St Clare's Hospice

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Inspection report

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Date of inspection visit:
04 July 2016
05 July 2016

Date of publication:
16 September 2016

Ratings

Overall rating for this service	Requires Improvement	●

Is the service safe?	**Requires Improvement**	●
Is the service effective?	**Requires Improvement**	●
Is the service caring?	**Good**	●
Is the service responsive?	**Good**	●
Is the service well-led?	**Requires Improvement**	●

Summary of findings

Overall summary

This inspection took place on 4 and 5 July 2016 and was announced. We last inspected the service on 20 July 2013 and found the provider was meeting the regulations we inspected against.

St Clare's Hospice provides in–patient care for up to eight people with life limiting illnesses. At the time of our inspection eight people were staying at the hospice.

The hospice had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had breached the regulations relating to medicines management and good governance. We found people were not protected against the risks associated with medicines because appropriate arrangements were not in place to manage medicines. Although staff said they were well supported, we found no evidence of a structured approach to supporting staff. The provider did not have an agreed supervision and appraisal policy and procedure. Records we viewed were not always reflective of people's views about pain relief and their future care needs. Some important policies and procedures were overdue for review. You can see what action we told the provider to take at the back of the full version of the report.

People and a relative gave us positive feedback about their care. One person told us, "It's brilliant, I am definitely well cared for." Another person said, "This place is a life line." One relative said, "I can't fault it. It is the best place for [my relative]. It took a weight of our minds with [my relative] being in here. They are keeping [my relative] calm and relaxed."

People and a relative told us staff were kind and caring. One person commented, "Staff are lovely, just like one of the family." One relative said, "I can't fault the staff."

People told us the hospice was a safe place. One person said it was "definitely safe".

Staff had a good understanding of safeguarding and whistle blowing and knew how to report concerns. One staff member commented, "I think things would be fully investigated. There is an open environment. I wouldn't have any qualms, I would do it [raise concerns]."

There were sufficient staff on duty to meet people's needs. One person commented, "Oh yes, they come quickly. You don't wait very long, they are pretty prompt." Effective recruitment checks were in place to ensure new staff were suitable to work at the hospice.

Health and safety checks were carried out keep the hospice safe, including checks of the fire safety systems, water safety, gas safety and the environment. The provider had procedures in place to keep people safe in an emergency.

Incidents and accidents were logged and investigated. Action had been taken to prevent the situation happening again and to minimise the risk of future harm to people.

Staff received the training they needed to fulfil their respective roles in the hospice.

The provider acted in accordance with the Mental Capacity Act (MCA) 2005 including the Deprivation of Liberty Safeguards (DoLS). DoLS authorisations had been requested when people were deprived of their liberty. Staff had a good understanding of MCA and knew how to support people with decision making.

Staff supported people with their nutritional needs as required. One person said, "I am unable to eat, they are going to get a dietitian." Meals were supplied from the local health trust each day. The hospice has a supply of food so that people could be offered alternatives.

People's health care needs were met by the in-house medical team. This included consultants, a GP with special interest, an occupational therapist and a physiotherapist. One person said, "I saw the doctor yesterday."

Improvements had been within the hospice so that people living with dementia were cared for appropriately.

A holistic assessment had been completed for each person which detailed their needs and preferences. There were corresponding care plans which were generic in nature with little personalisation. There were no plans for people's future care needs or advanced care planning in the care records we viewed.

People had given very positive feedback about their care at the hospice. 85% of people completing a feedback questionnaire stated they would "extremely recommend" the hospice for the care of friends and family.

People's care and treatment was discussed in detail during the weekly multi-disciplinary team (MDT) meeting. The MDT included consultants, the hospice doctor, specialist nurses, an occupational therapist and a physiotherapist.

People were able to take part in activities if they chose to. One person told us, "We do silly things, have entertainers and play games." Another person described how the day centre allowed them to forget about their illness.

People knew how to complain but people we spoke with said they did not have any concerns about their care. One person said, "I would just tell them if I had concerns. I would just talk to them and ask them. They are easy to talk to." One complaint had been received which had been fully investigated.

Important areas of service delivery had lapsed, such as supervision, appraisal and key policies and procedures.

