Barnsley Hospice Appeal

Barnsley Hospice

Inspection report

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Date of inspection visit: 11/01/2022
Date of publication: 01/06/2022

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?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

We carried out a comprehensive inspection of this service as part of a follow up, as the service had previously been inspected between 28 April 2021 and the 4th May 2021, rated inadequate and placed into special measures. Services placed in special measures are inspected again within six months.

At this inspection we found significant safety concerns and we imposed urgent conditions using our section 31 powers on the provider's registration to drive improvement and ensure patients were safe. These conditions were specifically in relation to the clinical assessment review and risk identification of patients, admission assessment processes and COVID-19 management processes and policies. The application of conditions required the provider to urgently complete a full review of all patient records to ensure appropriate documentation and risk management process were in place. We issue conditions where the care a 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.

We found the provider had made some improvements but there remained significant concerns and the provider remains in special measures. In addition, we told the provider that it must take prompt action to comply with the regulations.

Our rating of this location stayed the same. We rated it as inadequate because:

- Staff did not have training in key skills and did not manage safety well. This is a re-occurring breach from the last inspection.
- The service did not always control infection risk well. Staff assessed risks to patients but did not act on them. Staff did not always keep good care records. Records were not clear or complete. This is a re-occurring breach from the last inspection.
- The service did not always manage safety incidents well and did not learn lessons from them. This is a re-occurring breach from the last inspection.
- Managers did not monitor the effectiveness of the service well and did not make sure staff were competent for their roles by producing guidance and support through policy development.
- The provider did not ensure staff understood their responsibilities when obtaining appropriate consent.
- The service undertook limited planning to meet the needs of local people and did not take account of patients' individual needs through personalised care planning.
- Governance processes were not in always in place or embedded to ensure risk was identified and managed. The provider did not always collate performance data to ensure the quality of the service was measured and improved.

However:

- The service had enough staff to keep patients safe and medicines were managed well. The provider had taken steps to improve medication reconciliation processes.
- Patient feedback was generally positive.
- Staff felt valued and praised the leadership of the service following the departure of several senior staff, this had improved from the last inspection.
- Leaders of the service demonstrated a genuine willingness to learn and improve and build sustainable quality service for the future.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Inadequate 	We rated this service inadequate, as although it had made some improvement, it was insufficient to affect the overall rating. Please see the summary section above for further information. We imposed conditions using our section 31 powers on the providers registration to drive improvement and in addition told the provider it must take prompt action to comply with the regulations.

Summary of findings

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Summary of this inspection

Background to Barnsley Hospice

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

The hospice is registered as a charitable trust and 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 April 2021. The hospice was rated as inadequate and placed into special measures.

How we carried out this inspection

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

Our inspection took place between 11 January 2022 and 14 January 2022, using our comprehensive inspection methodology. The inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We observed care and treatment, looked at five sets of medicines administration records, five sets of patient notes, staff and volunteer files. We spoke with nine members of clinical and non-clinical staff. We looked at compliments received by the service as well as patient feedback surveys. The provider had not received any complaints since our last inspection.

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

Areas for improvement

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with three legal requirements.

This action related to one service.

- The service must ensure staff always follow national guidance when patients lack capacity to give consent. Staff must always use measures that limited patients' liberty appropriately. Regulation 11(1)
- The service must provide care and treatment in a safe way, assess risks to all patients and do everything practicable to remove or reduce risks. Regulation 12(1)(2)(a)(b).
- The provider must have robust procedures in place for escalation in the event of an emergency and ensure staff are provided with the tools to assess and respond to patients who may require urgent treatment. So that in an emergency, patients are not exposed to unnecessary risk. Regulation 12(1)(2)
- The provider must have a system in place to ensure equipment is serviced and electrical safety is monitored and recorded. Regulation 12(2)

Summary of this inspection

- 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) **Re-occurring breach**
- The hospice must ensure that patient isolation policies are clear, appropriate, in line with current COVID-19 guidance, adhered to and understood by all staff. Regulation 12(2)(h)
- The service must ensure that patient records are completed consistently and appropriately. (Regulation 12).
- 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) **Re-occurring breach**
- The service must ensure they have effective policies which are fit for purpose and which are regularly reviewed in line with national guidance. Regulation 17(2)(a).
- The service must monitor the effectiveness of care and treatment and use their audit findings to assess, monitor and improve the quality and safety of the service. Regulation 17(a)(f).
- The service must ensure robust governance processes are in place to lead, manage, risk assess and sustain effective services. 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) **Re-occurring breach**

Action the service SHOULD take to improve:

- The service should ensure they identify, meet, and support the information and community needs for patients with a learning disability or dementia impairment and make reasonable adjustments
- The service should consider improving the environment on the inpatient unit
- The service should consider access to a member of staff whom has completed level 4 safeguarding for both adults and children to gain advice and support
- The service should ensure their diversity policy includes all protected characteristics
- 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 patients 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	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate

Inadequate

Hospice services for adults

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

Are Hospice services for adults safe?

Inadequate

Mandatory training

The service provided mandatory training in key skills; however, this was not comprehensive and not all staff completed it.

Staff received and kept up to date with their mandatory training, although mandatory training was not comprehensive to meet the needs of patients and staff.

At the last inspection we saw the provider did not ensure that staff kept up to date with their mandatory training and we issued the provider with a warning notice and told the provider it must take action to improve this. At this inspection we saw the provider had taken some steps to improve the internal mandatory training compliance and support staff to complete the required elements.

Managers monitored mandatory training and staff compliance was monitored through an electronic platform. We reviewed the providers training spreadsheets and saw that 100% of nursing staff had completed mandatory training, however 33% of registered nurse bank staff had not completed it. This equated to two staff.

Medical staff mandatory training compliance was 86%. This percentage equated to one member of staff whom had not completed it. In addition, we saw one of the bank medical staff had also not completed their mandatory training. The provider told us that these staff were advised not to work within the hospice into the training had been completed.

Clinical staff had not received training in relation to care of the deteriorating patient, despite five of the six patients reviewed at the time of inspection, identified as unstable and deteriorating. This had the potential to affect the safe care and treatment of patients currently admitted at the hospice. We raised this as a significant safety concern at the time of inspection and this was included in the urgent enforcement action to impose conditions on the provider.

All staff we spoke with told us that managers supported them with mandatory training needs and felt positive changes were taken to recognise staff training needs.

Safeguarding

Inadequate

Hospice services for adults

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff received training on how to recognise and report abuse and knew how to apply it in practise.

