St. Cuthbert's Hospice Durham

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

Summary of findings

Overall summary

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

- The service did not ensure all staff completed mandatory training in accordance with the provider's policy and target compliance rate.
- Not all staff received appropriate levels of safeguarding training in accordance with Intercollegiate guidance (2019).
- The provider's safeguarding policy did not include guidance for female genital mutilation (FGM).
- The service did not always control infection risk well.
- The service did not have clear admission and exclusion criteria to ensure only appropriate patients were admitted to the hospice.
- Not all staff had training in key skills, for example, competency training and refresher training to manage patients with complex needs including but not limited to tracheostomy, nasogastric tubes (NGT) and percutaneous endoscopic gastrostomy (PEG) tubes. Policies for staff regarding management of patients with these medical devices were not relevant and specific to the services provided.
- The provider did not evidence that all staff completed a full induction programme, in accordance with the provider's policy.
- Managers did not always assess and monitor the effectiveness, quality, and safety of the service in accordance with the provider's policy.
- The provider did not have service level agreements for some services provided by the local NHS trust.
- Leaders did not always have oversight of risks. For example, they did not ensure all identified risks affecting the service in line with local policy were escalated to the risk register and mitigated as far as possible. These included but were not limited to infection prevention and control (IPC), management of the cold room, staff training compliance and competencies and disclosure and barring service checks for volunteer staff.
- The provider did not ensure its statement of purpose was up to date and accurately reflected management and regulated services provided.

However:

- The service had enough staff to care for patients and keep them safe from harm and abuse.
- Staff assessed most clinical risks to patients, acted on them and kept good care records.
- They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it.
- Managers mostly monitored the effectiveness, quality, and safety of the service in accordance with the provider's policy.
- Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.

Summary of findings

- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Requires Improvement 	Our rating of this service went down. We rated it as requires improvement. See the summary above for details. We rated this service as requires improvement because safe and leadership requires improvement. Effective, caring and responsive were good.

Summary of findings

Contents

Summary of this inspection

Background to St Cuthbert's Hospice

St Cuthbert's Hospice Limited is an independent provider, owned by St Cuthbert's Hospice Limited. It is a registered charity, that is partially funded by the NHS and was registered with CQC since 2011.

It provides treatment of disease, disorder, and injury, to adults aged 18 to 65. The hospice does not provide regulated activities to children.

St Cuthbert's Hospice has a registered manager. It is a purpose built, palliative care consultant-led unit with 10 in-patient beds, which are commissioned by the NHS.

In addition, it offers hospice day care services in their on-site Living Well Centre, including physiotherapy and occupational therapy.

The hospice also provides non-regulated services such as complementary therapies and bereavement counselling services to children, adolescents, and young adults. It provides support for patients living with dementia through their Admiral Nurse and Namaste community care service. However, these are not within scope of this inspection, as the service does not deliver regulated activities.

Our inspection was unannounced (staff did not know we were coming). We last inspected the service in 2014.

How we carried out this inspection

During the inspection visit, the inspection team:

• inspected and rated all five key questions

• looked at the quality of the environment and observed how staff cared for service users

• spoke with the Registered Manager and Nominated Individual

• spoke with 7 other members of staff including nurses, doctors, allied healthcare professionals, reception staff, volunteers, senior leaders, and trustee staff

• reviewed 7 service user records and medicine prescription charts

• looked at a range of policies, procedures and other documents relating to the running of the service

• Spoke with 4 service users

After our inspection visit, we reviewed performance information about the service and information provided to us by the service.

Summary of this 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 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 service must ensure all premises and equipment, including but not limited to, the cold room, are safe, clean, and properly maintained, and that this is recorded appropriately. **(Regulation 12(1)(2)(d)(e)(h))**
- The service must ensure that staff providing care and treatment have the training, qualifications, competence, skills, and experience, to do so safely. This includes but is not limited to, mandatory training, management of deteriorating patients, safeguarding and management of patients with medical devices. **(Regulation 12 (1)(2)(c))**
- The provider must have clearly defined exclusion criteria and clear ceilings of care, to ensure only appropriate patients are admitted to the hospice. **(Regulation 12(2)(a))**
- The provider must ensure disclosure and barring checks for volunteers are completed in accordance with the provider's policy, they must be updated regularly and a comprehensive record of when to update these checks must be held. **(Regulation 17 (1)(2)(b))**
- The provider must have suitable and sufficient risk assessments in place to evidence how actual and potential risks, are mitigated, as far as reasonably practicable. This includes, but is not limited to, risk assessments for management of volunteer staff, and cold room infection prevention and control risks. **(Regulation 17 (1)(2)(b)).**
- The provider must have formal service level agreements with third party providers, including but not limited to, all services provided by the local NHS trust. **(Regulation 17 (2)(d))**
- The provider must ensure all policies and procedures are relevant and specific to the services provided. **(Regulation 17(1))**
- The provider must ensure staff have access to a policy to support the identification, management, and escalation of female genital mutilation. **(Regulation 17 (2)(b))**
- The provider must implement effective systems and processes to ensure all nursing, medical and volunteer staff are compliant with all mandatory training, including but not limited to, safeguarding vulnerable adults and children, to a level appropriate for their role. **(Regulation 17(1)(2)(a)(b))**
- The provider must maintain securely such other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity, including but not limited to, comprehensive induction records for all staff roles. **(Regulation 17 (2)(d))**
- The provider must ensure all identified risks affecting the service in line with local policy are escalated to the risk register. **(Regulation 17(1)(2)(b))**
- The service must assess, monitor, and improve the quality and safety of the services provided in the carrying on of the regulated activities. **(Regulation 17(2)(a)).**

Summary of this inspection

- The provider must ensure their statement of purpose is up to date and accurately reflects registered manager details and regulated services provided. **(Regulation 12(3), (Registration) Regulations 2009).**

Action the service SHOULD take to improve:

- The provider should consider providing additional equipment to meet people's needs, including but not limited to, ECG monitoring equipment and cooling blankets.
- The service should consider ways to raise awareness and improve staff compliance with reporting of all incidents and near misses, such as deviation of cold room temperature from the required range.
- The provider should continue work to upgrade of the IT system at pace and agree clear timescales and contingencies for staff to follow, until the work is completed.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Hospice services for adults

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

Is the service safe?

