Darlington & District Hospice Movement

St Teresa'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	Good
Are services safe?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed 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.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. 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.

However:

- Venous thromboembolism risk assessments were not routinely carried out.
- Regular checks of syringe driver administration of medicines were not consistently carried out for one patient and there was no risk assessment undertaken relating to this.
- There was no process for checking patient own controlled drugs awaiting destruction.
- There was no clear protocol for when staff scored below 100% on the safety of medicines administration safety checks assessment processes.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good 	Our rating of this service stayed the same. We rated it as good. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to St Teresa's Hospice

St Teresa's Hospice is a hospice providing palliative and end of life care to adults with life limiting conditions. The hospice is situated in Darlington. The hospice has 10 inpatient beds, however at the time of the inspection they had 6 inpatient beds open. There were two patients being supported in the inpatient unit at the time of the inspection.

Facilities include an inpatient unit, a community rapid response service, hospice at home service, outpatient services and wellbeing and family support services. The head of workforce development was the registered manager.

The service is registered with the CQC to provide:

Treatment of disease, disorder and injury

How we carried out this inspection

We visited the hospice and spoke with staff delivering services. We held interviews with service leads. We spoke with 14 staff including the chief executive officer, the registered manager and head of workforce, inpatient unit manager, clinical lead nurse, clinical nurse specialist, human resources staff, learning and development leads, community services staff, facilities staff, chair of the board of trustees, registered nurses and healthcare assistants and administrative staff. We also spoke with one patient who was being supported by the service. We observed staff providing care and treatment and reviewed data about the service and reviewed seven patient care records.

We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed to seek assurance about this decision and to identify learning about the DMA process. This was a focused inspection of the safe and well-led key questions.

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 SHOULD take to improve:

- Service leads should continue with plans to adapt a venous thromboembolism risk assessment for use on the inpatient unit and ensure that assessments are completed on all patients.
- The service should ensure that checks of syringe drivers are carried out in line with the hospice policy.
- Ensure that patient own controlled drugs awaiting destruction have regular stock checks.
- Have a clear protocol for action when staff score below 100% on competency assessments around checking medicines administration.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospice services for adults	Good	Not inspected	Not inspected	Not inspected	Good	Good
Overall	Good	Not inspected	Not inspected	Not inspected	Good	Good

Good

Hospice services for adults

Safe	Good
Well-led	Good

Are Hospice services for adults safe?

Good

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. Training compliance ranged between 85% and 100% depending on subject areas. For example, some aspects of medicines competency and the use of medical devices were at 85% - 93%. All other modules were between 95% and 100%. This was against a target of 90%.

The mandatory training was comprehensive and met the needs of patients and staff. This included modules such as infection control, health and safety, fire safety, manual handling, pressure ulcers and the use of medical devices.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. All staff had completed autism and learning disability awareness training. Dementia friends training had been completed by 93% of staff at the time of the inspection.

Managers monitored mandatory training and alerted staff when they needed to update their training. A compliance review was carried out monthly and action taken to address areas of training that fell below the expected level. This included line managers receiving emails to follow up individual staff. Staff were given time to complete their training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Training was completed at appropriate levels in line with national guidance. Patient facing staff completed adult safeguarding training at level two, with nursing managers and senior clinical staff completing level three training. The safeguarding lead was trained to level four. Compliance with safeguarding training was at 100%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The hospice had a safeguarding team that included the safeguarding lead, social worker, senior counsellor and a senior member of the nursing team. The team met regularly and reviewed safeguarding concerns, liaising with the local authority safeguarding teams as required.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was clear guidance for staff in raising concerns. We viewed posters in clinical areas instructing staff on making a referral. This included relevant contacts of safeguarding leads internally and externally. We noted that the internal contact for the social worker who had left their post a few days prior to the inspection had not been updated. Senior staff confirmed this had been addressed following the inspection.

Staff followed safe procedures for children visiting the ward.