Staff did not have regular opportunities to meet as a team to share their views with colleagues. The registered manager told us regular updates were issued to staff but the last one we saw was dated September 2015.

Quality assurance was inconsistent and did not address all areas of the service, such as medicines management. Some audits had identified areas but these required improvements were not always apparent. For instance, improving the quality of the recording of people's pain levels in care records. The provider had already identified the quality assurance process needed improving and was working on plans to develop this area.

Risk management was not always effective as measures to control risks not always carried out. For example, we found issues with controlled drugs during our inspection which the provider had not identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

Medicines were not managed properly.

People said the hospice was safe.

Staff showed a good understanding of safeguarding and whistle blowing, including how to report concerns.

There were enough staff to meet people's needs. Effective recruitment checks were in place.

The provider had procedures to keep people safe in an emergency situation.

Is the service effective?

Requires Improvement ●

The service was not always effective.

The provider lacked a formalised approach to supporting staff employed at the hospice. Staff training was up to date.

The provider was following the requirements of the Mental Capacity Act (MCA) 2005.

People were supported to meet their nutritional requirements.

People had access to medical assistance at all times.

Is the service caring?

Good ●

The service was caring.

People said they had been well cared for at the hospice.

People told us staff were caring and treated them with kindness and respect.

People were supported with their physical, emotional and spiritual wellbeing.

People were in control and involved in all decisions about their care and treatment.

Is the service responsive?

Good ●

The service was responsive.

Care plans were in place but were not always personalised.

People's needs had been fully assessed.

People's future care needs and preferences were discussed.

People knew how to complain and none of the people we spoke with raised any concerns with us.

Is the service well-led?

Requires Improvement ●

The service was not always well led.

Some policies and procedures were not up to date and records did not always reflect people's needs and preferences.

The quality assurance process was inconsistent and did not cover all clinical areas.

The hospice had a registered manager.

Structured opportunities for staff to share their views with colleagues were limited.

St Clare's Hospice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 4 and 5 July 2016 and was announced.

The provider was given 24 hours' notice so as not to disrupt the day to day running of the service and to enable nursing staff, who were caring for very unwell people, to be available to speak with us.

On the first day of this inspection there was one inspector, a pharmacist inspector and a specialist advisor with experience of palliative care. On the second day of this inspection there was one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we reviewed the information in the PIR as well as all the information we held about the service, this included notifications of significant changes or events.

Prior to the inspection we contacted external health care professionals and commissioners of the service from the Clinical Commissioning Group (CCG) by email. We did not receive a response from this contact.

During our inspection we spoke with two people and one relative.

We also spoke with a range of staff including the registered manager, the lead nurse, a staff nurse and two health care assistants.

We reviewed a range of records including three care plans and people's medicine records. We also reviewed staff files, including staff recruitment, training and appraisal records, records relating to the management of the hospice, quality assurance checks and a range of policies and procedures.

Requires Improvement ●

Is the service safe?

Our findings

We looked at how medicines were handled on the ward and saw appropriate arrangements were in place for checking and confirming people's medicines on first admission to the hospice. When people were discharged we saw that detailed information about their current medicines, including changes made during their stay in the hospice, was given to the person. This would ensure that up to date information about people's medication would be available to a person's GP if required.

We saw that a lockable cabinet was located in each room for the secure storage of medicines. We were told by staff that no one was managing their own medicines and people were not routinely asked if they wanted to manage their own medicines on admission to the hospice. When we looked at the medication records we saw one person was managing their own inhalers. There was no risk assessment in place to make sure this was safe and appropriate as detailed in the hospice self- medication policy.

Appropriate arrangements were in place for the recording of medicines. Medicines were prescribed by the in-house medical team. The medication records we checked showed people received their medicines as prescribed. For a medicine that is administered as a patch, a system was in place for recording the application, location and removal of the patch.

The provider had systems in place to ensure people's medicines were safe and fit for purpose; these were not always effective. We looked in the medicine lockers for two people in the hospice. For both people we saw, and were told, that staff were administering medicines which were brought into the hospice having been dispensed by community pharmacies for different people. We also saw that one of these medicines was over three months old and this was contrary to the hospice medicine policy. Two liquid medicines did not have a date of opening noted, so could still be in use after the date recommended by the manufacturer. This meant that staff could not be sure this medicine was safe to administer.