Requires Improvement

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

Mandatory training

The service provided mandatory training in key skills. However, the provider did not make sure all staff completed it.

Staff received mandatory training and the training policy explained how staff would receive training. Although mandatory training requirements by job role were not defined in the training policy, requirements were clearly defined in a separate electronic spreadsheet.

The provider's compliance target for all mandatory training modules was 90%. Managers monitored mandatory training and staff compliance on a training matrix. However, the training matrix and the training records did not always include content or detail to outline the training that was completed. This was a particular concern regarding caring for patients who may deteriorate quickly and those admitted with medical devices.

Not all clinical staff received specific training relating to care of the deteriorating patient, despite the hospice accepting patients with complex needs. For example, patients admitted with tracheostomy, nasogastric tubes (NGT) and percutaneous endoscopic gastrostomy (PEG) feeding tubes. This had the potential to affect the safe care and treatment of some patients admitted to the hospice.

We raised this as a safety concern at the time of inspection. Following our inspection, we saw evidence managers had added the risk to the risk register, sourced appropriate competency training for management of NGT and PEG tubes and provided a schedule for roll out and completion of the training by relevant nursing staff.

We also saw from the training matrix, that some named staff had not completed fundamental modules. For example, resuscitation and anaphylaxis training (69% compliant), infection prevention and control (IPC) training 89% compliant with level 1, and 79% compliant with level 2), and food hygiene (78.7% compliant). In addition, the senior specialist doctor's name was not on the training matrix. This meant we were unclear what training they had received.

Managers told us that some staff training records were held on paper, and some were electronic. Records we reviewed were not consistently stored and therefore some training certificates were missing. The provider recognised that some improvements were required to strengthen oversight of the training staff had completed.

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

Staff understood how to protect patients from abuse. However, staff, including medical staff, did not always receive training on how to recognise and report abuse.

The service's adult and children safeguarding policies, referenced national guidelines, and contained links to local authority safeguarding information and PREVENT. PREVENT is a government led programme which aims to safeguard vulnerable people from being drawn into terrorism.

However, the provider's safeguarding policies did not include NHS England guidance on safeguarding women and girls at risk of female genital mutilation (FGM). This meant there was a risk staff may not know how to fulfil their mandatory duty to report FGM if it was disclosed or discovered.

Staff did not always receive training specific for their role on how to recognise and report abuse. For example, the provider's training matrix showed the named safeguarding lead (head of clinical services / registered manager), had received level 3 training. Although they had access to a level 4 trained named individual through local authority contacts, the provider's safeguarding policies stated they also required level 4 training, in accordance with Intercollegiate guidance (2019).

The matrix showed a senior non-clinical manager had not received level 3 safeguarding adults and children refresher training when it was due in March 2023, and another senior clinical manager had not received level 3 adults safeguarding training when it was due in March 2023.

The senior specialist doctor's name was not on the training matrix, which meant we were unclear what level of safeguarding training they had received.

In addition, we reviewed the trustees training records and saw 4 of 14 had not received safeguarding refresher training when it was due in March 2023. This was a particular concern as managers we spoke with told us these staff were required at times to meet service users and their families upon arrival. The provider acknowledged that this training was overdue and would be reviewed as a priority.

The providers adult and children safeguarding policies mandated level 1 adult and children safeguarding training for volunteers. Training compliance data provided showed current compliance was 65% against the target of 90%. However, the compliance data was for 75 volunteers in various roles and at the time of inspection, we were told there were over 300 volunteers working at the hospice. This meant we were not assured all volunteers had received safeguarding training in accordance with the Intercollegiate guidance (2019) and the provider's policy.

We also saw the provider did not carry out disclosure and barring service (DBS) checks for some staff, including volunteers who worked on reception. Records we saw showed 28 of 330 volunteer staff, had no DBS evidence on file. These staff had the potential to work in an unsupervised capacity with service users and their families and therefore posed a risk to vulnerable adults and children.

DBS checks for volunteers were not updated regularly and the service did not hold a comprehensive record of when to update these. The provider did not have a suitable and sufficient risk assessment in place to evidence how potential risks were mitigated. We brought this to the immediate attention of the provider. Following our inspection, the provider submitted a risk assessment for the provider's practice not to carry out DBS checks for reception volunteers, as they did not have access to unaccompanied vulnerable people. However, we were unclear how the provider was assured no lone- working volunteers without suitable DBS clearance were actively working.

We raised our concerns with managers and the provider immediately asked for a list of all clinical volunteer roles and whether they are providing one to one unsupervised interaction between them and vulnerable adults or children. They asked for confirmation that those who are, should have a DBS check according to the provider's existing risk assessment and requested assurance from managers that those who should have DBS clearance, have one.

All staff we spoke with were able to define safeguarding protocols and understood who 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. We saw safeguarding referrals had been made at the time of inspection.

We saw staff received safeguarding supervision and worked closely with external health care professionals including district nursing colleagues and social care organisations, to share safeguarding concerns.

