Prospect Hospice

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Our rating of this service went down. We rated it as **Requires improvement** overall.

We found the following issues the service provider needs to improve:

- Staff completed, but did not always update risk assessments for each patient to identify, remove or minimise risks. Nursing staff did not always keep detailed records of patients' care and treatment. Records were not always clear, up-to-date or easily available to all staff providing care.
- The service did not always have enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment in the community clinical nurse specialist team.
- Staff did not manage prescription documents, in line with the provider's policy. NHS prescription stationery usage was not tracked as required by national guidance.
- Staff recognised and reported incidents and near misses. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service.
- The service did not provide care and treatment based on national guidance and evidence-based practice. Managers did not always check to make sure staff followed guidance.
- Staff did not monitor the effectiveness of care and treatment as there was no participation in relevant quality improvement initiatives. Staff did not always document their assessment of patients regularly to manage their pain. They did give additional pain relief to ease pain.
- The service did not always plan and provide care in a way that met the needs of local people and the communities served. Nor was the service inclusive and did not always record patients' individual needs and preferences. Waiting times from referral to achievement of preferred place of care and death were not documented in line with good practice.
- There was no overarching governance system to systematically improve service quality or safeguard high standards of care. The service did not have embedded systems to fully identify risks, with clear plans to eliminate or reduce them. The service did not always collect, analyse, manage and use information well to support all its activities.
- Some staff did not always feel respected, supported and valued. The culture did not always encourage openness within the organisation.

However, we also found the following areas of good practice:

- The Chief Executive Officer was clear on the organisational priorities and, with the senior leadership team, had identified ways of working to improve the position of the service. It was recognised that work was still needed to improve the culture and ensuring the service was a good place to work.
- Managers at all levels in the service had the right skills and abilities to run a service providing good-quality sustainable care. There were new members of the senior leadership team.
- The service provided mandatory training in key skills to all staff and ensured most staff completed it. This was an improvement from the last inspection in August 2018.
- 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. This was an improvement on the last inspection in August 2018.
- The hospice was designed to meet the needs of families and relatives of patients.
- The service-generally controlled infection risk well. They used control measures to prevent the spread of infection before and after the patient died. They kept equipment and the premises visibly clean. This was an improvement on the last inspection in August 2018.

Summary of findings

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies. Key services were available seven days a week to support timely patient care. Staff gave patients practical support to help them live well until they died.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. They provided emotional support to patients, families and carers to minimise their distress. They also understood patients' personal, cultural and religious needs.
- We saw a committed team who wanted to work well together, inclusively for the benefit of people using the service.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements. Details are at the end of the report.

Ted Baker
Chief Inspector of Hospitals

Overall summary

Prospect Hospice is operated by Prospect Hospice Limited. The service provides community and inpatient hospice care. The inpatient service is registered as a 16-bedded facility which provides respite care, symptom control and care for 12 patients at the very end of life.

During this inspection we inspected the inpatient unit and their community services.

Prospect@Home provides hands-on care in the patients' home, night and day. It has a team of nurses, nursing assistants and specially-trained home support volunteers who work alongside the patient's own GP, community nurses and others involved in a patient's care. It provides coordinated care, designed and delivered to meet the wishes of patients who wish to be supported at home. The Prospect clinical nurse specialist team are community based and offer care and support to people in their homes. This team supports patients and their family soon after diagnosis and for as long as they are needed. They also have nurses dedicated to supporting patients who live in care homes, working alongside care staff to support and care for the patient.

Within the past 20 months the hospice has been inspected three times. The hospice was inspected in February 2018, at that inspection we issued a warning notice warning notice for Regulation 17: Good Governance. Another inspection took place in August 2018 which was a focused inspection to review the provider's actions in respect of the warning notice. While some improvements had been made, these were not enough to provide full assurance. As a result we imposed conditions upon the provider's registration which included monthly risk and health and safety reports. For the most recent inspection, we inspected this service using our comprehensive inspection methodology. We carried out this unannounced inspection on 25 and 26 June 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so, we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Requires improvement 	We rated this service overall as requires improvement. Safe, effective responsive, and well-led require improvement. Caring was good.