Cleanliness, infection control and hygiene

Staff used infection control measures when caring for patients.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. Cleaning schedules were in place and standards of cleaning and infection control management were regularly audited.

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

Staff followed infection control principles including the use of personal protective equipment (PPE). There was clear guidance in place for staff and visitors, including the ongoing use of face masks when in clinical areas. Handwashing facilities and hand sanitisers were available throughout the hospice. We observed staff using PPE appropriately and washing their hands when working on the inpatient unit.

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

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.

Patients could reach call bells and staff responded quickly when called. We observed staff responding quickly to patient's requests for support.

The design of the environment followed national guidance. Patients were cared for in individual rooms with en-suite facilities. There was clear guidance for visitors entering the inpatient unit in relation to Covid-19 requirements to wear face masks and wash hands.

Staff carried out daily safety checks of specialist equipment, including equipment for use in emergencies. Clinical equipment was calibrated and subject to maintenance in line with manufacturer recommendations. Staff monitored equipment while in use, including checks of syringe driver pumps (for continuous administration of medicines) to ensure they were working properly. However, on the day of inspection we saw gaps in monitoring records on the inpatient unit where not all checks were carried out every four hours in line with the hospice policy. Following the inspection, we were told that one patient had requested they were not disturbed during the night, so a decision was taken not to check their pump at this time. However, there was no risk assessment carried out relating to this.

The service had suitable facilities to meet the needs of patients' families. This included facilities for refreshments and quiet space for reflection and to have private conversations.

The service had enough suitable equipment to help them to safely care for patients. Staff told us they had access to equipment that they needed.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

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

Staff completed risk assessments for each patient on admission to the service, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments were comprehensive and were used to inform care planning for patients on an individual basis. Examples included assessing the risk of falls, pressure ulcers, mobility and nutrition.

Staff knew about and dealt with any specific risk issues. They had a sepsis screening tool and followed a recognised process for identifying and treating sepsis. The electronic patient record had a venous thromboembolism (VTE) risk assessment built in, which would normally be used to assess the risk of developing blood clots in patients. However, this was not being used at the time of our inspection. Following feedback to the provider about this, they consulted with colleagues, including their local palliative care consultant. As a result, they were in the process of developing their own VTE screening tool that was specific to assessing risk in patients with palliative care needs or at the end of life.

The service had 24-hour access to mental health liaison and specialist mental health support through the local NHS trust if staff were concerned about a patient's mental health.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. We observed a handover on the inpatient unit and saw that this included personalised information being shared, based on the needs of the individual patients.

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. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction.

The service had enough nursing and support staff to keep patients safe. At a senior level, the hospice had been unable to recruit to a vacant nurse consultant post in recent months. However, they had a palliative care clinical nurse specialist who provided support to the inpatient unit, including admitting patients and prescribing.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. They had a patient dependency tool which they used to identify staffing numbers based on the needs of the patients on the inpatient unit at any one time. At the time of the inspection occupancy levels on the inpatient unit were low and there were two patients being cared for. We reviewed staffing rotas and saw that there were two registered nurses and two healthcare assistants on during the day. At night there was one registered nurse and one healthcare assistant working. In addition, there was a registered nurse and a healthcare assistant providing 24 hour cover for the rapid response service who would also provide support to the inpatient unit as needed.

The managers could adjust staffing levels daily according to the needs of patients. Staff worked flexibly to cover shifts and the hospice had their own team of bank staff to provide cover, including some at short notice. The number of nurses and healthcare assistants matched the planned numbers.

The service had a vacancy rate of 10% at the end of June 2022. They did not used agency staff and provided cover internally. Managers made sure all bank staff had a full induction and understood the service.