At the last previous inspection, we saw staff did not fully understand how to protect patients from abuse and not all staff had received the mandatory safeguarding training. At this inspection we saw that safeguarding training compliance had much improved and 100% of clinical staff, including all registered nurses and medical staff had received safeguarding adults training level two.

Staff did not always receive training specific for their role on how to recognise and report abuse.

At the last inspection the provider was told it must ensure staff have the correct level of safeguarding training and must have the necessary training in order to safely carry out their roles. However, at this inspection we saw not all staff were up to date with their training. For example, the Chief Nurse did not have the recognised accredited safeguarding training level, in line with the intercollegiate guidance (2019). They had undertaken executive safeguarding training; however, we saw a trustee's adults' level one safeguard training was shown to be expired on the providers training spreadsheet. The provider states within their safeguarding policy that level one safeguarding training should be refreshed every three years. The provider acknowledged this quickly and took steps to update this training.

The provider employed a social worker who promoted safeguarding understanding and supported staff when making and reviewing safeguarding referrals.

We saw the social worked held level three adults safeguarding and was the nominated safeguarding lead for the service. This individual supported staff with their safeguarding understanding and took a lead on safeguarding referrals.

However, all of the staff we spoke with were able to define safeguarding protocols and understood whom to contact with safeguarding alerts. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff provided examples of safeguarding alerts that were in place at the time of inspection and were able to explain how these safeguards were managed and investigated. We saw staff worked closely with external health care professionals to share safeguarding concerns including district nursing colleagues and social care organisations.

The provider also actively participated safeguarding awareness week and held specific master class sessions to ensure staff fully understood safeguarding principles and requirements.

We reviewed the providers safeguard policy and supporting guidance and saw that all volunteers were also to receive safeguard training. At the time of inspection there were no volunteers working at the hospice, but the provider confirmed that safeguard level two training for both adults and children would be completed before volunteers commenced their role.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use control measures to protect patients, themselves or others from infection. However, equipment was visibly clean or stored correctly.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. The inpatient unit was bright and visibly clean. Patients each had separate rooms, with en-suite bathrooms. Hand wash and hand sanitisers were available throughout the ward and the hospice audited hand hygiene regularly.

We saw completed cleaning records, including deep clean dates on the individual patient room doors, which demonstrated that all areas were cleaned regularly. The additional cleaning arrangements had been introduced as a result of COVID-19 and we saw rooms actively cleaned in accordance with these enhanced protocols during our inspection visit.

At the last inspection we saw the service did not always control infection risk well. At this inspection we saw staff did not always follow infection control principles. The provider told us that COVID-19 status was not a barrier for admission and all patients who were awaiting a PCR test were isolated. In addition, staff told us that the door of the patient's room was marked with a red spot, so staff could easily identify which patients were isolating. However, we saw these processes were not followed as we observed a bedroom door propped open for a newly admitted patient whom was at potential risk of falls. This risk could have been mitigated if risk had been fully assessed prior to admission. The COVID-19 status at the time was unknown and we saw the door had been marked to show this.

At the last inspection we told the provider it must ensure that visiting policies were clear, appropriate, in line with current COVID-19 guidance, adhered to and understood by staff.

We reviewed the providers guidance in relation to management of COVID-19 and saw the provider had produced a 'Patients, relatives immediate infection prevention and control checklist'. The checklist stated that doors should be closed where possible when managing possible cases of COVID-19. This checklist contradicted the providers own infection prevention and control policy which states that the isolation of patients with or suspected of COVID-19 was mandatory.

We saw on the first day of inspection that screening processes for COVID-19 were in place and all visitors were asked to show lateral flow tests before entering. On the second day, inspectors entered the building without any of these screening checks. We observed a staff member also entering in the same way.

This was a risk to patients because there was the potential of contracting COVID-19.

We saw the provider conducted hand hygiene audits. We reviewed the results if the last audit completed for the period of October – December 2021 and saw that 80% of staff were compliant. The audit was due to be reviewed again in three months. We saw the provider clearly identified areas to action, however, we saw no evidence that the provider had followed this up.

Environment and equipment

The design, maintenance and use of facilities, premises mainly kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, some equipment used as part of resuscitation was not adequately serviced.

Patients were offered individual private rooms which were airy and spacious but did not always offer adequate natural light. Staff were mindful of this and additional electrical lighting was added to create a more welcoming environment. All rooms opened out into a patio garden.

We observed a lack of patient information generally throughout the area and this was a stark contrast to the colourful and bright main entrance to the building. The provider told us much of the paper printed information was removed due to infection prevention control issues during the pandemic.

Staff carried out daily safety checks of specialist equipment. Syringe pumps were serviced and tested, and staff knew how to report any concerns with specialist equipment. We reviewed the resuscitation trolley and saw that regular checks of the equipment were in place. However, we saw that the suction machine service schedule was out of date. We saw this was last reviewed in October 2021. We brought this to the immediate attention of the provider who provided assurance that this would be completed. All items checked including emergency medication, sharps, blood glucose monitoring equipment, and clinical supplies, were in date.

Staff told us that care of the deceased was managed in the individual patients' rooms and there was no requirement for a cold storage area. We asked staff if they used a cooling blanket to maintain appropriate temperatures in the warmer months, but we were told that there were often no need as funeral directors were able to care for the deceased quickly.

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 did not always complete and update risk assessments for each patient. Risk assessments did not consider patients who were deteriorating or were in the last days or hours of their life.

Staff used a nationally recognised tool to identify deteriorating patients however they did not always escalate them appropriately. We saw at the time of inspection that five of the six patients whom were admitted were noted to be unstable and deteriorating according to calculations using a recognised tool. However, the provider did not have a deteriorating patient policy or procedure to guide staff. Medical staff told us an escalation tool was in use and we reviewed records for the five patients deemed to be deteriorating. We saw that only a basic record was completed showing an escalation score, which was open to interpretation. There were no clinical detailed guidance and no personalised recommendations for clinical care situations where patients were not able to make decisions or express their wishes.

One of the six patients did not have an escalation form in place at all and their escalation status had been handwritten on another document. There was therefore a risk, that staff were not supported with appropriate guidance to support them to safely care for their patients.

As a result, it was not clear to staff what specific action they should take in the event of a patient's sudden deterioration. We brought this to the immediate attention of the provider and took enforcement action to ensure the provider took action to mitigate the risks to patients. Following inspection, we saw the provider had taken steps to develop guidance for staff to ensure patients were assessed routinely incorporating risk assessment and review.

