in and out of their visits and provided an hourly call back service if required.

The service had a policy to guide staff as to the frequency of clinical assessments and re-assessments. However, the policy was only applicable to the day care service and did not include when staff in the palliative home care team (PHCT) should reassess patients. For example, after identifying pressure damage there was no policy to advise of what action they should take to escalate this. We were told at the last inspection that a policy was being developed. However, at this inspection we found there was still no specific policy for assessing and responding to patient risk.

The service had no policy for escalation of patient deterioration. There was a handwritten document that was kept in the day care service that detailed steps for basic life support, but this was not an official policy and was not ratified by trustees.

Staff had not received training in how to escalate risk or patient deterioration and staff did not use a nationally recognised tool to identify deteriorating patients.

Risk assessments were completed, but there was no evidence of them being reviewed or of identified risks being escalated. For example, we looked at six patient's care records in the PHCT, four of these included pressure risk assessments that identified pressure damage with no evidence of escalation.

Records for four PHCT patients showed no escalation of high-risk scoring mouth care assessments that required an oral hygiene care plan to be commenced and a medical review.

The service had an up to date resuscitation policy which outlined the need for staff to undertake annual training in basic life support, however, the training matrix provided to us at inspection showed that no staff in the day care service had completed basic life support since 2020.

The service did not have a policy for how frequently patients who are dying should be reviewed or when their care might need to be escalated for medical intervention. Information provided to us after the inspection stated that care was the responsibility of district nurses, however none of the PHCT records we looked at showed any escalation of care to district nurses and records in a patient's home did not include contact information for district nurses.

The service did not have an admissions policy or criteria to guide staff around what assessments need to be completed on referral to the day care service. Following the inspection we requested this information, the provider stated that there is no admission policy as patients don't get 'admitted' to the service, however with no admissions policy it was unclear how staff knew what they needed to assess when seeing patients for the first time and thereafter.

Hospice services for adults

The service provided an up to date management and prevention of falls policy which stated that staff should undertake two yearly falls prevention training. The training matrix provided to us indicated that none of the PHCT or day care staff had completed this.

Falls risk assessments did not identify or capture high risks. For example, a patient in the PHCT who was taking an oral anticoagulant medicine did not have an associated care plan that highlighted risks or side effects such as bruising or bleeding.

Staff told us that when patients are referred to the service, they will have an initial assessment with a nurse when they first attend. The assessments included falls risk, nutritional, moving and handling. A patient version integrated palliative outcome scale (IPOS) was completed every eight weeks which allowed service users to highlight their symptoms. However, staff we spoke too said they would not always escalate high scoring symptoms they would just use it to identify that the patient had an additional need.

Our review of records found staff were providing aspects of care outside of their competencies and without appropriate training, supervision, support and guidance. This included non-registered staff completing risk assessments of service users without appropriate training.

Staffing

The service had enough nursing and support staff; however, they did not have the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The hospice employed two registered nurses, two health care assistants, four complementary therapists and two counsellors. They also had six palliative home care staff, three domestics and support from physiotherapists and a specialist nurse.

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

The number of nurses and healthcare assistants matched the planned numbers.

Managers made sure all bank staff had a full induction and understood the service.

Staff in the day care service felt there were enough staff to deliver good care. Staff told us they had plenty of time to spend with patients and develop relationships. Comments from patients reflected this.

The skill mix and competencies of staff in the home care service did not reflect the needs of people being cared for at that time. For example, patients at the end of life were not being cared for by staff that had been trained in palliative care.

Records

Records were stored securely and easily available to all staff providing care. However, records did not accurately reflect patient's needs.

Patient records were in paper format and contained initial basic patient information such as date of birth, next of kin, and allergies.

Hospice services for adults

Records in the day care service were stored securely in a trolley in an office, home care records were kept in the patient's home until the end of the care episode and then brought back to the hospice.

Allergies were recorded consistently in all records that we looked at.

Staff recorded evaluations of the care provided at the day centre and in the patient's home.

There was evidence of consent to sharing of records obtained, including for sharing with the patient's GP.

Patient records included printouts of all physiotherapy consultations, so staff had the most up to date record of patient's treatment.

An internal staff training matrix showed that staff did not undertake record keeping training as part of their mandatory or essential training.