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 and stored correctly.

There was an infection prevention and control (IPC) policy. The training matrix showed 89% of staff had completed IPC level 1 training and 79% had completed level 2 against the target of 90%.

However, we were concerned about potential IPC risks to staff and patients because cold room storage facilities did not comply with NHS England guidance for staff responsible for care after death (2011). The guidance stated cold rooms should be below 12°C (ideally 4-8°C). However, the service's temperature monitoring records from January to October 2023, showed the cold room temperature was consistently outside the required range when it was occupied. For example, in May 2023, on days when the room was occupied, actual temperatures ranged from 5.6°C to 20.1°C.

There was no risk assessment in place, no evidence of actions taken to mitigate risks when the temperatures were outside the required range, and staff did not report on the provider's incident reporting system when temperature recordings were above 12°C when occupied.

We saw the service's annual IPC audit of the cold room completed 09 May 2023, (when it was unoccupied) recorded 100% compliance. Temperatures were recorded as minimum 5.6°C, maximum 21.1°C and actual was 20.8°C. The audit result recorded there were no actions required. However, managers we spoke with told us they were aware the cold room temperatures were consistently out of required range when occupied. Staff we spoke with told us they were unsure whether this was recorded on the provider's risk register.

In addition, the provider's records showed the cold room was not always cleaned when occupied. For example, for 2 weeks during September 2023. Managers we spoke with were unclear whether this risk was on the provider's risk register.

The cold room was occupied during our inspection, and we made managers aware of our concerns at the time. The provider promptly installed a temporary portable air conditioning machine, which reduced actual room temperature to 7°C.

Following our inspection, the provider submitted risk assessments for use and cleaning of the cold room when occupied. In addition, we received assurance that funding to replace the cooling unit was approved, and there was an agreed date for installation, within 2 weeks of our inspection.

We were concerned there were no cooling blankets available for patients after death. Although these are not compulsory, cooling blankets help to maintain the appearance, condition, and dignity of the deceased. We noted purchase of cooling blankets was an action on the risk register, to help mitigate risk associated with the inadequate cold room facilities. However, we discussed this with managers at the time and were told funding was still to be approved before they could be ordered.

Staff used personal protective equipment (PPE). We observed staff complied with 'bare arms below the elbows' policy, in accordance with National Institute for Health and Care Excellence (NICE) guidance.

We observed how staff shared information about patient infection risks at a multidisciplinary handover meeting. For example, when staff handed over that a patient who was awaiting wound swab results was now confirmed to have a positive Meticillin resistant staphylococcus aureus (MRSA) result, staff were signposted to review the MRSA policy to remind them of the correct precautions to take when managing the care needs of this patient.

We saw the provider scheduled and completed inpatient unit and Living Well Centre hand hygiene audits twice a year, in September and March.

Environmental cleaning and on-site laundering of clothing, curtains and bed linen was completed by the housekeeping staff. There was a dedicated washing machine, laundry policy and schedules in place for this. A separate machine was used to wash non-disposable mop heads and the provider had a new standard operating procedure describing the process for this.

Waiting, reception and clinical areas were visibly clean, and had suitable furnishings which were clean and well-maintained. We saw rooms actively cleaned in accordance with schedules during our inspection visit.

Patients each had separate rooms, and some also had en-suite bathrooms. The vinyl floors were in good order, and we saw staff had access to spillage kits in the event of a spillage of bodily fluids.

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

Legionella flushing of taps was completed by nurses and there were no gaps in the records.

Waste bins were pedal operated and contained the correct colour coded liners.

We observed public areas had posters which promoted COVID-19 awareness. There were sufficient hand wash basins and hand gel stations. There was information on the provider's website about current COVID risk measures and IPC advice displayed in patient bedrooms.

Requires Improvement

Hospice services for adults

Environment and equipment

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

The hospice was purpose built and had suitable and sufficient day and inpatient services facilities.

Access to the premises was via automatic doors and via a buzzer entry system after hours. Reception staff had a clear line of sight to the entrance door.

Access to restricted areas such as administration and storage areas, was controlled with key-pad locks. The environment was bright and spacious.

All fire extinguisher appliances inspected were signposted and serviced within an appropriate timescale. Fire exits and corridors were clear of obstructions. The service had a fire evacuation plan and conducted annual fire evacuation drills.

The design of the environment followed national guidance. For example, fabric furnishings and curtains in patient bedrooms were designed for hospital use, were wipe-clean or washable, for thermal disinfection and certified to BS5867 Part 2C, to ensure they were inherently flame retardant.

There were systems for recording the service and planned preventive maintenance of equipment, identified through a central log and equipment compliance stickers, which indicated the dates tests were due. An external provider conducted portable appliance testing of electrical equipment. All clinical equipment we inspected was serviced and fit for use.

Substances hazardous to health were stored safely.

Patients could reach call bells and staff responded quickly when called.

Staff accessed basic airway management equipment and suction equipment in the dressings room on the ward and there was a defibrillator at main reception. Weekly checks were completed and recorded.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

The service did not have clear admission criteria and staff did not always receive appropriate training to ensure deteriorating patients and those with complex needs were cared for safely.

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.

We requested a copy of the admission and exclusion criteria. Although the provider recorded reason for delay and declined referrals on a spread sheet, none of the policy and guidance documents we saw identified clear ceilings of care for admission or exclusion criteria for the safe acceptance of patients. For example, the provider's procedure stated criteria for admission as: ''Person aged 18 years and above with advanced progressive illness and life limiting illness requiring specialist palliative care.''