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. As St Teresa's hospice was a nurse led service, day to day medical care was provided by the patient's own GP if they were local. If patients did not live locally, they were provided with a local GP for the duration of their admission. In addition, the hospice had a clinical nurse specialist who was also a prescriber. There was a palliative care ward round held weekly where a specialist palliative care consultant from the local NHS trust visited the hospice and reviewed patients. They also provided prescribing and clinical supervision support to the nurse prescriber/clinical nurse specialist. In addition, consultant cover was available by phone at other times when advice was required.

The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all relevant staff could access them easily. An electronic patient record system was in use and staff access was password protected and secure. The electronic system was compatible with some other primary services within the locality and therefore accessible to other staff involved in the patient's care with appropriate permissions and consent.

Records were stored securely.

Medicines

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

Staff followed systems and processes when prescribing, administering, recording and storing medicines. Patients' allergy status was documented.

Administration of medicines was accurately recorded, and if a patient missed a dose the reason was documented on their chart. However, one patient's syringe driver was not checked in line with policy on 14 out of 24 occasions to make sure it was working properly. A syringe driver is a small, battery-powered pump that delivers medication under the skin at a constant rate throughout the day and night.

Staff followed current national practice to check patients had the correct medicines, this was completed by the clinical specialist on admission to the hospice. There is a procedure and storage facilities to allow people to self-administer their medicines if they wished.

Discussions with patients to inform them about their medicines and consent to treatment was recorded in the electronic system used by the hospice. Patients' choices were listened to and respected. We also saw that patients' medicines were regularly reviewed.

Staff stored and managed medicines and prescribing documents safely and in line with the provider's policy. Controlled drugs were stored according to legal requirements. Staff checked stock balances of controlled drugs except for patients' own controlled drugs awaiting destruction. Following the inspection the hospice informed us they had implemented checks of patients' own controlled drugs awaiting destruction.

Medicines were kept at the right temperatures and the temperature of the clinic room and medicines fridge were appropriately monitored.

The hospice has a comprehensive range of SOPs (standard operating procedures) covering the management and use of medicines. Regular audits were conducted to ensure that SOPs were being followed.

Staff knew how to respond to palliative emergencies, but emergency medicines were not easily accessible. Naloxone (a medicine used to reverse the effects of opioids) and flumazenil (a medicine used to reverse the sedative effects of other drugs used in palliative care) were not stocked at the hospice. There was no written risk assessment for this decision at the time of our inspection, however, following the visit a risk assessment was completed, stating that naloxone and flumazenil were not kept as stock due to the hospice being a nurse led service where intravenous medicines were not administered. As a result, action in the event of this type of emergency was to make contact with the specialist palliative care medical team at the local NHS trust or to dial 999 in an emergency.

The hospice had a service level agreement with a national pharmacy company. The agreement included the supply and management of stock medicines, a fortnightly visit from a pharmacist and medicine audits. The service had an arrangement with a local community pharmacy to obtain medicines promptly if needed for individual patients. Medicines for patients cared for by the community team were prescribed by their own GP.

The service had systems to ensure staff knew about safety alerts and incidents, and any necessary action taken was recorded. Staff followed the service's process for reporting and learning from incidents.

An innovative approach to clinical staff training and competency checking was a Drugs Quiz which included dose calculations. Two staff had achieved a high score overall and passed their medicines competency assessment but scored less than 100% in the calculation questions. This was a risk as these two staff could be on duty and calculating drug doses together. The manager said that they would review how staff's medicine competency was assessed.

Bi-monthly medicines management meetings were held. The clinical risk register, medicine incidents and reports from the CDLIN (controlled drugs local intelligence network) were discussed at the July meeting.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff raised concerns and reported incidents and near misses in line with the service's policy. This included completing an incident form that was then logged and graded by the registered manager.

Good

Hospice services for adults

Staff reported serious incidents clearly and in line with the service's policy. This included reporting serious incidents to external agencies as appropriate.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff shared information with patients and their families and apologised as appropriate.