Medicines were being kept securely and only accessible to staff authorised to handle medicines. We saw that the temperature of the medicines refrigerator was regularly monitored although the temperature of the treatment room itself was not recorded.

The arrangements for storing and recording controlled drugs needed to be reviewed and strengthened to comply with schedule 2 of the Misuse of Drugs (Safe Custody) Regulations 1973. We saw that two stock medicines were stored securely in the controlled drugs cupboard however the appropriate records were not kept. We also saw twelve controlled drugs which had been ordered as discharge prescriptions for five people were stored in the controlled drugs cupboard. These had not been given to the individual people because the medicines had changed or were no longer needed. There was no record kept by the provider of these medicines and destruction or return had not been made in a timely manner. Patches for one person had been stored without a record made since April 2015. Nurses completed weekly audits of controlled drugs but these had not identified or addressed the issues we found. Records of the receipt and use of controlled drugs are necessary to help identify any loss or discrepancies promptly.

Medicine errors were recorded on a monitoring system. Good records were kept of the actual incident; however we could not see evidence of the actions put in place to prevent them from re-occurring. The provider had produced a 'self- assessment medication workbook' in October 2014 which included a reflection of incident document. The registered manager told us that only two out of the current eleven staff nurses had completed the workbook and we saw the incident document had not been used after a significant event in October 2015. All the staff members we spoke with were aware of how to report any medicines incidents. Staff told us they received training in medicines management and also specialist equipment such as syringe drivers. However their competency for administering medicines was not assessed annually as detailed in the provider's policy.

Prescription pads were stored securely but there was no system in place to monitor their use. The registered manager was informed of this on the day of inspection and they agreed to implement a monitoring form in line with national guidance. The leadership team should monitor this new process to ensure it becomes embedded in practice.

Emergency medicines were easily accessible to staff and all staff knew of their location. These medicines were found to be in date and suitable for use.

The registered manager told us that all of the policies and procedures for medicines management were out of date and currently under review.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the hospice was a safe place to be. One person said, "Staff come straight away when I need help. So many different staff pop in to talk to me, the chaplain, helpers and nurses." Another person told us they were "definitely safe". Staff also felt the hospice was a safe environment. One staff member commented, "It is a very safe place. We specialise in end of life care."

Staff showed a good understanding of safeguarding, including how to report concerns. They were able to give us examples of various types of abuse and the potential warning signs to look out for. Six safeguarding concerns identified during 2016 had been dealt with in line with the agreed procedures. Appropriate referrals had been made to the local authority safeguarding team and the Care Quality Commission as required.

Staff demonstrated a commitment to keeping people safe and knew how to raise concerns through the provider's whistle blowing procedure. Staff told us they had not needed to use the whistle blowing procedure but would not hesitate to do so if required. One staff member commented, "I think things would be fully investigated. There is an open environment. I wouldn't have any qualms, I would do it [raise concerns]." Another staff member told us, "I would report it [any concerns] straight to the manager. I think they would be dealt with very professionally, very open."

The provider carried out assessments when required to help protect people from potential risks. For example, in the care records we viewed we found assessments relating to skin damage, poor nutrition and falls. These had been completed appropriately and identified the measures in place to keep people safe. A moving and handling assessment had been competed for each person, which detailed the support people needed with mobility.

Sufficient staff were on duty to ensure people's needs were met in a timely manner. One person commented, "Oh yes, they come quickly. You don't wait very long, they are pretty prompt." Staff also said they were enough staff. One staff member said, "Yes there are enough, definitely. Compared to some places it is good. If it gets really busy we are given extra." Another staff member told us, "There are a lot more staff [than in hospital]. We have more time for the patient." The registered manager told us they had started a review of staffing levels. They felt four staff was adequate but they were reviewed daily and adjusted depending on people's dependencies.

Effective recruitment checks were carried out to confirm prospective new staff were suitable to work with people using the hospice. Pre-employment checks had been carried out, such as requesting and receiving references and checks with the Disclosure and Barring Service (DBS). DBS checks are carried out to confirm whether prospective new care workers had a criminal record or were barred from working with people.