The day care hospice overview of a patient's 'do not resuscitate' (DNACPR) status was to write on a paper record within a file whether the patient required resuscitation. There were no copies of the DNACPR and there was a risk to patients as an error in recording could incorrectly indicate a patient was not for resuscitation.

Medicines

The service did not have systems and processes to safely administer, record and store medicines. The service did not have medicine policies or medicine care plans for the day care and palliative home care service.

Staff did not follow systems and processes to administer medicines safely. We were told by the registered manager, that no staff administered medicines, however care records and discussions with staff contradicted this with evidence of staff administering eye drops and supporting the administration of controlled drugs without relevant training.

Staff did not complete medicines records, there were no medicine administration charts in use within the service, despite staff in the home care service supporting with medicine administration. For example, we seen in a patient's care records that a relative would measure out a dose of medicine and leave it for PHCT staff to give to the patient.

The service could not be assured that staff were administering medicines safely to patients in their own homes as none of the staff had received appropriate training or competency assessments.

The service did not have a standard operating procedure, guidance or policy for the safe handling or destruction of medicines.

There were mixed messages from staff in the day care setting as to whether they could administer medicines or not. One nurse told us they could not administer any medicines, and another said they can support with administering medicines such as if a patient has Parkinson's disease or if they required medicines via a PEG (percutaneous endoscopic gastrostomy) if it was required. This practice was not supported by any hospice policies.

Incidents

Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Hospice services for adults

The service had not reported any safeguarding incidents since our last inspection.

Staff in the day care service told us that they would report incidents using a cause for concern form or they would escalate to their line manager if it was a serious incident. However, as not all staff had received training in incident reporting, we could not be assured that staff knew what incidents they should report.

Staff told us they received feedback from investigation of incidents and learning was shared through team meetings or in emails.

The Duty of Candour (DoC) is a legal duty to inform and apologise to patients if there have been mistakes in their care that has led to moderate or significant harm. Staff we spoke with understood the duty of candour and when this should be applied. The service had an up to date duty of candour policy.

The service had not had a never event since our last inspection. Never events are serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Leaders of the service said it had not had any incidents since our last inspection; therefore, we could not assess how managers investigated incidents. However, we did see an example of a medicine incident that had been shared for learning via email.

Staff did not meet to discuss the feedback and look at improvements to patient care. There was no evidence that improvements were discussed in team meetings with staff.

Incidents were discussed as part of the leader's quality, safety and risk committee meeting.

The provider had a system to receive and act on any national patient safety alerts.

Are Hospice services for adults effective?

Inadequate 

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

Evidence-based care and treatment

The service did not provide care and treatment based on national guidance and evidence-based practice.

The service was part of the County Durham palliative and end of life care steering group which was in place to ensure that end of life care for the populations of County Durham was personalised and well-co-ordinated, enabling real choice for individuals. However, we found that the service did not follow national guidance that are in place to ensure quality of care for patients at the end of life.

Hospice services for adults

Patients' needs were not considered in line with national guidance such as 'Care of the dying adults in the last days of life and NICE quality standard QS144 regarding individualised care. The service did not provide guidance for how staff could assess pain or escalation procedures.

Patients in the palliative home care team (PHCT) did not have individualised care plans that reflected their personal preferences and detailed symptom control and psychological, social and spiritual needs in line with national guidance.

It was unclear if staff delivered care to patients in the last days of life that met the 'five priorities of care of the dying person'. We saw staff communicated with patients and relatives in a sensitive and supportive way. However, the patients did not have personalised care plans to ensure they were receiving individualised care. This was not in line with the National Institute of Health and Care Excellence quality standard QS13, end of life care for adults, and national guideline NG31 care of dying adults in the last days of life.

We were not assured that the provider fully considered all national and best practice guidance in relation to end of life care.

Nutrition and hydration

Staff did not identify and escalate patients at risk of dehydration.

Due to the COVID-19 pandemic day care services were not running as they previously had. This meant that patients were not provided with any nutrition or hydration due to the nature of the services they now offered. However, patients we spoke with told us that they would be provided with water or a hot drink if they asked for one.