Staff received feedback from investigation of incidents, both internal and external to the service. They met to discuss the feedback and look at improvements to patient care. Meetings were held every other month to review and discuss incidents and near misses. We saw evidence of reflective statements completed by staff involved in incidents, highlighting areas for learning.

There was evidence that changes had been made as a result of feedback. For example, a near miss relating to medicines administration led to changes to the medicines quiz staff completed as part of their medicine's competency assessments.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. This included reviewing action taken, staff involvement and levels of harm as a result of the incident.

Managers maintained a log of relevant patient safety alerts and these were cascaded to relevant staff for action.

Data relating to falls, pressure ulcers and medicine incidents was submitted to Hospice UK as part of national benchmarking. Data showed the incidence of harm relating to these areas. For example, we saw that falls data showed no or low harm in all falls in 2021/2022.

Are Hospice services for adults well-led?

Good

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed 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.

Senior staff and managers had clear leadership roles. They demonstrated the skills, capacity and capability to deliver a sustainable service. The chief executive officer (CEO) worked across two local hospices, having been commissioned by St Teresa's to provide CEO services earlier in 2022.

Service leads understood the issues and challenges within the service and demonstrated a comprehensive understanding of the priorities for supporting patients within the local community. They worked collaboratively with partner organisations and professionals to deliver high-quality, patient centred services.

Staff told us that leaders were visible and approachable, and there was a clear focus on the needs of patients and the wellbeing of staff.

Staff had opportunities to develop their leadership skills, this included additional leadership training and taking on 'acting up' roles as part of their development. Leadership development was one of the hospice's strategic priorities.

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.

St Teresa's Hospice had clear strategic priorities that included the provision of sustainable services that met the needs of patients. They were in the process of reviewing the strategy and had a planned away day for the senior leadership team and trustees in October 2022. Work to date included a review of the mission and purpose of the hospice with 10 priorities that included reducing inequalities, sustainability, leadership development, workforce recruitment and retention and solving problems through meaningful cross sector collaboration and sharing.

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.

Staff told us they enjoyed working at the hospice and felt supported by management. They had a focus on promoting personalised care across services and reducing inequalities in access to palliative and end of life care.

Staff had completed equality and diversity training and they had an understanding of promoting equality within the work and care environments. Hospice leads had an understanding of the demographic of the local population and were taking action to encourage diversity within the hospice. This included training for staff in areas such as dementia, suicide awareness, awareness of the needs of the travelling communities, disability awareness and LGBTQ+ training.

Patients, those close to them and staff were encouraged to provide feedback on the services and what it was like to work at the hospice. We saw that action was taken to address concerns and most feedback was positive. The hospice had a whistleblowing policy and a freedom to speak up guardian so that staff had access to support outside of the line management structure should they wish to raise concerns.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective governance structures, processes and systems of accountability and a clear governance framework to support the delivery of the hospice strategy. The hospice senior leadership team were accountable to the board of trustees. Information was shared at board of trustee's meetings where chief executive officer and director reports were reviewed by trustees.

Members of the board of trustees committee also chaired specific sub committees. This included clinical governance, finance, fundraising and marketing, human resources and retail. We saw that issues around quality and risk were discussed at these meetings. Senior leadership team meetings were held where performance, quality and issues of safety were reviewed. These included incidents, audits, health and safety, operational matters, safeguarding and risks.

Policies were regularly reviewed, kept up to date and ratified by the board or sub committees as appropriate.

Staff were clear about their roles and accountabilities and who to report to. Staff were committed to improving the quality of service and maintaining high standards of care. They were involved in discussions about the performance and were encouraged to work collaboratively to develop the service.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There were clear processes for identifying and managing risks. Clinical and operational risk registers were maintained. Risks included those relating to staffing levels and we saw that action was planned to mitigate the risk. For example, an area of risk identified related to issues admitting patients when the clinical nurse specialist was on leave. Action to mitigate the risk included consulting with the NHS specialist palliative care team and GPs providing medical cover to ensure that admissions can go ahead with appropriate medical input. Health and safety risks were identified and mitigated with regular safety checks and relevant contract arrangements.