This was unsafe, as staff were potentially admitting patients whose conditions could not safely be managed. We brought this to the immediate attention of the provider who took prompt action to implement written exclusion criteria for admission. The revised document we received after our inspection indicated admission exclusion criteria to be ''requires tracheostomy management, total parental feeding, has a nasogastric tube in situ''. This was because during our inspection, the provider was unable to evidence that staff were suitably trained and competent to care for patients with these needs, safely.

The provider did not have suitable and sufficient policies in place for staff to follow when caring for patients with complex needs. For example, the policies we saw for care of tracheostomies and nasogastric tubes were not relevant and specific to the services provided.

The provider had policies to advise staff of the safe management of clinical emergencies, anaphylaxis, and resuscitation. All staff we spoke with understood emergency arrangements for the patients receiving care and treatment. Staff were advised to ring for an ambulance in the event of sudden deterioration.

Staff, (69% against the target of 90%) received basic life support and anaphylaxis training. The most recent UK Resuscitation Council guidance (2021) for management of anaphylaxis was displayed in the clean utility room for staff to refer to, although the link in the provider's current anaphylaxis policy was to 2008 guidance.

The 2021 anaphylaxis treatment algorithm displayed advised application of monitoring equipment, including electrocardiogram (ECG), which the hospice did not have available.

Known risks were assessed prior to admission and patients were assessed again by both nursing and medical staff at the point of admission. We reviewed the electronic records of 7 patients and saw that these assessments were fully completed. In addition, we saw risk assessments were in place for aspects of fundamental care such as falls, tissue viability and nutrition. We also saw that staff had personalised these assessments to ensure they were tailored exactly to the needs of the patients.

We saw emergency health care plans were in place for patients as appropriate.

We reviewed training records for clinical staff in relation to escalation and managing care of the deteriorating patient. We saw some staff had received a short training session which was not accredited and did not outline the providers own policy or processes. It was not clear from these training documents what areas were covered in the event of sudden deterioration.

After our inspection, the provider told us 13 staff had completed a palliative care foundation course, which included proactive identification of the deteriorating patient. They provided evidence that one staff member had attended this specific course, and another had attended an advances of palliative care course. However, we were not assured that all appropriate clinical staff received specific training relating to care of the deteriorating patient.

Staff however, ensured all patients were discussed during the inpatient unit daily 8am nursing handover and 8.30am Living Well Centre huddle meeting. We observed a daily 9am doctors' handover, which was attended by the multidisciplinary team, and this included all necessary key information to keep patients safe. Risks including those patients likely to deteriorate were discussed. Care plans created due to risk were reviewed weekly and at the point of any immediate changes.

In addition, the service held a virtual multidisciplinary team meeting once a week. The service implemented a tele-support team system from 01 October 2023 and received clinical advice by arrangement with the local NHS trust palliative care team.

Nurse and allied health professional staffing

The service had enough nursing, allied healthcare professional and support staff to keep patients safe. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough nursing, allied healthcare professional and support staff to keep patients safe. An advanced nurse practitioner supported medical staff as a non-medical prescriber (NMP).

The managers used an acuity tool to calculate requirements and adjusted staffing levels daily according to the needs of patients.

The service had low vacancy and turnover rates.

Medical staffing

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

There were 4 specialist GP doctors who provided on- site medical cover between 9am and 5pm Monday to Friday (not including bank holidays).

A senior specialist doctor fulfilled part of the medical director role as interim since March 2023, while the provider continued actively recruiting to the medical director post.

Staff had access to out of hours medical advice and/or support via an on- call telephone advice rota for palliative medicine doctors based at the local NHS trust.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, and stored securely.

Patient notes were comprehensive, and all staff could access them.

Paper and electronic records were stored securely in accordance with the provider's policies. Electronic records were accessed by a secure smart card system.

After death, patient paper records were archived off site prior to secure destruction in accordance with policy.

Medicines

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

Staff accessed the medicines management policy on the intranet.

Staff we spoke with described the action to take when reporting a medication error.

There was a substantive pharmacist appointed to the hospice Monday to Friday 9am to 5pm and out of hours advice was available.

The pharmacist conducted periodic audits of medicines management compliance against policy. For example, controlled medicines and Hospice UK medicines audits were completed quarterly, and medicines charts were audited weekly to monitor prescribing practice. The pharmacist discussed any non-compliance directly with practitioners and they described an example of how medicines safety had improved following audit activity. Learning from pharmacy audits was shared during weekly multidisciplinary team meetings.

Controlled drugs balance checks were completed weekly in the register.

Patients had paper prescription charts for medicines that needed to be administered during their admission. We reviewed 5 prescription charts and found staff had completed them correctly.

Staff reviewed (reconciled) each patient's medicines on admission and recorded this on the electronic patient record. Staff provided advice to patients and carers about their medicines.

Patients assessed and documented as having mental capacity were enabled to self-medicate and medicines were stored in secure cabinets in the bedrooms.

Staff monitored and recorded medicines fridge temperatures and knew to act if there was variation.

Medical gases were piped to each bed. Cylinder gases were stored in the dirty utility room and were chained/secured, and hazard notices were displayed. All cylinders we checked were in date.

Incidents

The service managed patient safety incidents well. Staff recognised and reported most incidents and near misses. Managers investigated incidents and shared lessons learned with the team. When things went wrong, staff apologised and gave patients honest information and suitable support.

The provider had an electronic incident reporting system.

Staff we spoke with knew how to report incidents. Information provided by the service showed for the reporting period April 2022 – March 2023, there were 147 incidents reported and 2 near misses. Incident reports we reviewed were completed comprehensively.