The provider carried out health and safety checks to help keep the hospice a safe place to receive care. These included checks of the fire safety systems, water safety, gas safety and the environment. These were up to date at the time of our inspection. There were procedures in place to deal with emergency situations, such as a business continuity plan. Some areas identified as a potential risk on the most recent Fire Risk Assessment had not been actioned. For example, the location of a cool cabinet to store drinks and the number of thank you cards displayed on notice boards. The registered manager told us a decision had been taken during a Board meeting to leave these in place and was documented in the minutes.

Incidents and accidents were logged and investigated with details of the action taken to help keep people safe. Following each incident a risk assessment had been carried out to help prevent the situation happening again. The registered manager analysed incidents and accidents regularly to look for trends and patterns. Details of incidents and accidents were reported to the clinical governance meeting every three months. This included information about the number of incidents, a summary of each one and the action taken to help keep people safe.

Is the service effective?

Our findings

The provider lacked a structured approach to supporting staff. The registered manager confirmed there was no documented policy or procedure outlining what staff should expect from the provider to support them in their role. We found no evidence of formal opportunities for staff to discuss their support, training and development needs. The registered manager told us no one to one meetings had been held or were planned for in the future. Appraisals were overdue for most staff. For example, from records we reviewed for one member of staff we found their last documented appraisal was in September 2014. The registered manager told us the format for recording appraisals had been improved and these were in the process of being rolled out. We saw records which confirmed these had commenced.

The registered manager told us there was no documented policy or procedure for clinical supervision. They told us staff could have a session with the clinical psychologist if they felt they needed one. One member of staff interviewed told us they had previously had a group session with the clinical psychologist. Staff said support happened in an unplanned way "on the job". The registered manager commented there were plans to start reflective practice sessions following incidents in small groups of two to three. The first session was held in June 2016 at which there were no staff members present. The dates of future sessions were displayed on an information board and available to all staff members. Following the inspection the registered manager advised us three staff had attended a session in July 2016.

There was no formal process in place for revalidation of qualified nurses. Two staff members had completed revalidation with the assistance of the clinical lead. The registered manager told us revalidation would be discussed at appraisal with each nurse, and assistance given. One nurse told us they were confident they would get the help they needed from the other staff at the hospice.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the provider did not have a formalised approach to supervision and appraisal, staff said they felt well supported. One staff member commented they were, "Really well supported." Another staff member said they were "very supported". They told us, "There is not a member of staff that I could not go to. They are all open and willing to listen to your problems. We help each other out." Emotional support was available for staff of they needed it. Staff told us they could have reflection time or speak with a counsellor. They went on to say, "We are always asked if we are okay." One newly appointed staff nurse said they felt "supported by all staff members with expanding my knowledge and skills". They went on to tell us, "Peers are all approachable."

Records we viewed showed essential training was up to date for all staff. This included training to verify a person's expected death, as well as Mental Capacity Act (MCA) and safeguarding adults training. Staff were supported to complete relevant academic qualifications. For example, one staff nurse was completing a degree course for palliative care and health care assistants had vocational qualifications. Volunteers had their training provided in-house by the provider.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection people were not being deprived of their liberty. We saw examples of previous authorisations that had been requested where people lacked capacity to consent to their admission to the hospice. We saw Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) documents were present in all care records we reviewed. These had all been completed correctly with involvement from the person. We saw evidence of these discussions documented in people's care records. Staff we spoke with showed a good understanding of the principles of the MCA.

People were supported to ensure their nutritional needs were met. One person said, "I am unable to eat, they are going to get a dietitian." They went on to say they "agree with this" and were happy with this decision. The local health trust provided meals to the provider which were delivered each day. People chose from a menu which changed every two weeks. The trust was able to cater for all special dietary requirements or cultural needs. The provider kept a stock of food supplies on-site so that if people did not like the options on the menu an alternative could be offered. For example, soup, custard, eggs and bacon.