We reviewed training for clinical staff in relation to escalation and managing care of the deteriorating patient. We saw staff had not received any accredited or formal training on the deteriorating patient. Medical staff told us they provided guidance to staff informally as a chat, or as part of daily meetings. However, there was no documentation of these discussions, nor of who had attended, therefore the provider was unable to provide evidence of training.

The service had introduced a 'safety huddle' each day, which included nursing, medical and allied health care professionals. However, these huddles were not recorded.

We reviewed the records of the same patients whom were recorded as unstable and deteriorating. Staff told us that they provided regular support and observation to all patients however, we saw evidence that while some patients appeared to have been attended to undertake support and care such repositioning, others had not, especially at night. For example, one patient records showed that the patient was visited at 3.05am when continence and mouthcare needs were checked and met. This patient was not seen again until 5:30am, when it was noted to be not breathing. Staff contradicted each other when asked in interview if they had, or had not, been checked upon in the interim. We brought this to the immediate attention of the provider and took enforcement action to ensure patients receiving care and treatment, were no longer at risk of harm.

In another record we saw that the patient stated upon admission that their skin was dry, indicating skin integrity could be at risk. We saw within nursing records that the patient was to be placed on a specific tissue viability mattress, however body maps were not completed, and skin condition was not formally assessed at any point during their stay. Pressure relieving mattresses were in place, but the provider acknowledged that not all staff had received formal training to ensure these were the most appropriate types of mattress.

We saw bruising noted upon admission was not investigated or documented using a body map. We spoke with staff to ask why this would not be considered and staff told us assumptions were made as to the source.

We reviewed a newly admitted confused patient and saw that they were at high risk of falls. Neither factors were present on their admission form, and the patient had to be moved overnight to reduce their risk of falls.

We saw risk was not considered formally, as part of the admission assessment process. One question was included on the form, which asked staff to consider whether a patient smoked or not, but no clinical risks were documented.

We asked staff what the ceiling of care was when admitting patients. For example, which patients would not be suitable for admission. Staff told us they would not exclude specific patients and could not recall and occasion when they refused to admit anyone into the hospice. This was unsafe, as staff were potentially admitting patients whose conditions could not safely be managed. The absence of clear risk identification including risk mitigation, meant there was a high risk of potential patient harm. We reviewed the providers admission policy which corroborated this. We brought this to the immediate attention of the provider and took enforcement action to ensure patients being considered for admission, were no longer at risk of harm.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. We saw the number of nurses and healthcare assistants matched the planned numbers which 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.

At the last inspection we told the provider it should consider implementing a staffing model. The provider told us they were working closely with Hospice UK to look at an agreed national tool that could be implemented in the future. Currently staff used the Australia-Modified Karnofsky performance scale (AKPS) which was an assessment tool used to predict the levels of care terminally ill patients will require. We saw staff reviewed them daily in accordance with the staffing numbers to ensure they were appropriate.

We saw the ward sister was not included in the staffing numbers which meant they could assist when were required.

Staffing numbers were generally static and were sufficient to meet the patients' needs according to the current admission numbers.

The Chief Nurse and Associate Chief Nurse completed a review of staffing levels in November 2021 which resulted in a 22% uplift being applied to staffing numbers.

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 on duty matched the planned number for the number and acuity of patients. 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. Patients were reviewed daily including weekends and although there were no doctors onsite after 5pm on weekdays, a medical on call rota meant nursing staff could access specialist advice seven days a week.

The provider also offered GP trainee placements.

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.

The provider did not utilise one overarching system in which to record patient 's care. Staff stored records using electronic and paper-based systems and told us that the lack of one centralised system was not ideal as record keeping was dis-jointed. Medical staff told us they maintained their own records and were not aware of the content of the nursing documents.

Patient notes were not always comprehensive or up to date. We reviewed the records of five patients and saw documentation was not completed fully and in some areas, it was found not to have been completed at all.

We saw the referral forms used to gather the initial patient information to assist with clinical admission decision making. All forms we reviewed showed sections which were incomplete or in some cases not shown on the electronic system. We asked staff how missing information would be gathered and were told it would be covered as part of the multi-disciplinary discussions. We reviewed the electronic systems in which the multidisciplinary team (MDT) was recorded and saw the information gaps were not discussed.

We reviewed the electronic medical assessment records and admission checklists and saw that they were inconsistently completed in all five records we reviewed. This presented a risk to patients as key information that would be used to determine whether a patient could be safely admitted was not documented which may result in harm or potential harm. We brought this to the immediate attention of the provider and took enforcement action to ensure patients being considered for admission, were no longer at risk of harm.

We reviewed care plans relating to specific care needs for all five patients and saw that they were not systematically reviewed. We requested a copy of the providers policy in relation to the clinical assessment of patients and review of clinical needs, but the provider told us they did not have a policy. Staff told us they completed nursing records regularly but there was no formal process in which to ensure care planning was documented, reviewed and summarised. We brought this to the immediate attention of the provider and took enforcement action to ensure risks to patients were quickly identified and reviewed to ensure patients were no longer at risk or potential risk of harm.

None of the records we reviewed were personalised. We reviewed the records for one patient whom had been deemed as being at the end of their life. The documents and care plans used were generic and had not been amended or updated for this patient. This included the last days and hours of life.

The provider had not carried out any recent audits in relation to documentation completion and records. The last audit showed gaps in record keeping, for example, only 54% of patient chart entries, 47% of repositioning and 67% of skin assessments were signed.

However, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) reviewed within the records were up to date, fully completed and stored securely. Patient records were stored in the office in the inpatient unit, accessible only to staff.

Medicines

The service had systems and processes in place to safely administer and record medicines use and respond appropriately to patients' symptoms.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The service had a dedicated pharmacist who worked at the hospice. Medicines were supplied from the local community pharmacy and direct from suppliers. The pharmacist was actively engaged in medicines optimisation and provided leadership and advice and a pharmacy technician ensured stock medicines were available and suitable for use. The pharmacist also attended MDT meetings and worked with the senior leadership team to ensure the safe use of medicines within the service.

Following a recommendation from the previous inspection the service had obtained an emergency medicine (flumazenil), which is used to reverse the effects of a group of drugs called benzodiazepines.

The service had a system to record when a medicine patch was used, however it was not always clear whether staff had left enough time between using the same area of skin again in accordance with the manufacturer's instructions.