Summary of findings

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Summary of this inspection

Background to Prospect Hospice

Prospect Hospice is operated by Prospect Hospice Limited. The service opened in 1980. It offers community and hospice care and services the communities of Swindon, Marlborough and North Wiltshire. The organisation is a charity, of which 70% is funded by the local community through fundraising. Of its income, 30% is provided by statutory organisations such as the local NHS acute trust and the local Clinical Commissioning Group.

The hospice has not had a registered manager in post since November 2018. At the time of the inspection, a new manager had been appointed and had applied to CQC to be considered for registration. There was a new Chief Executive Officer in post, and they were aware of their responsibility to register with us.

Our inspection team

The team that inspected the service comprised of an inspection manager, two CQC inspectors, an assistant inspector, a pharmacy inspector, and one specialist advisor with expertise in adult hospice care. The inspection was overseen by Mary Cridge, Head of Hospital Inspection.

Information about Prospect Hospice

The inpatient service is registered as a 16-bedded facility which provides respite care, symptom control and care for 12 patients at the very end of life. There are seven individual patient rooms and two four-bedded male and female bays. Since December 2017, when a review of bed occupancy and staffing took place, staffing levels had been set to provide cover for 12 out of the total 16 beds.

At the time of our inspection in August 2018, we had been informed that only six inpatient beds were in use. At this inspection the hospice now provided care for 12 patients with 11 inpatients at the time of the inspection. We were told that staffing levels could be increased if more than 12 patients were assessed as requiring admission or if patient acuity rose significantly.

The service also included community services, Prospect@Home (end of life care delivered in patients' homes by a team), clinical specialist nurses and a single point of access team. The provider employed a team of clinical nurse specialists working within a local acute trust identifying end of life patients suitable for care in the community. A clinical nurse specialist was also employed by the provider to provide expertise to local nursing/care homes for end of life care.

The hospice had 134 admissions between August 2018 and June 2019, 291 patients on the community clinical nurse specialist caseload and an average of 20 patients on the Prospect@Home caseload.

This was an unannounced (they did not know we were coming) comprehensive inspection of the hospice, Prospect@Home and the clinical nurse specialist teams. During the inspection, we visited the inpatient unit, Prospect@Home team (a team working in the community) and the clinical nurse specialist team. We spoke with 37 members of staff including; nurse specialists, registered nurses, health care assistants, volunteers, reception staff, medical staff, clinical leads, the chief executive, members of the senior leadership team and trustees. We reviewed eight sets of patients' records. We spoke with four patients and two relatives. We observed the care and treatment of patients in the inpatient unit, day therapy unit and in two patients' homes. We also looked at and analysed data about the organisation and information provided by the provider.

The hospice has one inpatient ward and is registered to provide the following regulated activities:

Summary of this inspection

- Diagnostics and screening
- Treatment of disease, disorder and injury
- Transport services, triage and medical advice provided remotely

Track record on safety from April 2018 – June 2019

- No never events
- 45 Clinical incidents with no serious injuries
- From June 2018 to May 2019, there had been three incidences of hospice acquired MRSA and two incidences of hospice acquired Clostridium difficile.

The provider received 29 complaints of which two were concerned with clinical care.

Services accredited by a national body:

Their education services retained the quality assurance standard in March 2019 of the education body Council for Awards in Care, Health and Education, NCFE/ CACHE (NCFE CACHE provides qualifications for those who care and educate).

Services provided at the hospice under service level agreement:

- Clinical and non-clinical waste removal
- Interpreting services
- Grounds maintenance
- Laundry
- Maintenance of medical equipment
- RMO provision

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

Our rating of safe went down. We rated it as **Requires improvement** because:

- Staff completed, but did not always update risk assessments for each patient to minimise risks.
- Managers regularly reviewed staffing levels and skill mix, however, they did not always ensure there were enough staff in the clinical specialist nursing team.
- Nursing staff did not always keep detailed records of patients' care and treatment. Records were not always clear, up-to-date or easily available to all staff providing care.
- Staff did not manage prescription documents in line with the provider's policy. NHS prescription stationery use was not tracked as required by national guidance.
- Staff recognised and reported incidents and near misses. Managers investigated incidents but did not share lessons learned with the whole team and the wider service.