People had regular access to the medical team within the hospice. The provider had a service level agreement with the local foundation trust which provided access to two consultants. The provider also employed a number of hospice physicians, covering all day time sessions and out-of-hours medical cover. One person said, "I saw the doctor yesterday." Another person described how a doctor had changed their treatment in the hospice. They told us they were now not "as tired, had more energy and didn't spend as much time in hospital". The provider employed a physiotherapist who could offer people help with managing symptoms and fatigue. Complementary therapies were also available, such as massage, aromatherapy and reflexology.

Improvements had been made to raise staff awareness of the needs of people living with dementia. For example, all staff had been trained to be 'Dementia Friends' and also had completed specific dementia awareness training. The provider had established links with a specialist dementia nurse to advise on further adaptation to the hospice. This included changes to the environment and introducing new documentation to be used as part of the care planning process.

Good ●

Is the service caring?

Our findings

We received only positive feedback about the care provided at the hospice. One person told us, "It's brilliant, I am definitely well cared for." Another person said, "This place is a life-line." They told us about how the hospice had given them their life back to enjoy. One relative said, "I can't fault it. It is the best place for [my relative]. It took a weight of our minds with [my relative] being in here. They are keeping [my relative] calm and relaxed." Staff told us they had chosen to work in the hospice due to the level of care they felt they could deliver to people and their families every day.

People told us kind and caring staff provided their care. One person commented, "Staff are lovely, just like one of the family." One relative said, "I can't fault the staff."

There were numerous cards displayed on notice boards complimenting the service and thanking staff for the care people had received during their stay at the hospice. Words used to describe the care people received included marvellous, compassionate, excellent and dedicated.

People were in control of their care and their views were listened to. One person commented, "They keep you involved, they get consent first. They let you know what is happening and what they are doing." One person told us they wanted to be cared for in St Clare's. We found this had been documented in the person's care records. One relative said, "They explain everything to us." One new staff nurse told us how she had "time to care, time to talk to patients and relatives".

People were treated with dignity and respect. We observed dignified interaction between people and staff. We saw people were given choices and questions were answered in ways to help people understand the information they were given. Staff confirmed maintaining dignity was a priority for the service. One staff member said, "We maintain dignity at all times to make people feel at ease. Maintaining dignity is a massive thing." Another staff member told us they aimed to promote "dignity at all times". They went on to describe how they would always keep people covered with a towel, continually explained what they were doing, get consent and keep doors and blinds closed.

People were able to access emotional and spiritual support if they wished. The provider had a chaplain, supported by a team of 20 volunteers, who provided a counselling service both in and out of hours. The provider also had a psychologist for three days a week to provide support to people and their family. One person told us, "I was offered to see the chaplain but I didn't want to." A relative told us they had been very well supported by the chaplain. The relative said they had "very good chats with the chaplain". They said their relative had also been supported. They said they had been given a personal number to contact them at any time. They told us, "The chaplain keeps popping in and out and knows [my relative] well. That is a comfort for [my relative]." Another person received regular weekly visits from their own priest to maintain their religious needs.

Bereavement support service was available to help with all levels of need. Bereavement support was provided at the hospice and another site to help with people accessing this service. The hospice held 'carer support days' in the day centre. Feedback from relatives who had used the service was very positive. Relatives had described how the service had "really helped". Words used to describe the bereavement service were wonderful, very positive and lovely.

Families had the option of attending a memorial service for their relative if they wished. The chaplaincy team organised remembrance services every three months as well as an annual 'Tree of lights' service.

People told us staff took time to ensure their preferences and choices were met. One person said, "They are there for everything you want, popping in all of the time. Nothing is too much bother." One staff member commented, "We speak to the patients. We follow their preferred routine, we put moisturiser on, wash hair and put make-up on. We get the hairdresser to come."

A relative told us they had been given written information about what to expect from their relative's care and the services available to them. Each person was given a copy of the 'Patients Guide' which contained information about the services provided at the hospice and the provider's complaints procedure.

Good ●

Is the service responsive?

Our findings

People spent time with staff on admission to discuss their needs and preferences. One person said, "I sat with the doctor and nurse and went through lots of questions." Staff told us they were responsive to people's needs on a daily basis. One staff member said, "Every day we do what we can and more."