Patients receiving care from palliative home care team (PHCT) had regular mouth assessments to monitor for dehydration, however high scoring risks were not escalated and the staff conducting the assessments had not been trained.

The PHCT did not use nationally recognised screening tools to monitor malnutrition or fluid balance charts to monitor fluid input and output, despite some of the patients being catheterised.

Staff had not been trained in specialist feeding techniques such as PEG feeding, however a staff member told us they could do this if it was needed by a patient.

Pain relief

Staff monitored patients to see if they were in pain, however; it was unclear how the need for pain relief was escalated.

The palliative home care service did not have a robust system for pain management and escalation of pain. Staff did not monitor pain using a recognised tool to be assured that patients were comfortable.

Staff were not trained administer medicines and there was no process in place for them to follow should a patient request additional pain relief.

The home care service did not have a pain management policy. The provider told us that this was not needed as they did not administer medicines, however there was no guidance for staff to follow to ensure they escalated pain concerns appropriately.

Hospice services for adults

Day care staff told us that they assess people's pain as part of their risk assessments, however they did not escalate high scoring pain outside of the service and said that the scoring was just used to identify an additional need.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment or use the findings to make improvements and achieved good outcomes for patients.

We saw in day care; staff collected some data on the integrated palliative care outcome scale (IPOS) but there was no evidence to show how the information was being used to drive improvement.

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

There was a programme of annual audits which included infection control, hand hygiene and uniform audits.

The service had implemented a measure yourself concerns and wellbeing (MYCAW) assessment tool. This allowed patients to monitor their health improvements or decline, patients would complete it at their initial assessment when joining the service and would then complete another each month.

Staff had not used the results from assessments to improve patients' outcomes or respond to individual need. For example, one patient whose pain score had increased did not have this acted upon and staff told us the score just identified that the patient had an increased need.

The service shared with us a service evaluation questionnaire that patients had completed in October 2021. The questionnaire asked for ways it could improve and how beneficial their treatment was.

The service did not have any evaluations of care for the patients in the home care service.

The service did not have clear approach to monitoring, auditing and benchmarking the quality of the services and the outcomes for people receiving care and treatment.

Competent staff

The service did not always make sure staff were competent for their roles.

Staff we spoke with said they received an induction when they started in their role. This was a combination of face to face and electron learning modules.

E-learning had been introduced for staff and volunteers to access mandatory training modules.

Registered nurses at the service told us how they kept up to date with their revalidation.

We looked at staff files and volunteer files. All contained evidence of safe recruitment practices

Hospice services for adults

including current disclosure and barring checks and evidence of nursing qualifications where appropriate.

Staff told us that they tried to have team meetings weekly, and where this was not possible important information was disseminated in an email to ensure staff are kept up to date.

The service had a resuscitation policy, however the training matrix provided to us showed that not all staff had completed the essential basic life support training.

Registered nurses and health care support workers had not all completed additional role specific training. For example, they had not undertaken training in catheter care despite patient notes indicating that they emptied catheter bags.

Following our inspection, we requested appraisal rates and clinical supervision rates for all staff, however this was not provided. We therefore could not be assured that managers supported staff to develop through yearly, constructive appraisals of their work or provided regular ongoing supervision.

Multidisciplinary working

Nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff within the service demonstrated positive working relationships. All of the staff we spoke with said they felt a part of the team.

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

The service had onsite physiotherapists and a multiple sclerosis (MS) specialist nurse, they worked closely with the nurses and health care assistants and care records reflected the care and treatment patients received from the multidisciplinary team.

Nursing staff in the day care service could describe how they were able to refer directly to the GP if they had concerns about a patient.

Staff advised patients of alternative therapies to suit their needs, for example one patient who was attending the service for physiotherapy had been advised to also try some complementary therapy to improve their health.

Staff worked with other agencies when required to care for patients. For example, referrals into the service came from district nurses and other care agencies were involved in the care of patients in the palliative home care service.

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

Seven-day services

Key services were available seven days a week to support timely patient care.

Home-care services were available seven days a week to support timely patient care. The day care service operated three days a week.

Hospice services for adults

Health promotion

There was limited support and advice on leading healthier lives was available to patients and their families.