However:

- The service provided mandatory training in key skills to all staff and made sure most staff completed it. This was an improvement from the last inspection in August 2018.
- 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. This was an improvement on the last inspection in August 2018.
- The service, on the whole, controlled infection risk well. They used control measures to prevent the spread of infection before and after a patient died. They kept equipment and the premises visibly clean. This was an improvement on the last inspection in August 2018.

Are services effective?

Requires improvement

Our rating of effective went down. We rated it as **Requires improvement** because:

- The service did not provide care and treatment based on national guidance and evidence-based practice. Managers did not always check to make sure staff followed guidance.
- Staff did not always document their assessment of patients regularly to manage their pain. Patients did not raise concern about this and were provided with pain relief when required.

Summary of this inspection

- Staff did not fully monitor the effectiveness of care and treatment as there was no participation in relevant quality improvement initiatives. They could not assure themselves where improvements were required to achieve good outcomes for patients.
- The service did not ensure records of training evidenced that staff were competent for their roles in the community clinical nurse specialist team.

However:

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.
- Key services were available seven days a week to support timely patient care.
- The service made adjustments for patients' religious and cultural needs.
- Staff gave patients practical and emotional support to help them live well until they died.
- Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Are services caring?

Good

Our rating of caring stayed the same. We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Are services responsive?

Requires improvement

Our rating of responsive went down. We rated it as **Requires improvement** because:

- The service did not always plan and provide care in a way that met the needs of local people and the communities served.
- The service did not always take account and record patients' individual needs and preferences.

Summary of this inspection

- Waiting times from referral to achievement of preferred place of care and death were not documented in line with good practice.

However:

- The hospice was designed to meet the needs of families and relatives of patients.
- Patients could usually access the specialist palliative care service when they needed it.
- The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Are services well-led?

Requires improvement

Our rating of well-led went down. We rated it as **Requires improvement** because:

- The service had a vision for what it wanted to achieve, however, this was under review with plans for future development with the whole staff team.
- Some staff did not always feel respected, supported and valued. The culture did not always encourage, openness within the organisation. However, this had improved since our last inspection and the senior leadership and staff had worked hard to support staff and recognised this was an area for continued support.
- The service did not have overarching governance systems to systematically improve service quality or safeguarded high standards of care.
- The service did not have imbedded systems to identify risks, or an overarching plan to identity, eliminate or reduce them, and cope with both the expected and unexpected.
- The service did not always collect, analyse, manage and use information well to support all its activities.

However:

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care and there were new members of the senior leadership team.
- Trustees were visible and involved.
- Staff told us they really enjoyed working in the hospice.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

Requires improvement

Hospice services for adults

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

Are hospice services for adults 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 to all staff and ensured most staff had completed it. At our inspection in August 2018 we found compliance with mandatory training for staff was poor. At this inspection we found mandatory training had been completed by most staff including volunteers. All training and development was overseen by the education manager. A system had been introduced so that all mandatory training could be recorded, and reminders were sent to staff when training was due. All managers could access the electronic system to monitor progress of their staff training. Staff told us that more mandatory training courses were available since the last inspection.

The provider did not set a target for completion of mandatory training, but rated completion levels in categories, such as red (not achieved), amber (nearly achieved) and green (achieved). Mandatory training included, manual handling, basic life support and infection control. The provider confirmed that as of June 2019 the e-learning modules in the inpatient unit had achieved 87.6% compliance and Prospect@Home staff had a compliance of 93.1%. The inpatient unit showed 93% of nurses and health care assistants had completed all areas of mandatory training.

There were also 19 core competency training modules available that were also rated. This included safeguarding adults and child protection, nurse led swallow assessments, syringe drivers, wound care and leg ulcer management. Of these modules 75% of nurses had completed and 78% of health care assistants had completed them. The Prospect@Home nurse team had completed 62% of the modules and the health care assistants had completed 79% of the training. Training completion for volunteers was recorded at 100% completion.

There was a structured vetting and orientation process for agency nurses which was completed when they started work at the hospice. At our previous inspection in August 2018, we found a new system had been introduced to ensure agency nurses were appropriately vetted and provided with orientation before commencing their shift. When we looked through records we found the process was not being followed consistently. At this inspection we found an improvement with agency staff orientation checklists showing agency nurses were vetted and provided with orientation to the unit before commencing their shift.