Performance was monitored by the senior leadership team. This included monitoring of ongoing risk areas such as falls, medicines, safeguarding and infection control. Information was used to monitor activities relating to incidents, performance indicators, activity levels, patient feedback, staffing and other areas. Staff used audit to measure performance and improvement in certain areas. This included audits of health and safety, consent, medicines and patient records. There was a process in place where audit results were used to agree improvement actions. We reviewed a selection of audits and saw that results were positive, for example, 96% compliance for an audit of inpatient and community patient records. Key performance indicators had been established and agreed with service commissioners. These included targets for areas such as advance care planning.

The service had a business continuity plan in the event of disruption of service.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Information and data were used as part of ongoing monitoring of the service. Performance reports were used to demonstrate the effectiveness of services and identify areas for improvement. There was reliable information and data used to support decision making.

Staff had up to date and comprehensive information about patient's treatment and care. They used an integrated patient record system that was accessible to other providers involved in their care who were using the same information system. There were clear and standardised information governance processes that ensured the security of patient information. Computers were encrypted and password protected, and we observed staff maintaining the confidentiality of patient records.

Managers understood their responsibilities to notify external organisations, including the Care Quality Commission of incidents that met the reporting threshold. Information was submitted to Hospice UK about incidents relating to falls, pressure ulcers and medicines incidents as part of national hospice benchmarking.

Engagement

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

Patients were encouraged to provide feedback on services and service leads actively engaged with patients and those close to them to share their experience and make suggestions. We viewed patient feedback reports and saw that this was consistently positive.

There were a range of forums and networks that the service participated in to ensure engagement with the local community. These included the local integrated care system, primary care networks and pathway development groups for palliative and end of life care. The chief executive was a member of the Hospice UK board of trustees and was involved nationally the Hospice UK innovation group and a national palliative and end of life care commissioning and sustainability group.

The service actively engaged staff in decision making. They carried out an annual staff survey. Results for 2021 saw improvement in engagement from 78% to 82%. Staff were satisfied with the support they received from managers, feeling valued and team working. Areas for improvement were identified and specific action planned, for example, in relation to improving staffing levels. Specific areas of action for improvement as a direct result of staff feedback included the implementation of a bicycle rack for safe storage for those staff cycling to work.

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 and participation in research.

The hospice used quality improvement methodology such as clinical audit and surveys to identify areas for action and improvement. We viewed reports and plans that demonstrated improvement action was taken. We also saw that incidents and complaints were reviewed and action taken to improve. Learning was shared to ensure that improvement was embedded in practice. This included monthly key messages where all learning points from audits, incidents and complaints were collated and shared with staff. We also reviewed minutes of staff meetings and saw that learning and improvement were regularly discussed.

The hospice produced an annual quality account. This provided progress updates against the previous years' quality priorities and set out the priorities for the current year. For example, we saw the hospice had been successful in expanding competency frameworks for staff to improve assessment processes using clinical audit. Improvement plans for the current year included the development of a service user consultation forum. In addition, we saw that the hospice was working on developing the specialist palliative care model to increase clinical nurse specialist and GP with a specialist interest input into the services. There was an aim for implementation of this by 2024.

Good

Hospice services for adults

Leaders encouraged innovation and service developments to meet the needs of patients in the local community. The hospice had developed a wellbeing hub where they offered services such as exercise, social activities, carers and bereavement support to people living with long term conditions or progressive illness. They worked collaboratively with other services that included the Alzheimer's Society and MS (Multiple Sclerosis) Society.

The hospice was in the process of opening a 7th bed for continuing care for patients who required non-specialist additional care and could not be cared for at home.

The hospice had developed a school support programme for child bereavement, providing training and support to staff working in schools to better support children affected by grief.