Staff assessed each patient's health when admitted into the service and provided, however they did not routinely assess individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not know how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

The service had an up to date Mental Capacity Act and Deprivation of Liberty Safeguards policy.

Staff knew how to access the policy and get advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Staff asked for and documented consent for photos and information sharing and clearly recorded consent in the patients' records.

Staff in the day care service had documented advanced decisions including do not attempt cardio-pulmonary resuscitation DNACPR and it was recorded in patient records. However, copies of DNACPR records were not held in patient files as the patients were required to carry them to the day care service. There was no clear record in the patient file if the decision had been made appropriately and in line with national guidance.

After the inspection, we requested DNACPR audits. We were told that they are not relevant as they are not an inpatient service, however day care records clearly recorded and documented that patients had a DNACPR in place but there was no oversight of monitoring or auditing these.

None of the six staff for home care had completed mandatory training in deprivation of liberty. This meant we could not be assured staff had the necessary training or understanding to appropriately apply deprivation of liberty safeguards.

Staff did not understand how and when to assess whether a patient had the capacity to make decisions about their care. They told us that all patients accessing the service had full mental capacity so this would not need to be done.

A patient in the home care service who had dementia had no care plan in place to help staff know how to care for their specific needs. Staff had not received training in mental capacity and DoLS so we could not be assured that staff were supporting patients who may lack capacity to make decisions about their care in line with legislation and guidance.

Staff in the day care service did not show a good understanding of the needs of patients who may lack capacity, for example one staff member told us that if they were to accept patients that lacked capacity, the doors locked so they would be able to keep them safe. We were also told that capacity assessments are not completed routinely, but they could do them if a patient was 'off the rails'.

We looked at ten patient care records, the records detailed personal information such as medical history and spiritual preferences, however they did not include person centred care plans that reflected patient preferences and needs. For example, one patient with dementia had no details of their specific needs and another patient who was noted to shout out when agitated had no details for how to de-escalate their agitation.

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 and respected their privacy and dignity.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a respectful and considerate way.

We observed that staff all had good communication skills and had a caring approach when interacting and engaging with patients.

All patients that we spoke with said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Staff showed us thank you letters and cards from service users and their families that demonstrated they had a particularly caring approach. Comments included that staff were dedicated, caring and empathetic.

We saw that staff had good rapport with patients and their relationships were well developed. Patients were trusting of staff and able to disclose their concerns.

The hospice took part in the Friends and Family Test monthly, results for the day care service showed a response rate of 16% in December 2021 and 100% in January 2022. The home care service had a 100% return rate for their survey in November 2021. All comments returned were positive.

Staff understood and respected the personal, cultural, social and religious needs of patients.

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

The service had a privacy and dignity policy that stated all staff would receive in training, however this training was not part of the essential or mandatory training, so we were not assured that staff had completed this.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help and advice when they needed it. Staff were positive and attentive to the needs of patients at the hospice.

The hospice no longer offered use of the chapel to service users, this was now used as a storage facility. However, the service provides a quiet room which could be used as a multifaith room as required.

Hospice services for adults

The hospice has a family support service, which offers support to families facing bereavement or who have been bereaved.

Staff had a good rapport with patients and patients told us that they had come to know staff well and always felt well supported and listened too.

Patients told us that they missed the social aspect of the day care service, which had been suspended due to the COVID-19 pandemic, it was clear that it was a well-received.

Staff felt supported by their colleagues and managers and they all offered each other emotional support.

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

The hospice offered complementary therapy to patients which included aromatherapy, acupuncture and reflexology.

Staff did not complete training on bereavement and loss or breaking bad news.

Understanding and involvement of patients and those close to them

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

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

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

We observed patient care in their own home. The patient's relative was present and told us how they felt involved in their loved one's care and praised the home care staff for their support.

We spoke to two of the day care service users. One said that they felt they had good moral support from staff and that coming to the day care service helped with their wellbeing as well as physical health. Another patient said that interactions are always positive, and they felt well supported and listened to by all staff.

We did not see evidence in care plans of considerations taken when a person was in the last days and hours of life, there were no details of patient or relatives being involved in decisions about treatment or care preferences in the final days.

It was unclear how staff ensured that sensitive communication takes place between themselves, the patient and those identified as important to them as staff had not undertaken appropriate loss and bereavement training or learning in breaking bad news.