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. At our inspection in August 2018 we found staff understanding of safeguarding poor, so we could not be assured that vulnerable people were protected from abuse. At this inspection staff could articulate what safeguarding was, and their duties to report and support patients at risk. Staff told us training in safeguarding had improved as this was now face to face rather than online training and was offered to volunteers as well as employed staff.

Safeguarding link nurses had been identified for each of the hospice teams. Staff we spoke with were aware of the hospice's point of contact for safeguarding and were aware of the safeguarding policy. This had been issued in January 2019 and was due for review in November 2021.

Staff knew how to identify safeguarding risks and were made aware of safeguarding risks already known. Staff told us that usually any patient at risk of harm had been identified prior to admission. However, they were clear how to identify safeguarding risks including financial abuse, and controlled drug misuse. Staff could give us an example of when a patient had raised concerns about another patient. Both patients had been managed appropriately with support offered.

Cleanliness, infection control and hygiene

Staff used recognised infection control measures and were clear on their responsibilities in relation to this. There was a clear infection control policy to guide staff and direct practice. Staff kept the equipment and the premises clean. They used control measures to prevent the spread of infection. At our inspection in August 2018 we found systems and processes to prevent and protect people from healthcare-associated infection were not effective and did not keep people safe. At this inspection we found infection control measures had improved. Staff we spoke to knew the isolation procedure for patients who had infections.

We found staff were bare below the elbow in line with provider policy. This promoted effective hand washing and prevented long sleeves from touching patients, therefore reducing the risk of spreading infection.

Safety and safeguarding systems, processes and practices were recently developed but not fully implemented. At our inspection in August 2018, we found the infection and control policy had been out of date and did not reflect current best practice. At this inspection we found a new infection control policy had been issued on January 2019, for review in November 2021.

It included a standard operating procedure (SoP) for care of a patient with Methicillin-resistant Staphylococcus aureus but hospice acquired Clostridium difficile was a separate SoP sent after the inspection".

The policy stated a schedule of regular audit would be undertaken or arranged by the infection control link nurses bi-monthly to cover public areas, inpatient areas, clinical rooms, bathrooms, dirty utility and the domestic rooms. There was also six-monthly audits for the kitchens and handling of linen with annual audits for waste of disposal, sharps, patient equipment, hand hygiene, personal protective equipment and clinical practices. The annual results were going to be made known to the infection prevention lead and reported to the Board of Trustees through the Patient Services Committee. This would then be fedback into the Hospice quality and audit cycle. However, not all of these audits appeared on the audit schedule and annual audits had not yet been undertaken.

The provider monitored infection levels. The provider was monitoring infection control practices of hygiene audits to establish staff compliance. From June 2018 to May 2019, there had been three incidences of hospice acquired Methicillin-resistant Staphylococcus aureus (MRSA), and two incidences of hospice acquired Clostridium difficile (C.Diff).

Hand hygiene audits were completed monthly to assess compliance with National Institute of Health and Care Excellence (NICE) Quality Statement 61 (Statement 3). The hand hygiene audit for May 2019 showed that 13 separate observations had been completed and all seen had been fully completed.

Staff took precautions to protect people from healthcare-associated infections. Hand sanitiser gel was available in all clinical areas we visited. Each individual area had hand cleaning facilities for staff, patients and relatives. We saw staff and relatives using the hand gel or washing their hands. This was in line with the National Institute of Health and Care Excellence (NICE) Quality statement 61, (statement three).

Cleanliness, infection control and hygiene were observed being managed. A cleaning audit was undertaken monthly. The outcomes for May 2019 cleaning audit had been added to an ongoing action plan and the resulting actions delegated and monitored for improvement.

An infection prevention audit report dated June 2019 was shared with the inspection team. This showed infection prevention compliance at 97% overall. This covered 16

areas, of which 12 areas received a score of 100%. These included: clinical practice; clinical equipment; sharps and waste management and pressure sore management and chronic wound care. The clinical environment scored 93%; hand hygiene scored 95%, urinary catheter management scored 94%, and governance and documentary evidence scored 87%. It was not clear whether targets had been set for these areas, and actions for improvement were not included within the report. The organisation advised us following the inspection an action plan was in progress.