We observed a 'safety huddle' and found information about patients' symptoms, medicine choices and non-pharmacological measures were discussed between all members of staff.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Prescribing was clear, safe and appropriate to be able to respond to symptoms that patients may experience during

their stay. If medicines were not administered, reasons were clearly recorded on the paper prescription chart. Staff reviewed patient's medicines regularly and there was evidence of medicines being appropriately titrated to respond to patients' increasing symptoms. At discharge the patients were provided with a list of their medicines and how to take them.

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

Incidents

The service did not always manage patient safety incidents well. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. However, staff were able to recognise and report incidents and near misses. When things went wrong, staff apologised or gave patients honest information and suitable support.

At the last inspection the provider was told they must take action to ensure that incidents are properly reported, investigated and that learning is embedded to prevent similar incidents from occurring in the future. We saw the provider had introduced a new electronic database system for logging and monitoring incidents. Staff had received some training for this system, but managers told us there was still more work to do with staff as the system was still new.

At this inspection we saw that staff knew what incidents to report and were able to articulate how they should be reported. However, incidents were not always investigated thoroughly and were found to contain conflicting information.

We reviewed three separate incidents and how they were investigated. We saw inconsistencies in all three investigations and gaps in information we reviewed. We were not assured that the incidents were investigated correctly as summaries and recommendations were not consistent with the findings in the Root Cause Analysis (RCA) reports. For example, a tissue relieving mattress was not provided to one patient until after 20 days when the concern was first noted. The manager completing the RCA summary of the same incident documented that pressure relieving equipment was provided as appropriate. We also saw skin checks were not completed in accordance with the skin bundles. Skin bundles are an evidence-based checklist to assist staff in implementing pressure ulcer prevention strategies. In one file we saw this was commenced 6 days after the skin deterioration was noted.

We also saw the lessons learnt section of the document does not provide clarification for staff, stating 'Key safer practice issues identified during investigation, but which did not materially contribute to the incident'. One of the actions required showed that patient checks must not be missed but the incident investigation action plan does not include a review of future documentation. This incident was graded as low harm and a manager had indicated that this incident was unlikely to re-occur.

Investigation reports did not identify when actions had been completed after the investigation had concluded. We reviewed the incident spreadsheet that the provider had developed to provide an overview of incidents within the organisation, but actions taken were not dated. Actions showing as complete were not audited to ensure clinical practice had improved.

Inadequate

Hospice services for adults

We reviewed the providers incident management policy and saw that it did not include timescales for the investigation of incidents. This is a risk to patients, as it may result in a delay of actions to be taken to mitigate further incident.

We observed a patient safety meeting which was a newly created to share learning from incidents within the organisation. The meeting was well attended, however key learning from each incident was not clear and we were not assured that the chair had sufficient information in which appropriately share the incidents. We saw no one took minutes of this meeting to ensure discussions were shared with those staff whom could not attend.

Therefore, we are not assured that the providers incident management and investigation processes were robust and would prevent further patient harm or risk of patient harm.

We saw however staff reported medication incidents that were reviewed and shared with all pharmacy staff so the appropriate actions could be taken, and duty of candour was consistently applied across all incidents.

Are Hospice services for adults effective?

Requires Improvement

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not always check to make sure staff followed guidance. Staff did not always protect the rights of patients subject to the Mental Capacity Act 2005.

The provider acknowledged that the process that they had outlined to review and update their policies was not yet completed and the provider told us that a number of polices were still to be reviewed.

We requested several of the providers policies including the clinical assessment and review of patients receiving care at the hospice, the care of the deteriorating patient and a copy of the providers policy or procedure for the use of cooling blankets used when caring for the deceased and the procedure for staff when carrying out last offices but they did not have any of these policies in place.

The provider acknowledged that a number of clinical policies and information was missing when reviewing incident investigations. This included the lack of provider guidance when using specialist equipment such as mattress's and information for staff regarding pressure damage and moisture lesions.

Clinical practice was not audited or formally reviewed and although staff told us they discuss clinical care and treatment in accordance with evidence-based guidance, we did not see records of these conversations.

ReSPECT forms where a patients' individual choices and preferences are captured was not used by the provider. However, this was an agreed regional decision across the palliative collaborative.

Therefore, we were not assured that the providers' processes to ensure staff followed national guidance or evidence-based practice were adequate and would either prevent further patient harm or reduce the risk of harm.

Nutrition and hydration

Staff gave patients food and drink and used special feeding and hydration techniques when necessary. The service told us they made adjustments for patients' religious, cultural and other needs. However, records detailing fluid and diet intake were not always appropriately completed.

Staff used a screening tool to monitor patients at risk of malnutrition. We saw this was appropriately completed in the care records of patients we looked at. However, patients identified as high risk were not systematically reviewed to ensure their dietary needs were sufficient. We asked staff when high risk patients should be re-assessed but there was an apparent lack of clarity due to the lack of provider policy or guidance. Re-assessment was at the discretion of the nursing staff.

Staff told us they would offer dietary choices in accordance with patients cultural or religious choices but patients receiving care at the time of inspection had not requested these options.

Referral to specialist support staff such as dieticians was not routinely made. We reviewed two patient records both showing a decline in Waterlow scores which is a nationally recognised tool to assess a person's risk of developing pressure sores. One patients score declined to a state of anorexia but no referral for support was made.

Staff did not always accurately complete patients' fluid and nutrition charts where needed. In all five of the patient's fluid balance charts we reviewed (100%), we saw staff recorded fluids as a descriptive rather than a measure. For example, staff recorded the patient had a cup of tea. Therefore, staff were not accurately recording patients' daily input of fluids to ensure patients received enough hydration.

None of the patients were weighted for dietary purposes and staff did not seek to assess weight loss or gain as part of their stay at the hospice.

This presented a risk to patients as key information that would be used to determine whether a patient was at risk of losing/gaining weight was not documented, which may result in harm or potential harm. We brought this to the immediate attention of the provider and took enforcement action to ensure patients being considered for admission, were no longer at risk of harm.

However, we saw patients had water provided within reach and staff offered drinks to patients and their visitors throughout the day.

Pain relief

Staff monitored patients following administration of pain relief. However, they did not always support those unable to communicate using suitable assessment tools.

We saw patients were asked how their pain levels were, following administration of analgesia. The provider did not use any formal pain scoring tool. Staff told us and we saw analgesia given was reviewed but this was not always documented. This is not in line with best practice and national guidance in relation to palliative and end of life care.