We saw a holistic assessment covering each person's needs and preferences had been completed. This was available to view in care records. The provider had implemented a document called 'This is me' which was used to record people's likes and dislikes. This helped staff develop a better understanding of the needs of people in their care.

Where needs had been identified we found corresponding care plans were in place which matched the person's symptoms. The format used for care planning was a standardised care plan with space to personalise each plan to the individual needs and preferences of each person. Both sets of care plans we viewed had little personalisation other than the person's name added to the care plans. For example, for one person care records did not document any non-medicine symptom relief. Although their care records did show regular communication with the person and relatives.

Each person's care and treatment was fully discussed during the weekly multi-disciplinary team (MDT) meeting. This included changes in their health and care needs. We observed the MDT meeting which comprised of a range of professionals including nursing staff, the chaplain, medical staff, an occupational therapist and a physiotherapist. Although we did not see documented advance care plans, the MDT included a discussion of future planning needs. The meeting was also an in-depth discussion of each person's placement, the person's wishes and goals, including whether the person's preferred place of care had been achieved. Discharge plans were also discussed. The MDT discussions were clearly documented in all of the care records we viewed.

From viewing care records we saw medical staff completed a pain mapping tool to monitor people's pain levels. We discussed the use of pain scores with nursing staff. They told us people were asked to score their pain using a scale of 1-10. They then gave appropriate medicines or heat packs. People were then asked to re-score their pain level to assess whether the treatment had worked. We observed throughout the inspection people's requests for pain relief were answered promptly.

People had the opportunity to attend activities in the day hospice if they chose to. One person told us, "We do silly things, have entertainers and play games." Another person described how the day hospice allowed them to forget about their illness. The day hospice was well equipped and stocked with the materials required to provide a wide range of activities, such as arts, crafts and reminiscence. The day hospice sister told us the provider was currently looking at further development of the day service. The sister was visiting other hospices as part of the review.

Feedback about people's care at the hospice was gathered when they were discharged. 27 people had completed a questionnaire in the previous 12 months with most (85%) stating they would "extremely recommend" the hospice for the care of friends and family. While the remaining (15%) would "strongly recommend" it as the preferred place of care. The results from the survey had been fed into the clinical governance meetings. This was done to discuss improvements or suggestions people had made.

People knew how to make a complaint if they had concerns about their care. One person said, "I would just tell them [staff team] if I had concerns. I would just talk to them and ask them. They are easy to talk to." The provider had a complaint procedure for people to access if they wanted to make a complaint. We viewed the provider's complaint log which confirmed one complaint had been received in 2015. This had been fully investigated and the outcome fed back to the complainant.

Requires Improvement ●

Is the service well-led?

Our findings

We found during this inspection some important areas of the service had either lapsed or required further development. For example, there was no structured approach in place for supporting staff. We also found some policies and procedures were overdue for review. For instance, we found the provider's key policy document relating to the 'care of the dying person' was due for review in 2012 and was now out of date. The registered manager provided us with a copy of the new policy after our inspection but this had not yet been agreed by the board members. The registered manager told us areas of the service had lapsed as they had only recently returned to work following a planned absence. The provider could not be assured they were obtaining all their medicines in accordance with current legislation and best practice.

Some records we viewed were not always accurate and up to date. For example, staff told us they did not always document information about pain management in people's care records. They did not also consistently record the person's views about how pain relief affected their day. Although people's future care needs were discussed during the MDT, we found people did not have care plans which detailed their preferences for their future care needs or advance care planning in line with National Institute of Clinical Excellence (NICE) guidance. For example, one person had identified the hospice as their preferred place of care. We found no other information about their wishes documented in their care records. NICE guidelines clearly state the importance of personal goals and wishes, such as a person's preferred care setting. We asked staff about advance care planning. They were unable to identify any people who had made advance plans about their care. Staff also told us no-one from the provider's day hospice had conversations with people about what was important to them when they approached end of life. The provider had leaflets that would be used in the day hospice to record people's wishes. However, we did not see any leaflets people had completed.