Hospice services for adults

Are Hospice services for adults responsive?

Requires Improvement 

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met some of the needs of local people and some of the communities served.

Managers planned and organised services, so they met the needs of some of the local population. The hospice had identified that there was a high prevalence of neurological conditions and in particular; Multiple Sclerosis (MS) in the local population. As a result, the team worked with the NHS MS nurse specialist to provide a more tailored service for these patients.

Facilities and premises were appropriate for the services being delivered.

Staff we spoke with said they had never accessed translation or interpretation services but said they would be able to if needed.

Due to the pandemic, patients had to attend the day service alone and communal areas were not in use. However, after the inspection we were told that quiet rooms are available if required.

The day service had no acceptance criteria and staff told us that admittance to the service was at the manager's discretion, however staff we spoke with said they did not accept patients who lacked capacity. One staff member said that they could accept them as 'the doors lock' so they can be kept in, but they hadn't had any form of dementia training.

Staff we spoke with said they would not accept people into the service if they had challenging behaviours. However, the hospice did not have an exclusion policy, stating that every case was judged individually. This was a risk to patients because there was no clarity around which patients it would not be best placed to support.

The service had no accessible multi faith room or chapel due to the pandemic. However, following the inspection the provider told us that quiet rooms could be used if required.

The service did not have systems in place to help care for patients in need of additional support or specialist intervention.

Meeting people's individual needs

The service did not always take account of patients' individual needs and preferences.

The service offered complementary therapies to patients in the day care service, this included reflexology and aromatherapy. These services were very well received by the patients that we spoke with.

Hospice services for adults

Care plans were in place for patients in the day care and palliative home care services. These were not person centred and did not include discussions about what was important to the patient or their more specific care needs.

Staff did not support patients living with dementia and learning disabilities by using 'This is me' documents.

Staff said that they would be able to access interpreters or signers if they needed to help with communication. However, there were no signs in patient or public areas to let people know that this was available.

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

Staff and managers did not believe there were barriers to who could access the service, however there seemed to be a focus on patients who had multiple sclerosis (MS) due to its high prevalence in the area. Staff also told us that they would not accept patients into the service that had dementia. Therefore, we were not assured the service had equal access opportunities to all groups

The service did not have information leaflets available in alternative languages. There was no written material, nor any posters or signs on display to let families or service users know that this was available.

The service had a chapel; however, this was not accessible to patients due to the COVID-19 pandemic.

Care plans were not person centred and did not include patient preferences. For example, one care plan we looked at stated that a patient would shout when they were confused, but the care plan had no information for how this could be deescalated to prevent the patient from becoming agitated

Access and flow

People could access most of the services when they needed it and received the right care in a timely way. Patients could access the specialist palliative care service when they needed it.

Referral to the hospice services could be made by a healthcare professional, however there was no referral criteria in place for the day care or palliative home care service.

For the home-care service patients had to be receiving care from a community nursing team and the community nursing service needed to be aware of the referral.

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

Referrals to the home care service were submitted by health professionals. People were not able

to self-refer. These were then assessed and prioritised by the care co-ordinator based on urgency. At the time of the inspection the home care service had eight service users and none on the waiting list.

Patients that we spoke with said that they had no delays accessing the day care services as numbers of patients attending were lower due to the COVID-19 pandemic.

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Hospice services for adults

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients we spoke with said they would feel confident to raise a complaint with staff if they needed too.

Staff told us they would escalate patient complaints to their managers.

The service displayed information about how to raise a concern in patient areas and it had an up to date complaints policy.

Following the inspection, we were advised that the service had not received any recent complaints.

We could not be assured that managers shared feedback from complaints with staff and learning was used to improve the service as we were not provided with evidence of this, despite requesting them.

Are Hospice services for adults well-led?

Inadequate 

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

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

Leadership

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

The hospice was overseen by a board of trustees and led by a chair. The senior leadership team was made up of the chief executive and director of care. The director of care was also the registered manager and was responsible for this site and two other Butterwick sites. The individual services were led by a homecare coordinator, a clinical sister and the family support lead practitioner.

Local managers were visible to staff and patients and staff described their leaders and line managers as supportive, caring and approachable.