Clinical waste was managed safely and appropriately. We saw clinical waste was separated from regular waste into the correct colour coded bags in separate bins. This prevented the spread of cross infection. Clinical and domestic waste was stored in large bins in a locked compound on site before being collected weekly. There had been no audit of clinical waste undertaken at the time of our inspection.

The provider had a process to care for the body of a deceased person. The hospice did not have a mortuary but had a cold room to store the deceased person until the undertakers arrived. The cold room had good infection control procedures. The provider also had a viewing room for relatives situated next door to the cold room. The hospice provided personal protective equipment for funeral directors to use when collecting the deceased.

Environment and equipment

The service had suitable premises and equipment and looked after them well. At our inspection in August 2018 we found some equipment on the inpatient unit had not been properly maintained. We also found consumable items for use in emergency situations significantly out of date. Prior to this unannounced inspection, and part of their conditions of registration, the provider sent us copies of their audits of emergency equipment included in their emergency bag. These audits were for March 2019 and they were completed in full. At this inspection we found that all consumable items for use in emergency situations were within date range. We also checked the dates and checks on resuscitation trolley equipment, the emergency grab bags and blood spillage kits. We found all were within date. At this inspection we found resuscitation equipment was checked daily and was consistently completed.

Sharp instruments were disposed of safely. The service provided safe sharp bins to dispose of sharp instruments. We found these to be used to a safe level and not overfilled.

Equipment was safe, ready to use and stored appropriately. Equipment was serviced and checked in accordance with manufacturers' and local requirements. Safety testing stickers showed the equipment had been tested in the last year. This was carried out by an outside contractor. However, the provider did not have a complete asset register of all equipment on the premises.

Changes had been made to the environment. We noted at our previous inspection that some aspects of the facilities did not always keep people safe. There were carpets in some clinical areas which was a risk of cross infection. At this inspection, in clinical areas, carpets had been replaced with vinyl flooring which meant it was easily cleaned. The provider told us of their plans to eventually replace all carpets.

Assessing and responding to patient risk

The initial admission assessment for inpatient respite patients were not always completed within the timescales set by the service. All patients had an initial assessment and risks were prioritised and actions taken. We found safe assessments of patients planning an inpatient respite visit were not consistently completed. An inpatient respite audit was completed during January 2019 to March 2019 which looked at the process leading up to respite admission and included the support provided by different services patients received during their admission. The audit explored the phase of illness for all 13 planned respite admissions leading up to their respite stay. The report concluded three of the patients had deteriorated prior to being admitted, and it had been identified that they were to be physically seen within five days prior to their planned admission. Only three out of the nine admissions had been physically seen within five days prior to their admission. This shortfall was an area recognised by the service and they had plans for this to be reviewed further.

There was effective assessment, action planning and review for community patients which was understood by the patient and their family and supported patient choice. We visited two patients in their own home with the clinical nurse specialist. We

observed patients treated with compassion and dignity. They allowed time for the patients and relatives to ask questions and to listen to their concerns. Advanced care planning and preferred place of death were both discussed.

Staff did not always assess and respond to patient risks and these were not always recorded correctly. During our inspection in August 2018, we found that risk assessments were not always carried out for patients. At this inspection we found this had only slightly improved. The provider was trialling an inpatient risk assessment booklet. Of the seven sets of patient notes we reviewed, five had this document completed correctly. The two other sets of notes just had risk assessments completed. However, we identified three patients who required regular pressure ulcer risk assessments, but these were not recorded. This meant patients may not be receiving the right level of intervention to reduce the risk of a pressure ulcer. Four patients with specific care plans for pain had poorly completed or no pain assessments documented. This meant patients trends/types of pain would not be identified and staff did not have clear pain assessments to follow. Patient records, including risk assessments, had been audited recently but the audit concentrated on grammar, spelling and not quality issues for example, timely completion of risk assessments.

Patients at risk and in need of mental health support were supported. The provider had a clinical psychologist who visited the hospice once a week for inpatients and held outpatient clinics. The provider also had a service level agreement with a local mental health NHS trust to refer the patients with mental health needs with the consent of the patient and their GP. The provider could also access an inpatient mental health facility at a local NHS acute trust. If a patient was already assigned a community psychiatric nurse, they were welcome to come into the hospice to see the patient during their stay.