Pain levels were recorded as part of the integrated palliative outcome scale (IPOS) scoring system. However, we saw some records which were taken incorrectly. For example, we saw staff assessed the pain score for patients unable to communicate through IPOS. The tool supports patients to assess their own pain scores to ensure accuracy.

We reviewed the clinical assessment for all patients at the point of admission and we saw that assessments were not recorded for risks associated with pain management. In one record we saw the patients reported that their pain level was 9/10 but no further scores were formally collated to monitor this patient's pain during their stay. Nursing documents showed that this patient was experiencing moderate to severe levels of pain, but they were not formally monitored. In the same records we saw that the patient told staff they were unable to eat if in pain. The provider did not produce a risk assessment for these concerns and the patients Waterlow score continued to deteriorate during their stay.

However, staff did discuss pain management amongst the internal multi-disciplinary team, and we observed this as part of the MDT meeting, we attended during the inspection. We also observed patients were comfortable and at rest during our visit to the hospice.

Patient outcomes

Staff monitored some aspects of the effectiveness of care and treatment. They used some of the findings to make improvements for patients. However, audit activity was minimal.

At the last inspection we told the provider it must collect appropriate and timely information and develop key performance indicators so that leaders had an overview of the effectiveness of the service.

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

The provider utilised a phase of illness measurement tool to assess the quality of the care that was provided during patients stay. This tool however, does not accurately consider the complexities of palliative symptom management and applies only a broad consideration of the patient's condition.

We saw the provider submitted data to Hospice UK and used this as a benchmark in which to monitor some patient outcomes.

Some data was also submitted as part of commissioning contract monitoring, we reviewed the last submitted data for October to December 2021 and saw that data was generally positive. For example, we saw 100% of patients were deemed to have moved from unstable to stable during the course of their admissions and 100% of bereaved relatives were very satisfied or satisfied with the way in which the hospice supported patient's dignity.

However, we saw in the same data that the number of outreach clinic contacts had declined and MDT training sessions were recorded as one only in any given month.

Competent staff

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

At the last inspection we saw a number of staff had not received an appropriate disclosure and barring (DBS) check and the providers policy did not advise that staff should be re-checked on a regular basis to ensure patients were safeguarded. At this inspection we saw the provider had strengthened and improved processes. We reviewed eight staff files and saw that appropriate checks were now in place and the providers' policy had been updated to ensure staff

received the appropriate checks. We also saw professional registration checks were now in place to include Nursing Midwifery Council (NMC) and the General Medical Council (GMC). We saw the provider had taken steps to improve the organisation and general housekeeping of staff files so that key information could be easily accessed and identified. We saw files were indexed and were comprehensive.

Managers supported staff to develop through yearly appraisals of their work. At the last inspection we saw staff were not supported through supervision and the provider was told it must provide appropriate ongoing supervision and training to ensure staff can carry out the duties they were employed to perform. At this inspection we saw managers had implemented both formal supervision and informal peer support discussions and staff were able to further discuss areas of clinical development during staff meetings and MDT sessions. Formal supervision sessions included reference to work performance and training development needs.

The provider offered staff a number of additional training opportunities, which further supported staff clinical training skills. These included time out days for ward sisters, controlled drugs accountable officer training, grief and loss training, medical gas and interpretation of blood results.

The service provided medical trainee placements and the ratio of medical staff to trainees was above the national requirement.

Managers of the service told us that the development of staff was a priority and following the imminent introduction of new managers, further developments would be implemented such as a new electronic database and recording system.

We saw the provider had developed a trainee trustee appraisal booklet which had recently been implemented, to support new trustees joining the organisation.

Multi-Disciplinary Working

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

Staff worked together to ensure patients information was shared. Managers had recently introduced a number of new staff meetings such as patient's safety and safeguarding meetings to ensure key information was known to all staff.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed an MDT and saw that it was well represented by all members of the hospice team including social work, physiotherapists, pharmacy, medical and nursing team staff members.

Electronic recording systems, however, were able to information sharing and we saw medical and nursing record systems worked in isolation of one another. Meetings offered an opportunity to share some of this information, however detailed clinical conversations were not always recorded.

Staff worked with other agencies when required to care for patients and sought information from national organisations such as Hospice UK. There was limited outreach and joint working with local GPs, care and nursing homes and the provider acknowledged this was an area for further development.

Health promotion

Inadequate

Hospice services for adults

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

The provider was unable to display paper versions of information leaflets due to the infection prevention control measures that were implemented due to COVID-19. However, information was provided verbally to patients and their families as they needed it and copies provided on an individual basis.

Day service provision was not fully operational, again due to the pandemic but patients were provided with ongoing companionship, exercise' programme supported by a physiotherapist, registered nurse and complementary therapists support services. Detailed information was provided in relation to symptom management advice and emotional well-being.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. However, they did not always follow national guidance to gain patients' consent.

Staff did not always gain consent from patients for their care and treatment in line with legislation and guidance. We reviewed five patient records and saw that consent was not sought for specific aspects of care and treatment. The provider had developed specific consent forms for personal data sharing and the reuse of patients own medication. However, in two records we saw nursing staff had signed on behalf of the patients whom were deemed unable to sign. However, this was not witnessed in accordance with the requirements of the consent form.

We saw the provider routinely swabbed patients for COVID-19 and this included those patients who were deemed to lack capacity. Consent was not obtained for those patients in the records that we reviewed.

Staff did not always understand the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. We observed a patient admission and saw that the patient was supported to complete the initial clinical assessment by a family member. However, this was not the patients next of kin and the patient was deemed to lack capacity which meant this was not in accordance with the Act.

Capacity was not recorded at the point of referral and was not considered until the patient was admitted. In addition, capacity was not formally assessed until a significant event occurred. For example, applying for a deprivation of liberty application. Therefore, we are not assured that appropriate documented consent was sought for all patients, in line with national guidance. However, we saw staff seek verbal consent prior to offering support with care and treatment.

Staff were able to describe best interest decision making processes and how they would be applied. We reviewed three Do not attempt to carry out cardiopulmonary resuscitation forms (DNACPR) and saw that they were appropriately completed.

Are Hospice services for adults caring?

Good

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. However, this was not always documented.

Staff took time to interact with patients and those close to them, in a respectful and considerate way. The environment on the inpatient unit was quiet and calming and we saw patients were relaxed during our inspection. Staff were observed completing visual checks whilst patients were at rest and assistance was offered in between the patient call bell patient prompts.

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

The provider actively sought feedback from patients and those whom use the service. We reviewed recent feedback questionnaire summaries and saw that 100% of patients said their privacy and dignity was respected and staff were polite and were treated with courtesy. We saw thankyou cards displayed around the ward area which reflected this.