Hospice services for adults

Senior managers told us they visited the service approximately once every two weeks. This reduced the opportunities for senior leaders to be visible in the service. Staff we spoke with told us they were happy with their local leaders and that they felt they were approachable. However, some staff we spoke with said that they had only met the director of patient care briefly which did not indicate senior leaders were visible in the service to all grades of staff.

Senior managers within the service demonstrated knowledge of the demographics of the area, and some of the needs of the local population. There was collaboration with external agencies such as other local hospices and County Durham clinical commissioning group.

Local and senior managers were passionate about their roles and were proud to work at the hospice. However, there was a lack of clarity for leaders around what the service could offer to patients. The service did not have a standard operating procedure or operational policy and we saw differences in practices between staff, for example some staff thought that they could support with suction and medicine administration and other staff did not.

We looked at board minutes for the last two meetings, the services at Bishop Auckland were not discussed. This indicated there was a lack of oversight of the priorities and issues the service faced.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. However, the vision and strategy were focused on sustainability of services but not aligned to local plans within the wider health economy.

The organisation had a strategic plan which was in place from 2019 to 2024. There was no indication that the written strategy had been reviewed or amended, despite the provider being placed in special measures following the inspection in December 2019. As this had not been reviewed, we were not assured that the targets outlined within the strategic plans were realistic or attainable by the provider.

The strategic plan did not reflect how national progress towards a model of integrated health and social care had developed locally. It did not include any details that referenced how this applied to the local community. There was an absence of detail in how the wider community or key stakeholders, such as clinical commissioning groups, had been engaged in the development of the strategy.

Leaders that we spoke with at local and senior level did not know what the organisation's vision and values were. One senior leader told us that the vision and strategy needed to be revisited due to the changes to the organisation over the last few years. We were therefore not assured that leaders had oversight of their strategic plan.

We looked at meeting minutes from two recent board meetings and the quality, safety and risk committee (QSRC) meeting minutes and the ongoing discussion of the strategy objectives were not discussed.

Culture

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

Staff we spoke with felt respected, supported, and valued by their leaders. Staff reported a no bullying culture and felt they could raise any issues they had. The organisation had a whistleblowing policy which was available to all staff and information on how to raise concerns was available within this document.

Hospice services for adults

Staff described an open culture and told us they would have no fear about raising concerns. Staff had

said they would be able to approach leaders if they had anything they wanted to discuss. There was a clear sense of teamwork across day hospice staff and everyone spoke very highly of their colleagues.

When speaking with staff it was clear that their priority was focussing on the needs of the patients they cared for. Staff were passionate about making the services the provider supplied work well.

The organisation had a duty of candour policy and staff we spoke with knew what duty of candour was. However, staff did not receive specific training around duty of candour despite this being listed as essential learning on their training matrix.

We asked the provider for staff survey results and actions taken as a result, however we were not provided with these despite an internal update document from November stating that results would be available in December 2021.

The provider's strategic plan made no reference to the physical and emotional wellbeing of staff, and

there was no data being currently collected. We were not assured the trustees, or the leadership team had data on or about the culture within the service.

Governance

Leaders did not operate effective governance processes throughout the service. Staff at all levels were not always clear about their roles and accountabilities and did not always have regular opportunities to meet, discuss and learn from the performance of the service.

There were gaps in policies that the organisation should have in place for the effective running of services, for example there was no operational policy, no referral criteria and the current policy for escalation of treatment was a handwritten document kept at local level and was not ratified by leaders.

The organisation did not have effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. They did not have a clearly defined purpose of the Hospice at Home service and staff were not trained to deliver care in line with this purpose.

Staff were not provided with appropriate policies and guidance to support them to deliver care in line with the service's purpose. There was no appropriate oversight of the service provided at Bishop Auckland to ensure staff were delivering care in line with the service's purpose.

Managers and staff could not explain the remit and purpose of the service at Bishop Auckland. The service does not have an admissions policy, operational policy, service specification, standard operating procedure or similar document which would identify the remit of the service and identify whether the service was able to meet service users' needs. Their current policy for escalation of treatment was a handwritten document kept at local level and was not ratified by leaders. Different staff held differing opinions on how the service could meet differing levels of service users' needs which risked the service admitting service users whose needs could not be met safely.