However, we were not assured staff always reported all incidents in accordance with the service's policy. For example, they did not routinely report when the cold room temperatures were outside the required range, which was a persistent issue.

Managers investigated incidents thoroughly. Managers we spoke with discussed a recent incident and described how they conducted a thorough review. Although they established there was no patient harm, changes were implemented to strengthen procedures and reduce risk of repeated incidents.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Requires Improvement

Hospice services for adults

Is the service effective?

Good

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Care pathways were incorporated into the electronic patient record system and included templates which closely followed ReSPECT documentation. The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs.

Meals were prepared in house, and we saw menus with broad options of meal choices and foods with modified textures were available. Kitchen staff were aware of patient's dietary needs and any food intolerances.

We saw patients had water provided within reach and staff offered drinks to patients and their visitors throughout the day. There was a beverage bay for families and carers to use as required.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists was available from the local NHS trust for patients who needed it.

Pain relief

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

We observed pain management was discussed for all patients at daily handover meetings.

Patients were asked how their pain levels were, following administration of analgesia and recorded the information as part of the integrated palliative outcome scale (IPOS) scoring system. Patients we spoke with told us they received pain relief soon after requesting it.

Staff prescribed, administered, and recorded pain relief accurately.

Pain management audits were completed by the pharmacist and recorded electronically.

Patient outcomes

Staff mostly monitored the effectiveness of care and treatment. They used the findings of some audits to make improvements.

Managers we spoke with told us the service participated in some national clinical audits. For example, Hospice UK toolkit audits. The service also had an annual schedule of clinical audits.

We requested evidence of the most recent audits and action plans undertaken at local and national level. The tracker document we received showed most scheduled audits were completed until September 2023. However, the provider's risk register (updated October 2023) confirmed (risk C08) that audits were not completed due to the governance and compliance manager vacancy and lack of senior leadership team capacity. This was also confirmed by senior managers we spoke with.

Although the inpatient unit continued to collect some outcome data, for example, Karnofsky score and Individual Performance Outcome Score, used to compare effectiveness and assess the prognosis in individual patients, managers explained this data was not collated, due to lack of capacity and capability to complete data analysis. However, they also confirmed a governance lead was newly appointed and scheduled audit activities would resume as a matter of priority.

We saw, managers and staff used some audit results to improve patients' outcomes. For example, a thematic falls review was undertaken to improve patient safety and reduce avoidable falls incidents, by improving falls prevention awareness, falls risk assessment process and falls prevention care planning.

Competent staff

The service did not always ensure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The provider had a recruitment and selection policy. This stated human resources staff were responsible for ensuring robust monitoring mechanisms and for conducting audits to monitor compliance against the policy and procedure. However, managers we spoke with explained staff personnel files were not routinely audited and they were moving to an electronic system which would facilitate audit. Seven staff files we looked at were not easy to navigate because documents were not all filed in a consistent way. However, we found all safer recruitment checks were complete.

The provider had a formal induction programme for new nursing staff, which was included on the provider's mandatory training matrix. New staff we spoke with had partially completed their induction programme and were supported by a named colleague.

However, the training matrix showed only 46 of 123 (37%) staff were recorded as having completed all modules of their induction. In addition, medical staff we spoke with confirmed there was no formalised induction for medical staff, although this was 'work in progress'. This meant there was a risk some staff may not be fully prepared for their role.

Managers supported staff to develop through yearly, constructive appraisals of their work. Completion was documented on a tracker and appraisal rate compliance for all clinical staff was 91% against the provider's 90% target.

Managers supported nursing staff to develop through clinical supervision of their work. However, the provider recognised staff uptake was not in accordance with the providers clinical supervision policy and put plans in place to improve compliance.

Managers supported medical staff to develop through constructive clinical supervision of their work. For example, doctors we spoke with told us they participated in peer reviews and attended medical complex patient meetings to discuss and share best practise. Doctors' performance and conduct were overseen by a named Responsible Officer based at the local NHS trust.

The pharmacist received clinical supervision from the head pharmacist of the commissioned pharmacy provider and nursing non-medical prescribers, were supervised by a senior hospice doctor.

The clinical educator supported the learning and development needs of staff.

Managers recruited, and supported volunteers to support patients in the service. For example, reception staff and drivers.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary (MDT) meetings to discuss patients and improve their care. For example, we observed a daily handover meeting where needs of patients and their families were discussed, and ongoing care was planned. This was attended by medical staff, nursing staff, allied health professionals (social worker, occupational therapist, and physiotherapist), pharmacist, and chaplaincy.

We saw that MDT discussions included symptom control, safeguarding, escalation plans, falls risk, nutritional risk, skin risk, and do not attempt cardiopulmonary resuscitation (DNACPR) choices. Discussion also covered approaches to family inclusion and patient involvement. We observed that symptom control discussions included patient feedback.

Staff were developed into link practitioner roles which aimed to maintain an overview of specific aspects of clinical practice, and ensure it was evidence based. Staff worked with other agencies when required to care for patients and sought information from national organisations such as Hospice UK.

Social work staff provided support and advice to patients and those close to them. This included (but was not limited to) advice and support in writing wills, obtaining benefits, and organising applications for power of attorney.

Seven-day services

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

Requires Improvement

Hospice services for adults

Senior doctors led daily ward rounds Monday to Friday. At weekends and out of hours, there was remote support available from the local trust palliative care team via an on-call rota. Hospice doctors also completed on-call duties and additionally, supported on a 'good will' basis, if nursing staff required support quickly.