Emotional support

Staff provided emotional support to patients to minimise their distress. They understood patients' cultural, and religious needs. However, this was not always documented.

We observed staff supporting patients with their emotional needs and we saw staff shared how they were supporting patients with these needs, during multi-disciplinary meetings. Staff worked together and we saw a verbal exchange of information regarding all if the patients. MDT meetings were well attended by different members of the team to support the sharing of this information.

The provider offered a bereavement service which was open to families, friends and carers of patients whom had specialist palliative care needs. Feedback from users of this service was also collated and we saw feedback was consistently positive.

Patients were also offered wellbeing enhancing complimentary therapies and counselling support and staff maintained this throughout the pandemic by ensuring patients were reached by telephone. Staff had developed 'mood boards' which were a visual aid for patients, families and staff to communicate using images and feedback for these were positively received.

Staff told us that cultural and religious preferences were respected but we did not see any evidence of this within care plans or individual assessments. Staff were able to describe how patients with varying cultural needs could be supported.

We asked staff if chaplains visiting the hospice would produce anything personalised to capture the religious needs of patients, but staff told us there was no chaplain attending the hospice at the time of inspection.

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.

Inadequate

Hospice services for adults

We observed an admission to the inpatient unit and saw that family members were involved in the admission and assessment process.

We saw families were updated regarding changes in the care and treatment provided and saw documented discussions within the electronic care records stating that both medical and nursing staff had spoken with families changes in care needs to families and carers.

However, we did not see any documented personalised wishes which were being supported by staff at the hospice. Staff told us that they shared this level of information at handovers and at multi-disciplinary meetings

At the last inspection we saw that the provider did not have a clear visiting policy. We saw at this inspection that policies and processes were in place which considered the emotional frailty of patients and the importance of physical visiting and contact but also maintained safe access into the building during the pandemic.

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

Are Hospice services for adults responsive?

Requires Improvement

Service delivery to meet the needs of the local people

The service took some steps to plan and provide care that considered the needs of local people and the communities served. We saw some plans had commenced to work with others in the wider system and local organisations to plan care, although progress was limited.

At the last inspection we saw four percent of the local population of the Barnsley area, identified as non-white British and the hospice had only treated one patient identifying as non-white British in recent years. At this inspection we saw the numbers of non-white British patients remained low and there were no established links in which the provider could demonstrate it was addressing the needs of the wider ethnic community. The provider told us some discussion had taken place with commissioners, but no plans were formalised at the time of inspection.

Outreach work was generally limited, despite many patients choosing to receive care at home during the pandemic.

We requested the numbers of patients admitted during the last twelve months with a non-cancer diagnosis and saw that this equated to 10% of all patients. Managers acknowledge that this was low and told us plans were to be developed to address this.

The hospice retained links with its local NHS trust and GP surgeries, but they had limited contact with nursing and care homes.

Facilities and premises were satisfactory for the services being delivered. Rooms were wheelchair accessible.

Inadequate

Hospice services for adults

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 support patients living with dementia learning disabilities. At the last inspection we saw that staff did not always make sure patients living with mental health conditions, learning disabilities and dementia, received the necessary care to meet all their needs. There was no learning disabilities or dementia link nurse in post. At this inspection we saw this had not changed and there were no additional provisions made. The inpatient unit was still not designed to meet the needs of patients living with dementia, with no contrasting colour or visual signage. There was still no requirement for clinical staff to complete mandatory training in learning disabilities and autism. Although dementia training was now considered mandatory. We told the provider at the last inspection that it should consider the introduction of link nurses for dementia care. The provider told us a staff nurse was identified as a dementia champion for the inpatient unit and had one day per month protected time to progress the agenda.

We requested evidence of occasions when the provider supported patients with a specific need such as a learning difficulty, but the hospice had not admitted anyone with these specific needs. The provider gave us an example recently when they had been asked to support a patient with bariatric needs and specialist equipment was sourced to provide the necessary care required.

The provider had not supported any individuals with transitional care needs since the last inspection.

Spiritual care provision was in place, however there was a current vacancy resulting in the provider acquiring sessional arrangements with the support of local chaplains. A new permanent chaplain was due to start soon, and staff told us that the hospice was well supported by local faith groups.

We saw the hospice counselling team also tailored their services as specific points in the annual calendar such as national grief week and reaching out to bereaved fathers.

At the last inspection we saw that the provider did not have clear visiting protocols and we told the provider it must ensure one was in place ensuring they are clear, appropriate, in line with current COVID-19 guidance, adhered to and understood by all staff. We saw the provider had developed clear visiting protocols which were developed in accordance with the patients physical and emotional needs. Patients were given a code on admission, according to the importance of receiving visitors and the impact of not receiving visitor contact during the pandemic. Codes were changed in accordance with patients fluctuating needs and were regularly communicated to all visitors.

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 patients know that this service was available.

In addition, the hospice still did not have an inclusion policy. However, we were provided with examples of recent admissions supporting individuals with protected characteristics.

Access and flow

Inadequate

Hospice services for adults

Patients could access the service when they needed it.

The provider did not have a detailed eligibility criteria for admissions or a defined ceiling of care. Staff told us they reviewed admissions on an individual basis but could not articulate when an admission should be declined. Patients were classified as being either urgent or non-urgent.

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

Occupancy levels fluctuated and the hospice had not been over 90% full since our last inspection. This was due to in part the COVID-19 pandemic and patients choosing to receive care at home. We saw in August 2021 occupancy was as low as 49%. The provider continued to offer counselling and bereavement services but data we reviewed showed there had been no day care provision in the last twelve months. The provider recognised that individuals from an ethnic minority groups had fewer options to access to bereavement support services and had taken steps to offer this.

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.

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. This was due to IPC guidance during the pandemic, resulting in the removal of some signage in the communal areas.

Staff understood the policy on complaints and knew how to handle them. We saw a complaints leaflet was available for patients and their families if requested. Staff knew how to acknowledge complaints and were keen to resolve any issues that were brought to their attention quickly. The provider had also developed a complaints management policy.

We reviewed the latest feedback submitted to the provider and saw that results were generally positive. We saw seventeen responses were received from thirty-five questionnaires, that were sent out. Patients scored 100% when asked if they felt fully informed regarding their care and 100% involved in their choices regarding their care.

The provider reported that they had received no complaints since the last inspection.

Are Hospice services for adults well-led?