Staff shared key information to keep patients safe when handing over their care to others. On the inpatient unit, a pre-recorded handover of patients care and support needs was completed at each shift change. They focused on the holistic needs of each patient such as clinical condition, comorbidities, ongoing assessments of the patients' needs as their condition changed and updating of family member involvement. After the handover there was a safety briefing which informed staff of particular risks faced by the patients, for example, high risk of developing pressure ulcers or the risk of falling. The nursing team used the handover process to plan their work for the day and to discuss any possible discharges or new admissions.

Managers regularly reviewed staffing levels and skill mix, however, they did not always ensure there were enough staff. At our previous inspection there was no set staffing establishment in the inpatient unit. The senior team told us that a staffing structure had been agreed and baseline staffing was being established. At this inspection, the core staffing numbers had been established for up to 12 patients. The provider was using a 'Dependency to Acuity' tool to aid professional judgement about staffing levels. This measured the intensity of nursing care required which in turn, influenced the number of nurses on a shift according to patients' needs. When we cross referenced the staffing numbers to the acuity score from 28 May 2019 to 4 June 2019, we found all the shifts had an acuity score which advised another registered nurse. An extra registered nurse had only been provided for one shift. Staff told us, despite the acuity score recommending another registered nurse, it was difficult to convince senior management to increase staffing. Some staff told us they felt the acuity scoring was a 'paper exercise'. However, on reviewing the staff roster of 540 shifts, from January 2019 to June 2019 for the Inpatient unit, there were eleven occasions when staffing fell below the prescribed three registered nurses in the daytime and one occasion at night. The organisation assured us that this only represented two percent of shifts. We found there were no specific patient safety incidents relating to those occasions of reduced numbers of registered nurses.

Staff told us that they felt the duty roster was not always fair and duties were changed at short or no notice. Contracts were being changed following consultation with staff to internal rotation to include night duty.

At our previous inspection, there remained insufficient oversight of the employment of agency staff and a lack of assurance about their level of competence. At this inspection we found most vacant shifts were covered when possible by substantive or bank staff. All agency staff undertook an introduction tour and completed a safety checklist.

Requires improvement

Hospice services for adults

Medical staffing

The service did not always provide assurance that they have enough medical staff to keep people safe from avoidable harm and to provide the right care and treatment. There were risks to the organisation not being able to provide consistent medical cover. During our previous inspection, we identified there was only one locum doctor available four days a week. In the absence of a consultant, two rotational GP trainees could access telephone advice from a neighbouring hospice or the local acute hospital.

At this inspection we found the locum consultant was still in post although the provider was actively recruiting a permanent consultant and a medical director. There were five speciality doctors who worked one or two days each to cover the service, including weekends. There was also a rotational post for first year GP trainees who worked at the hospice for three months at a time. Telephone medical advice out of hours was provided by the locum consultant or a consultant at another local hospice.

The provider held information which recorded reasons for patients not being admitted to the inpatient unit. On 12 occasions between August 2018 – June 2019, the reason the provider had given for not admitting patients was recorded as 'not enough medical staff'. When we spoke with the provider about this they told us that they had recognised that this data needed further investigation as they believed there had never been a situation when there was not medical staff on duty. After the inspection, the provider examined the issue of admissions during weekends. They told us they ensured there were always sufficient medical staff on duty to meet people's needs by prioritising admissions during the week and care of existing patients at weekends.

In the rotas from August 2018 to June 2019, there was always one doctor minimum and usually up to three, in the inpatient unit, during the day time. It was dependent on the medical needs of the other patients on the unit whether a second patient could be admitted when only one doctor was on the rota, as at weekends.

Nurse staffing

The service did not always have enough nursing staff working in the community to keep patients safe from avoidable harm and to provide the right care and treatment. At our inspection in February 2018 we found staffing levels had been assessed and were being monitored daily, but they did not always ensure they were flexible and sufficient to meet patient's individual needs. The inpatient unit also had a high number of vacancies. At our inspection in August 2018 we found there were many occasions where staffing on the inpatient unit left the ward potentially unsafe. At this inspection we found the provider had improved staffing on the inpatient unit.