Our review of records found staff were providing aspects of care outside of their competencies and without appropriate training, supervision, support and guidance. This included non-registered staff completing risk assessments of service users without appropriate training.

Hospice services for adults

The service did not have a policy or procedure for staff to follow in situations where service users' risks had changed, or where a service user had deteriorated or become seriously unwell. Staff were supporting patients with administration of medicines, including eye drops and controlled drugs without any training or competency assessments. There was no guidance or policy for staff to follow when administering medicines.

We looked at clinical review meeting minutes for the last six months, local leaders from Bishop Auckland had not attended any of the meetings despite topics for discussion relating to the services that they lead. It was therefore unclear how issues and concerns were cascaded to senior leaders and how they maintained oversight of these.

Management of risk, issues and performance

Leaders and teams did not have robust systems to manage all risks and performance effectively. They identified some risks and issues but did not evidence actions to reduce their impact.

The organisation had plans in place to ensure continuity of care in an emergency. The aim of the plan was to protect critical services and ensure the organisation continues where practicable in unforeseen circumstances.

The organisation had a risk register in place at the time of inspection. The risk register was discussed as part of the QSRC meeting which reported to the board of trustees. We requested copies of the meeting minutes for the QSRC and we were provided with a copy of the December 2021 meeting. The meetings were to take place on a bi-monthly schedule. We found that whilst the QSRC meeting had taken place, there were no details of the discussions around the risk register.

There was a lack of oversight of risks at local level, leaders told us that the service had no risks on the risk register. Board meeting minutes were around performance and compliance with the Health & Social Care Regulations 2014 to the satisfaction of the CQC, COVID-19 and its impact on patients and staff/volunteers, finances and the ability to recruit qualified and motivated staff. We could not be assured that risks were reviewed, escalated and monitored effectively.

The organisation did not have effective systems to assess, monitor and improve the quality and safety of the services provided. Governance systems did not identify or monitor the quality of care provided. The organisation did not audit patient records appropriately to identify, for example, where staff had failed to respond to changes in service users' risks or where staff were delivering care outside of their training and competencies or whether care plans were appropriate and person centred. Managers told us monthly performance reports focused on numbers of referrals but did not present information or escalate risks related to the quality or safety of the service provided.

Meeting minutes we looked at showed that policies were an ongoing agenda item, they talked about how policies were being sent to staff electronically with the expectation that they read it, sign it and send it back.

The organisation had an up to date safeguarding policy with the director of care trained to level four and acting as safeguarding adults lead.

Engagement

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

Hospice services for adults

The organisation had created positive links with other local hospices and was a part of the County Durham End of Life Commissioning Group. The purpose of the group was to support the local system and to ensure that end of life care for the populations of County Durham is personalised and well-co-ordinated, enabling choice for individuals. The work was set to involve pragmatic implementation of regional and national advice, guidance and programmes of work to support local implementation and facilitation of the transformation process to enable the development of services.

The hospice had a good presence in the local community with a number of local charity shops and two additional hospice sites based in Stockton.

Information was cascaded to staff electronically on a monthly basis and included information around items such as CQC update, policy implementation and expectation of staff, COVID-19 and reminders to complete the staff survey. However, we were not provided with any results of staff surveys so could not review the feedback from staff and we did not see evidence of how feedback was acted upon.

We saw that the service conducted patient surveys. Overall, the patient surveys shared with us were positive and complementary of the service people received.

Staff told us that they should hold meetings weekly, but these were often cancelled due to unforeseen pressures. Staff told us they did not meet with staff from other sites and they had only met senior leaders briefly.

Learning, continuous improvement and innovation

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

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

Staff we spoke with told us that they were passionate about improving the service. However, there was limited innovation and service development. Senior leaders told us of plans to get funding to implement namaste care. The project would embed the principles of namaste care into the delivery of day care services. Namaste care honours those patients who can no longer care for themselves without assistance; it is not a medical treatment but a programme designed to improve their quality of life by using techniques that bring pleasure and comfort to people who have been diagnosed with a life limiting illness.

The service had developed links and working relationships with other hospice providers in the area with the aim of sharing good practice.