We found team meetings were infrequent. We found there had been no recent team meetings held recently. The registered manager said they issued regular updates to all staff. However, the most recent updates available to view were dated June and September 2015. The guidance sheet issued with the updated prompted staff to read the update and sign a signature sheet to confirm they had read it before the date specified. We found the signature sheets for both updates were incomplete. For example, 29 staff out of 43 listed had not signed the September 2015 signature sheet to confirm they had read the update. This meant staff were not having regular opportunities to meet with colleagues and share their views.

We found the approach to quality assurance was inconsistent and ineffective in identifying issues or concerns. Regular audits were carried out across some clinical areas but not others. We looked at how medicines were monitored and checked by managers to make sure they were being handled properly and systems were safe. The registered manager told us medicine management was not included in the regular audit system. Therefore, issues found during our visit had not been identified. We saw one specific audit of medicine records which had been completed in August 2014. The action plan for this audit stated the next audit would be completed in three months but we were told that no repeat audit had been done.

We found following an audit of the pain assessment tool an action point for nurses and doctors to improve pain recording had been identified. This was due to be reviewed at the time of our inspection. However, from our own findings we concluded records were still inconsistent. The provider was looking to improve how audits were carried out in the future. The staff nurse responsible for carrying out audits told us a meeting had been arranged with one of the members of the clinical governance group to discuss the "way forward with the audits".

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other audits were in place to check on areas such as the pain assessment tool, a syringe audit, skin damage and hand hygiene. The audit results were reported to the clinical governance meetings. We viewed the minutes from previous meetings which confirmed the audit results had been discussed. Where the outcome of an audit was lower than expected, for example the hand hygiene audit was 70% in relation to the use of personal protective equipment, actions had been agreed and monitored to ensure compliance.

The provider had a registered manager who had been registered since 2010. They were aware of their legal responsibilities and had been proactive in submitting statutory notifications to the Care Quality Commission. Staff members described the registered manager as approachable. One staff member said, "[Registered manager's] door is always open for me."

Staff told us the hospice had a good atmosphere. One staff member said, "I love it, it's like a little family here. Everyone gels together." Another staff member told us, "It's good, it is not what people expect. We have some good laughs."

Three clinical governance groups had oversight of the running of the hospice. These groups covered clinical governance and quality assurance; finance; health and safety and human resources. The three groups reported to the board of trustees. The registered manager told us three trustees from the board were looking at development of the service and a policy review. The minutes we viewed from the governance meeting, also identified referrals to the hospice were not high thereby keeping bed occupancy low. As a result the provider was working with local teams to identify how the hospice could assist or tailor services to meet local need. The Macmillan nursing service was the biggest referrer of people to the hospice.

The provider had an over-arching service risk register, which was kept up to date. This detailed potential risks to people and staff, both clinical and non-clinical. The register also documented the measures taken by the provider to minimise these risks and how they would be monitored. However, the control measures identified on the register were not always effective. For example, in order to prevent the potential misuse of controlled drugs the provider would observe clinical practice and carry out audits. However, we found issues with controlled drugs during our inspection and a lack of a robust medicines audit. We also found a high number of policies and procedures were overdue for review.

The provider had been involved in joint working with other organisations to improve the experience of people using the hospice. These included work with The Alzheimer's Society to develop the service for people living with dementia and work with Age UK around advanced decision making and power of attorney. The registered manager also told they had a close working relationship with the local Macmillan team. The provider was currently involved in any research projects but was looking at ways of increasing referrals from people with a non-cancer diagnosis. For example, raising awareness of the service through visiting GP practices and community matrons. The provider had regular meetings with the commissioners of the service to discuss areas such as quality and performance.

The provider had a draft five year strategy for its future development focused on continuous improvements. The hospice's strategy acknowledged the current challenges and opportunities in caring for people at the end of their lives. Objectives had been set to develop expertise in non-cancer conditions, joint working with local hospices, effective use of resources and greater emphasis on research and development.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not adequately protected against the risks associated with unsafe or unsuitable care and treatment because medicines were not managed properly. Regulation 12(g).

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems to assess, monitor and mitigate the risks to people's health and welfare and improve the quality of their care. The provider did not always maintain an accurate record in respect of each person. Regulation 17(1), 17(2)(a), 17(2)(b) and 17(2)(c).