However, the clinical nurse specialists working in the community had a high level of short and long term sickness and two full time vacancies. This meant that band five registered nurses in the community had their own caseload when they should have been supporting the community nurse specialists. The band five registered nurses should not have had their own caseload, even though this was a developmental post, without the oversight and support from a clinical nurse specialist.

Records

Nursing staff did not always keep appropriate records of patients' care and treatment. Records were not always clear, up-to-date and available to all staff providing care. We reviewed seven sets of records paper and their corresponding electronic notes. We found the care plans for both paper and electronic copies to be brief, vague and not individualised. Care plans were pre-printed, with the patients name populated onto the care plan but these care plan lacked detail of the patient's individual needs and wishes. Some care plans were in paper form and a few (not all) were on the electronic system. Staff told us this led to them being confused about where they documented the patients care.

The provider had a 'personalised care plan information booklet' which was given to patients for their information about what they could expect to be recorded within their care plan. It had been recorded electronically for the medical and nursing staff to know this information booklet had been handed out to patients. This was also documented on the handover sheet. Following the inspection, the chief executive told us this booklet was part of a cross-organisational initiative to promote continuity of care across care settings. This was created as part of implementation of the 'Five Priorities for Care of the Dying Person' (2014).

Evaluation of care given to patients was usually recorded on the electronic system. A member of staff told us they thought the provider was going back to be completely paper based system. The mixture of recording was a temporary solution until moving to a complete electronic system but was confusing for staff. The organisation was in the process of improving the paper care planning documents before transferring all records to an electronic system. However, of the seven sets of notes we reviewed, only one had a comprehensive assessment and evaluation on the electronic system. We found little evaluation of care on either system. For example, one patient was admitted with pain had a basic pre-printed care plan for pain. We found there was no evaluation of regular pain relief given and no mention of effectiveness of pain relief given for breakthrough pain.

We also found gaps in documented care called 'intentional rounding'. This was to ensure patients were seen regularly for pressure area care, to be offered a drink or the toilet. We found in three of the seven sets of notes, gaps of six hours and one intentional rounding chart was blank at 3pm in the afternoon. We could not be assured that patients were receiving the care they required. We brought this to the attention of the Director of Services to be rectified.

After the inspection, the chief executive told us they had started a project to improve the paper care plans, overseen by a dedicated nurse.

Medical staff kept appropriate records of patients' clinical care and treatment. All clinical notes were documented on the electronic system. All notes were clear, concise and had a clear medical management plan for each patient. It was clear that patients had been consulted about their wishes and expectations. A speciality doctor had devised a series of prompts for junior staff when clerking patients. Medical and nursing staff jointly admitted patients onto the inpatient unit. Allergies were discussed with patients on admission and were noted in their records and on prescription charts.

There was good management of paper records. We found that staff of various disciplines recorded information into the patients' records. We found that information was recorded in a contemporaneous way and staff signed, dated and timed their entries and recorded their designation or role. Notes we reviewed were neat and legible and detailed the care the patient had received well. This was in line with good practice.

Prescription charts and records relating to medicines were of a good standard. We did not see any unauthorised omissions on the medicines charts we checked. The patient's allergy status was recorded on all medicine's charts reviewed.

Patient records and information were stored securely. We found paper-based records to be stored securely in a locked office. We found all computers locked and accessed by appropriate staff.

Medicines

The provider had systems for the safe storage, administration, prescribing and disposal of medicines. However, not all staff administering medicines had undertaken the services required training and had been assessed as competent. Patients received the right medicines at the right dose at the right time. At our inspection in February 2018 we found medicines management was not always safe. We issued a requirement notice for areas of concern. The provider sent us an action plan which said they had addressed the shortfalls. At this inspection we found staff stored and managed all medicines and prescribing documents in line with the provider's policy.

There were suitable arrangements for ordering and storing controlled drugs with a check of balance completed by two nurses daily. Stock medicines were stored securely with access restricted to registered nursing staff.

Medicines including emergency medicines and medical gases were stored securely and within their recommended temperature ranges. There were systems to monitor medicine expiry dates

In the day therapy unit, patients were assessed for the support they needed to administer their own medicines. There was a registered nurse in day therapy to support patients with administration of medicines if required, including medical gas therapy.