Living Well Centre services were operational on weekdays.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support. For example, there was a sporting memories group where people had the opportunity to engage in sport related discussions and activities safely. There was a strength and balance group, which included exercises and education for those who had a period in hospital, a recent fall or felt they were losing strength and mobility. We also saw information about practical fatigue management.

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff accessed the deprivation of liberty safeguarding policy via the intranet.

The training matrix showed only 68% of staff had completed mental capacity act and deprivation of liberty safeguards mandatory training, against the provider's 90% target.

However, staff we spoke with understood how and when to assess whether a patient had the capacity to make decisions about their care and knew who to contact for advice. Staff made sure patients consented to treatment based on all the information available and clearly recorded their decision. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

Staff we spoke with described the best interest decision making processes and how they would be applied. DNACPR forms we reviewed in patient records were up to date, fully completed and stored securely.

Is the service caring?

Good

Our rating of caring went down. We rated it as good.

Compassionate care

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

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

Patients we spoke with said staff treated them well and with kindness.

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

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. For example, the family support team in conjunction with inpatient services team provided bereavement services, including anticipatory grief support, links to faith and spiritual organisations and future planning support.

We found that it was not unusual for family pets to visit or for a therapy dog to come to the hospice for patients to spend time with. Patients had access to complementary therapies and staff helped them develop effective self-help techniques to manage symptoms such as breathlessness and anxiety.

Staff demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them.

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 made sure patients and those close to them understood their care and treatment. Patients and those close to them were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person. Staff empowered patients to have a voice about their care and treatment and to realise their potential by encouraging small daily achievements.

Staff talked with patients, families, and carers in a way they could understand. We observed the admission process to the inpatient unit and saw how family members were involved in the admission and assessment process. We saw electronic care records stated that both medical and nursing staff had spoken with families regarding changes in care needs and clinical needs.

Staff supported patients to make advanced decisions and informed decisions about their care.

Requires Improvement

Hospice services for adults

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. For example, we saw a "you said, we did" comments and suggestions box in reception and via electronic links on the hospice website.

Patients gave positive feedback about the service. For example, we saw compliment cards from patients and families identifying their positive experience of care provided to patients and significant others.

Is the service responsive?

Good

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service was part of the County Durham palliative and end of life care group which was in place to ensure that end of life care for the local populations was personalised and well-co-ordinated, enabling real choice for individuals.

Managers planned and organised services, so they met the needs of the local population.

Facilities and premises were appropriate for the services being delivered.

The service had systems to help care for patients in need of additional support or specialist intervention. For example, complementary therapies, and psychological support.

The Practice Development nurse and Registered Manager monitored the local demographic and engaged with the Queens Nursing Institute (QNI) professional community to explore how the hospice could work with others in supporting the end of life needs for hard-to-reach communities, such as the homeless, Roma, traveller, and gypsy communities.

In addition, the hospice had procedures in place to support the transition of the care of patients from Northeast prisons cluster to the hospice setting.

The hospice was developing social and educational groups to support people living with dementia, carer support and bereavement all within the local community.

Meeting people's individual needs

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

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Compliance with mandatory learning disability and autism training was 85.5% against a target of 90%. Dementia awareness level 1 was delivered at induction and 94% of staff had completed this. However, the compliance rate for level 2 training was 65% against a target of 90%.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. For example, there was a hearing loop system installed.

The hospice had a multifaith room and patients had access to multifaith chaplaincy services through the family support team. A volunteer chaplain visited once a week.

The hospice permitted patient's pets by arrangement, and a therapy dog visited regularly.

The service had information leaflets available in languages spoken by the patients and local community. For example, we saw leaflets with an accessible information statement, informing that they were available in large print, audio format, and in the service user's own language or any other format, upon request.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Patient's spiritual needs were explored during the admission process and during their stay and were recorded electronically (on the initial assessment document) and on the daily handover forms.

The service had clear visiting arrangements which were in accordance with patient's physical and emotional needs.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes.

The hospice accepted referrals from anyone who lived within County Durham council area. Referrals for in-patient care from other areas were considered if the patient specifically requested to come to the hospice, for example, if their family lived within County Durham, and were able to register with a local GP.

Referrals were received online by secure email and by telephone from health care professionals including GP's, district nurses, Macmillan nurses or clinical specialists.

Referrals for admission were discussed at the weekday daily handover meeting at 9am. In the case of obvious or urgent need, discussions took place outside of the morning team meeting in an MDT discussion involving a senior nurse and doctor. Staff told us they reviewed admissions on an individual basis. Following our inspection, the provider revised their admission criteria to include clear ceilings of care and reduce the risk of inappropriate admissions.

Requires Improvement

Hospice services for adults

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

The service recorded the patient's preferred place of death and accommodated this as far as possible. For example, a fast-track process was implemented to enable patients to be discharged home quickly with appropriate support.

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, relatives, and carers knew how to provide feedback, complain, or raise concerns and the service clearly displayed information about how to raise a concern in patient areas. For example, including at reception and within the in-room brochure.

They could submit complaints and feedback in different ways. For example, via social media platforms, via the hospice website, by post, via cards in a suggestions box and in person.

Friends and family test data we reviewed for the period April to September 2023, showed high satisfaction scores, although numbers of questionnaires returned were low compared with service user numbers.

Staff understood the policy on complaints and knew how to handle them. We reviewed 3 complaint responses and found the concerns raised were thoroughly investigated. Service users and families were involved in investigation, responses from the provider were timely, and final response letters were written sensitively.

Is the service well-led?

Requires Improvement

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

Leadership

Leaders had the skills and abilities to run the service. However, they did not always understand and manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The provider met the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors are fit and proper to carry out this important role.