Inadequate

Leadership

Inadequate

Hospice services for adults

Some leaders had the right skills and abilities to run the service. Not all leaders fully understood the priorities and issues that the service faced. For example, there was no shared view of organisational risk. There are some examples of leaders making a demonstrable impact on the quality or sustainability of services, however implementation was slow. Although, they were visible and approachable in the service for patients and staff and supported staff to develop their skills and take on more senior roles.

Since the last inspection there had been significant changes on the leadership team. The new team understood the challenges to address the concerns within the hospice but acknowledged that pace to drive improvement had been difficult. The hospice was overseen by a board of trustees led by the chair. The hospice executive team (HET) had seen a number of staff leave resulting in the appointment of a new Chief Executive whom was also acting as Registered Manager and Chief Nurse. A proposal to expand the existing HET had been developed and completed by the Chief Executive and this was approved by the board. Also new proposals for a revised organisational structure were to include: Director of Governance & Quality, Director of Human Resources & Organisational Development, Head of Income Generation, Corporate Administration Manager and a Facilities Manager. Recruitment into these positions had been successful but applicants were not yet in place at the time of inspection. However, the new appointments were seen as positive, in influencing the change within the service.

In addition, the following part-time posts were made full-time: Governance Officer, HR Advisor, and Volunteer Co-ordinator.

The new proposals for a revised organisational structure show that nursing leadership comprises of Chief Nurse (Combined with CEO role), Associate Chief Nurse and Ward Sister.

Leaders of the organisation acknowledged the impact of lack of key senior staff particularly across governance changes and improvements. Senior staff described many changes developments as 'in progress'. Areas of priority described by leaders included the must do actions the provider was told it must make following the last inspection, a focus on staff training and improving the culture. We saw that insufficient progress had been made resulting in reoccurring breaches across two of the legally required regulations.

The Chief Executive was able to demonstrate knowledge of the demographics of the local area and had commenced plans to reach ethnic minority groups living in the region through the development of the Quality Improvement project (QIP). The project aimed to explore access to inpatient services at the service from ethnic minorities in the local area.

At the last inspection we saw the hospice had recently recruited new trustees to the board after longstanding members had stepped down, however trustees did not all regularly attend meetings. We also saw there was little or no documented scrutiny of meetings by non-executive board members. Leaders outlined plans for further work in this area.

At this inspection we saw new trustees were supported with a training induction package and were required to undertake specific areas of development and improvement. However, this was not in place at the time of inspection.

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

Vision and strategy

Inadequate

Hospice services for adults

The service had a vision for what it wanted to achieve and a strategy to turn it into action. However, this had not been reviewed following the last inspection to consider the views of stakeholders and the wider economy. The strategy was not underpinned by, realistic objectives or plans for high-quality and sustainable delivery.

The provider told us that they would be reviewing the current strategy as part of future board and trustee meetings and therefore it had not changed since the last inspection. The provider had a one-year strategic plan with overarching key strategic objectives with a supporting action plan to show timescales for improvement.

We reviewed the action plan and saw strategic and service objectives had been developed for each aspect of the service. For example, inpatient unit, lymphedema service, training and human resources. The plan covered all services provided by the hospice and how it intended to expand or develop each service. We saw the plans were detailed but did not outline a target date for completion or whether objectives were therefore achievable. Leaders of the hospice told us it was difficult to complete these actions until the executive team had a full complement of staff and therefore, we were not assured that there was sufficient leadership capacity within the service to drive pace.

Senior members of staff told us they felt involved in the development of these strategic objectives and felt they could actively contribute to the future developments of the hospice provision. We did not see evidence of strategy development involving the wider community or regular dialogue with regional stakeholders to ensure the service met the needs of the wider community.

However, the chief executive had developed some links with the local NHS trust including estates to look at resource sharing and the local clinical commissioning groups to look at ways in which nurses working within the CCG may be able to retain their clinical skills by working at the hospice.

The hospices vision as described by the chief executive was to be an 'employer of choice for the people of Barnsley' and outlined plans to offer an attractive training and benefits package which was akin if not superior to NHS employee benefits. Staff had recently been awarded a pay award uplift following a proposal by the chief executive and additional training opportunities over and above mandatory training opportunities.

We saw strategic action points to address the low numbers of patients accessing the service whom had a diagnosis other than cancer and general access and flow review to address the current needs of the community. Although these plans had not commenced at the time of inspection.

The chief executive outlined plans to significantly review human resources (HR) with a new appointment to oversee the whole service. Job descriptions had not yet been written but it was recognised that radical changes were needed to ensure staff recruitment, retention and rewards were successfully supported. Plans were in place to commence these developments, once all members of the senior management team were in place.

Culture

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

Staff described leaders as open and approachable and acknowledged the passion dedication and hard work demonstrated by the Chief Executive to bring about changes and drive improvement. All staff we spoke with attributed

the vision to succeed and provide the best patient care to the changes made by the Chief Executive. Everyone acknowledged that the hospice was on a journey and understood the changes that were needed. Leaders of the service were open when describing areas that were still to be addressed but were able to articulate ambitious plans for the future.

Staff resignations had impacted the culture within the organisation, but staff felt engaged and invested in the future of the hospice. All staff we spoke with were able to describe the positive changes that had already taken place and felt the hospice was in a position to be able to speak out freely and describe honestly where they felt they were in their transformation journey.

The service had a whistleblowing policy in place and staff knew how to share concerns. The hospice did not have a freedom to speak up guardian or similar post at the time of inspection but acknowledged this would be part of the HR review.

Leaders of the organisation recognised staff contribution and the chief executive ensured staff received a pay uplift. Staff told us they welcomed the changes to the appraisal and training processes.

The provider had also held a staff wellbeing day, which acknowledged the difficulties staff had faced due to the pandemic.

Governance

Leaders did not operate effective governance processes, throughout the service and with partner organisations. Leaders were able to describe plans to improve governance processes, throughout the service and with partner organisations. However, they were not in fully in place at the time of inspection.

At the last inspection we saw governance processes were not in place to ensure patients were safe from risk of harm or potential harm. Leaders of the service did not have established processes to collect, review and improve data and risk management was not prioritised. The provider was told it must ensure that effective and robust systems are in place to support the management of governance, including risk and performance.

At this inspection we found some plans to improve governance processes had begun, for example the introduction of sub committees and patient safety meetings.

However, these processes were not embedded, and we saw significant gaps in key areas such as the safe management of deteriorating patients, effective clinical risk identification and management, incident investigations and the audit of clinical practice.

The lack of effective governance processes resulted in leaders of the organisation failing to identify significant risks across the service. Inspectors took immediate enforcement action to ensure patients were mitigated from risk of harm or potential harm.

Leaders of the organisation also told us that sub committees were to be developed to review clinical risk, training and HR processes. These committees had not yet been set up until the new Director of Governance and Quality and Quality and Risk Manager personnel were in place.

We were therefore not assured that leaders of the service had sufficient oversight of risk and the potential for risk.

Despite the acknowledgement of the planned changes within the governance structure, this remained a risk to patients because the service continued to have ineffective 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 patients in receiving those services).

We did not see the use of internal data or external benchmarking against similar organisations to drive improvement. The provider collated some IPOS data, but we did not see any action plans to improve the patient experience.

We asked senior members of the organisation, what information was collated and reviewed to drive improvement and inspectors were only told about patient feedback.

Managing risks, issues and performance

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

We saw the provider had introduced a hospice dashboard to help identify risk and monitor incidents. Plans were in place to further develop the dashboard in time, as the system had only recently been introduced. We did not see effective use of the data held.

Benchmarking against similar organisations had commenced with the introduction of data submission to Hospice UK but the provider acknowledged there was further work that was needed. We reviewed the data submitted and saw that the hospice performance was below the national average in all areas when compared to similar organisations. This included occupancy figures, discharge percentages and days available per bed. We did not see an action plan developed by the provider to address this.

We requested a copy of the risk register for the hospice including the clinical risk register, however, this was not provided.

We observed a patient safety meeting which was held during the inspection. We saw incidents were reviewed through the electronic system and the meeting was attended by different members of the hospice team. However, lessons learnt were not clear and the chair was unable to articulate what actions had been taken as a result of an incident occurring and what was required to mitigate against a recurrence.

We reviewed incidents and saw that they were poorly investigated with areas inconsistently completed in the records we reviewed. We saw incident investigation documentation was not audited.

We also saw records were not consistently completed and key information missing for some patients whom were admitted and in some patient records clinical risks were missed. Care records were not routinely audited which meant the provider could not assured patients were received appropriate and safe care.

General audit activity within the hospice was limited and although this was identified as an area of development, we did not see a proposed audit plan.

The provider did not consider what would constitute a ceiling of care and the risks associated with a lack of defined criteria for safe admission. We brought this to the attention of managers and issued immediate enforcement action.

At the last inspection we saw that services were not designed to support patients with dementia or leading difficulty. We also saw that the service did not fully support patients with mental health difficulties. We saw at this inspection that these patients were still not considered with inclusion within the service strategy or policy development. In addition, the provider did not have a clear admission criteria, which potentially resulted in the exclusion of specific patient groups.

Leaders of the organisation did not understand risk and failed to recognise organisational or clinical risks. We asked senior managers to identify the top three risks for the organisation and we were provided with different responses each time.

We saw the provider had developed several policies to manage major incident, disaster recovery and business continuity policies. However, leaders of the services told us that several key policies were under review across the service. This included clinical practice areas and assessment and intervention of patients receiving care and treatment.

Managing information

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

As some key senior staff were not in place at the time of inspection there was still no dedicated governance resource within the organisation, and overall responsibility for good governance sat mainly with the chief executive and associate chief nurse.

The introduction of the patient safety meetings and safeguarding review meeting marked the start of a series of new meetings to look at specific focused information and data, but they were not fully implemented or embedded at the time of inspection.

The patient safety meeting we observed demonstrated a lack of understanding by the provider regarding the identification themes and trends to enable them to mitigate further recurrence of incidents.

The new electronic recording system was not linked to other electronic systems which meant staff were required to log into different databases in order to view vital patient information.

The use of paper-based systems and three independent electronic systems did not support staff to create clear, outcome focused care plans and in all the records we reviewed information was located across all of these platforms. This presented a risk that key information could be missed, including significant risks which may cause patient harm or risk of potential harm. The provider acknowledged that this was a risk and was investing in a new information technology system to help address this.

The provider told us that it was in the process of reviewing policies and procedures, but we did not see action plans to ensure all policies were systematically reviewed. This resulted in a risk to patients using the service, as clinical guidance may not be current or in line with best practice or evidence based.

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, and plans to develop this further, although this was limited at the time of inspection

We saw the provider sought feedback using questionnaires which were manged by the individual services such as bereavement, counselling and inpatient units. We reviewed feedback and saw that it was generally positive but when feedback was lower than expected we do not see any actions plans in which to improve this. For example, we saw that some patients felt that they had not been fully involved when staff communicated aspects of their care, but no further work had been done by the management team to look at this.

We saw that further analysis of patient feedback was needed and this was included as an action within the strategic action plan. Therefore, at the time of inspection it was not clear from the feedback gathered, how this was directly used to improve services for people and their families. There was still regular staff engagement mechanism to review feedback however the provider told us the development of sub committees would support this flow of information.

Learning, continuous improvement and innovation

The provider outlined a number of areas of improvement for the future but outlined a significant change in staff culture as a major step in the transformation of the service.

Plans for improvement had commenced, such as the dashboard but were in their infancy due to staff vacancies.

The provider outlined plans to re-brand the orangery and to improve the existing building, to provide a dementia friendly environment.

'This little box' had been introduced across the service and staff demonstrated their ability to flex to the changing needs of the service caused by the COVID-19 pandemic.

We saw the provider supported managers through the Elizabeth Garrett management programme and provided additional training for the accountable officer for controlled drugs.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Staff did not have training in key skills and did not manage safety well. This is a re-occurring breach from the last inspection. • The service did not always manage safety incidents well and did not learn lessons from them. This is a re-occurring breach from the last inspection.

Regulated activity	Regulation
Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 11 HSCA (RA) Regulations 2014 Need for consent • The provider did not ensure staff understood their responsibilities when obtaining appropriate consent.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Managers did not monitor the effectiveness of the service well and did not make sure staff were competent for their roles by producing guidance and support through policy development. • The service undertook limited planning to meet the needs of local people and did not take account of patients' individual needs through personalised care planning.

This section is primarily information for the provider

Requirement notices

- Governance processes were not in always in place or embedded to ensure risk was identified and managed. The provider did not always collate performance data to ensure the quality of the service was measured and improved.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service did not always control infection risk well. Staff assessed risks to patients but did not act on them. Staff did not always keep good care records. Records were not clear or complete. This is a re-occurring breach from the last inspection.