The hospice was overseen by a board of trustees led by a chairperson. Trustees were encouraged and expected to provide appropriate challenge when it was needed. We saw trustees brought a diverse range of skills due to their different cultural and professional backgrounds. The senior management team reported to the board of trustees through regular board meetings.

Requires Improvement

Hospice services for adults

The hospice was led by a senior management team. This comprised of the Chief Executive, Head of Clinical Services/ Deputy Chief Executive (CQC Registered Manager), Head of Enabling Services and the Head of Income Generation.

However, leaders we spoke with had not identified, prioritised and managed all risks, including for example, risks associated with lack of staff competency training, lack of suitable and sufficient cold room facilities and lack of effective governance processes throughout the service.

The Consultant/Medical Director position was vacant since June 2023. However, the local NHS trust supported the hospice and provided an interim senior specialist palliative care doctor to undertake aspects of the Medical Director role.

The Head of Enabling Services was the lead for corporate governance. They were supported by a newly appointed Governance Manager.

Vision and Strategy

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

The provider had a formal operational plan 2022-27, which showed how the hospice's mission, vision and strategic goals would be met. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership. Senior managers monitored progress against the vision and strategic plan. For example, finance, performance, and customer experience were regularly discussed.

Vision and values were also published in the patient in-room information brochure and in the annual quality account. The values of the service were respect, professionalism, choice, integrity, reputation, and compassion. We saw staff display these values during our inspection.

Culture

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

All staff we spoke with said they enjoyed coming to work and felt they had good relationships and worked well as a team.

Staff mandatory training included equality, diversity, and human rights training. The provider's target was almost met, with 88.6% of staff compliant with training.

There was an employee assistance programme which supported staff and promoted a healthy, safe, and caring environment.

Staff we spoke with described an open culture and told us they felt their opinions mattered to managers. They said they were confident to raise any concern with their managers.

A former trustee was the provider's freedom to speak up guardian. They reported themes and trends to the clinical governance sub-committee and the board of trustees.

Patients we spoke with told us they felt confident and comfortable to raise any concerns with staff.

Staff we spoke with told us managers recognised their work and commitment to the business.

Governance

Leaders did not always operate effective governance processes. Staff at all levels were not always clear about their roles and accountabilities.

There was a corporate governance policy and framework which described governance arrangements, roles, and responsibilities.

Governance meetings held quarterly, incorporated papers and discussions from link practitioners and sub-committee groups such as IPC. Meetings followed a fixed agenda and were minuted. Clinical governance decisions were overseen by the clinical governance sub-committee, held quarterly, and chaired by an experienced trustee.

The provider also held quarterly meetings with the board and used a structured agenda.

Managers monitored clinical and non-clinical policy review dates, and the majority were up to date.

The provider had an annual schedule of audits with a colour coded tracker to indicate audits completed. The most recent audit tracker showed most scheduled audits were completed up to September 2023. The risk register (updated October 2023) confirmed (risk C08) that audits were not completed due to the governance and compliance manager vacancy and lack of senior leadership team capacity. This was also confirmed by senior managers we spoke with.

Commissioners of the hospice's services met with the provider quarterly to discuss contracts and quality. An assurance visit was conducted in August 2023. There were no immediate patient safety concerns identified. However, challenges identified included the impact of the Medical Director/Palliative Care Consultant leaving in June 2023, on both medical cover and the senior management team and governance at the hospice.

The provider had formal service level agreements with the local NHS trust, for services including NHS email, occupational health, Responsible Officer, pharmacy and provision of blood products.

However, we found no service level agreements in place to formalise arrangements for provision of key services such as dietician, speech and language therapy, microbiology and IPC advice, which were also provided by the local NHS trust. This meant there was a risk services may be withdrawn or may not be provided when required.

We brought this to the attention of senior managers at the time. Following our inspection, the provider sent us a draft service level agreement document, to be ratified and signed by the local trust. This was for services already provided informally on a 'good will' basis and included the provision of medical cover, Medical Director cover, out of hours cover and pathology and microbiology support.

In addition, the statement of purpose which described the services of the provider, was out of date and required review. We brought this to the attention of managers at the time and following our inspection, the provider submitted a revised statement of purpose.

Requires Improvement

Hospice services for adults

Management of risk, issues, and performance

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

The provider had a risk management policy, which described roles and responsibilities.

The safeguard incident and risk management (SIRMs) system was used for complaints management, incident reporting and risk. However, it was not always used effectively. For example, we saw no reporting of near miss incidents such as when cold room temperatures exceeded the required range. This had been an issue for many months but senior leaders we spoke with told us they were unaware it was a persistent problem.

There was a corporate risk register in place. The service escalated only high (red) risks to the board.

However, during our inspection, we identified areas of significant risk that were not on the risk register. For example, lack of formal service level agreements for some key services provided by third parties, lack of risk assessments regarding potential risks of one-to-one interactions between volunteers without DBS evidence, lack of competency training for staff managing patients with complex needs, and lack of clear ceilings of care.

This meant we were not assured all identified risks affecting the service in line with policy, were always escalated to the risk register.

The provider had a business continuity plan with actions for managers to refer to.

Information Management

The service collected limited data and did not always have capacity to analyse it. Staff could not always find the data they needed because the information systems were not always reliable.

Compliance with data security awareness training was 84% against the target of 90%.

The service did not always have capacity to review themes and trends from audits and follow up of action plans. For example, record keeping audits were not always completed consistently and in accordance with the provider's policy. We saw day services audited 4 sets of records in August 2023 and only 1 set was fully compliant. Although there was an action plan in place and a date for re-audit by end September 2023, there was no evidence to show this was done. The Living Well Centre had an action plan for records dated January / February 2023 but no evidence of re-audit to monitor effectiveness of actions. No data was provided to demonstrate records audits were completed by the inpatient unit.

The provider was aware, and the risk register confirmed scheduled audits were not completed due to the governance and compliance manager vacancy and lack of senior leadership team capacity. Senior leaders we spoke with told us the appointment of Head of Enabling Services was intended to improve audit compliance. However, it was recognised they required additional support and the provider had recently appointed a governance lead.

Information technology (IT) was identified by managers we spoke to as a top risk. Staff we spoke with also shared concerns that the electronic patient record and telephony, linked to the main computer system, were unreliable. For example, inbound calls often did not connect, or the caller was lost while waiting to be connected.

This concurred with the provider's operational plan 2022-27, which identified computers on the inpatient unit as ''a constant source of frustration and workplace stress for all staff''.

The report described persistent issues such as slowness of the computers, staff not being able to log on to the electronic patient record for hours at a time and the internet signal often dropped out, meaning staff lost what they were recording and had to start again. In addition, the issues with the IT system impacted negatively on technology reliant tasks such as compliance with mandatory eLearning completion.

Managers we spoke with shared concerns that provision of NHS email accounts for new staff was not always timely. This meant some administration staff were unable to undertake some aspects of their job, such as sending correspondence out to referrers, and were reliant on colleagues to do this for them.

We saw clinical governance sub-committee minutes February 2023 showed the IT risk score on the risk register was recorded as red (32) in September 2022. The board agreed in June 2023 to appoint an external IT consultant to review the IT provision. However, we did not see any firm plans or timescales for when this work would be completed.

Engagement

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

Managers carried out periodic staff surveys, which staff completed anonymously via an online platform. In the most recent survey, 61 responses were received, which equated to 61%. The provider developed an action plan and gave specific examples of changes made in response to staff feedback.

The Chief Executive provided a weekly summary of news and events at the hospice, which was posted on the intranet and e-mailed to all staff.

Staff and service users were encouraged to contribute ideas to make service improvements. For example, in the day centre we saw a mood board for feedback regarding proposed décor.

A monthly 'Hospice Happenings' newsletter was sent to all staff and volunteers and staff were asked to contribute articles.

The provider was proactive in improving staff health and wellbeing. For example, health advocates met up every month to discuss progress and plan events. A hospice employee was awarded Health Advocate of the Year 2022 in the northeast Better Health at Work Awards.

The provider also involved volunteers in their recruitment process, where the role had an element of working with volunteers in it. For example, a volunteer gardener was involved in the interviews for the grounds and maintenance co-ordinator role.

Learning, continuous improvement and innovation

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

The service employed a clinical educator and there was a dedicated education suite on site.

Requires Improvement

Hospice services for adults

The hospice supported students on placement from the local university.

Managers supported staff with specialist training. For example, non-medical prescribing training.

The hospice was referenced for its implementation of the gold standard Carer Support Needs Assessment Tool (CSNAT) in the new publication Palliative Care Mandate for Integrated Care Boards (ICB). This enabled tailored support for carers.

Managers promoted day services to encourage referrals. For example, they developed a cognitive stimulation therapy pathway, which integrated primary care networks and enabled improved quality of life for people living with dementia.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose • The provider did not ensure their statement of purpose is up to date and accurately reflects registered manager details and regulated services provided. **(Regulation 12(3), (Registration) Regulations 2009).**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service did not ensure all premises and equipment, including but not limited to, the cold room, are safe, clean, and properly maintained, and that this is recorded appropriately. **(Regulation 12(1)(2)(d)(e)(h))** • The service did not ensure that staff providing care and treatment have the training, qualifications, competence, skills, and experience, to do so safely. This includes but is not limited to, mandatory training, management of deteriorating patients, safeguarding and management of patients with medical devices. **(Regulation 12 (1)(2)(c))** • The provider did not have clearly defined exclusion criteria and clear ceilings of care, to ensure only appropriate patients are admitted to the hospice. **(Regulation 12(2)(a))**

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

- The provider did not ensure disclosure and barring checks for volunteers are completed in accordance with the provider's policy. They they must be updated regularly and a comprehensive record of when to update these checks must be held. **(Regulation 17 (1)(2)(b))**
- The provider did not have suitable and sufficient risk assessments in place to evidence how actual and potential risks, are mitigated, as far as reasonably practicable. This includes, but is not limited to, risk assessments for management of volunteer staff, and cold room infection prevention and control risks. **(Regulation 17 (1)(2)(b)).**
- The provider did not have formal service level agreements with third party providers, including but not limited to, all services provided by the local NHS trust. **(Regulation 17 (2)(d))**
- The provider did not ensure all policies and procedures are relevant and specific to the services provided. **(Regulation 17(1))**
- The provider did not ensure staff have access to a policy to support the identification, management, and escalation of female genital mutilation. **(Regulation 17 (2)(b))**
- The provider did not implement effective systems and processes to ensure all nursing, medical and volunteer staff are compliant with all mandatory training, including but not limited to, safeguarding vulnerable adults and children, to a level appropriate for their role. **(Regulation 17(1)(2)(a)(b))**
- The provider did not maintain securely such other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity, including but not limited to, comprehensive induction records for all staff roles. **(Regulation 17 (2)(d))**
- The provider did not ensure all identified risks affecting the service in line with local policy are escalated to the risk register. **(Regulation 17(1)(2)(b))**

This section is primarily information for the provider

Requirement notices

- The service did not assess, monitor, and improve the quality and safety of the services provided in the carrying on of the regulated activities. **(Regulation 17(2)(a)).**