Medicines related stationary was not managed safely and securely in line with guidance. We found medicines related stationery was not tracked as required by national guidance issued by NHS Counter Fraud Authority Management

Medicine incidents and errors were recorded on the incident reporting system. Medicine errors were discussed at the monthly risk and information meeting. A medicines errors report was extracted from the incident reporting system. In 2018-19, 71 medicines errors had been reported. The provider had recently changed the reflective tool used for staff, both medical and nursing, after a medicine error. This was to increase the level of scrutiny for medicine errors. We were given an example how changes had been made to staff practice following some recent incidents.

Training and competency assessment of all staff handling medicines was not always undertaken. Registered nursing staff were expected to complete an online medicines management module. However, to date, only 46% of registered staff had completed this. Healthcare assistants did not administer medicines in the inpatient unit but applied topical creams and ointments. The registered nurse signed for the administration but did not actually usually administer it. This was highlighted in a recently independent report, commissioned by the provider, into administration of medicines**.**

The provider had pharmacy input. Support was available from a local acute trust pharmacist. The acute trust was contracted to provide medicines with out of hours support also provided. Additional pharmacy support was provided by a local pharmacy three mornings a week.

Medicines reconciliation was carried out by a trained and competent healthcare professional. We reviewed seven inpatient prescription charts. We found all prescription charts had been reviewed by a pharmacist, there were no gaps in administration, 'as necessary' medicines were prescribed and administered, and the patient's allergy status was recorded.

Incidents

There had been some improvement in the reporting and investigating of incidents, however further improvements were required to build on this. At our inspection in February 2018 we found staff were not always supported to understand what constituted an incident. At our August 2018 inspection we found there was no formal incident investigation process to ensure that learning from incidents were identified and cascaded to staff to improve patient safety.

At this inspection staff told us there was an incident book held on reception, and information in relation to incidents were also held electronically. They told us of an example where a patient was injured getting out of their car, and this had led to training and learning on manual handling techniques. However, volunteers we spoke with told us they were not involved with incident reporting and therefore we could be assured that all who supported patients were aware of, or supported to, report incidents, when required, for investigation.

There was a formal paper-based incident reporting system, training for the investigation process and a clinical incident log to monitor incidents. The provider's incident policy had an incident grading matrix to classify incidents into none/near miss, low, medium, high and death. However, the incident log did not document the grade of risk of the incident. This meant that potentially serious incidents could be missed.

We saw there were databases and spreadsheets available for staff to record incidents and actions taken. However, there was variation across the organisation in the use of these. We found the corporate incident report did not contain any learning shared, and this was replicated in other departments. However, the single point of access team had recorded lessons learned. From this we could see team reflection had taken place following incidents, actions taken and integrated into practice.

Staff received training to undertake investigations, however, lessons learned were not always shared. In November and December 2018, 18 senior staff had received training for root cause analysis. However, our review of actions following a root cause analysis found lessons learned from investigations had not always been shared with the whole team and the wider service.

In team minutes there was limited mention of incidents. For example, we reviewed the incident log and compared the incidents that had occurred and whether they were mentioned in the limited amount of meeting minutes supplied to us; they were not. Also, the lessons learned, and dissemination of lessons learned were not

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consistently completed or recorded on the incident log. Staff told us they did not receive feedback from incidents in their team meetings or safety briefings therefore, learning from incidents was not consistently used to develop learning. For example, an inpatient falls audit had been completed to learn from and prevent recurrence of falls. The audit was of ten responses and demonstrated higher times in relation to shift patterns, the highest levels of falls were on Mondays at around breakfast, lunchtime and bedtime. There was no evidence provided that would demonstrate the information was used to inform staff, staffing levels or work plans.

From April 2018 – June 2019 there had been no Never Events and 45 clinical incidents with no serious injuries.

Are hospice services for adults effective? (for example, treatment is effective)

Requires improvement

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

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence of its effectiveness. Advance care planning was a process that enabled individuals to make plans about their future health care**.** Advance care plans provide direction to healthcare professionals when a person may not be able to either make and/or communicate their own healthcare choices.

The provider cannot be fully assured that care, treatment and support was always delivered in line with legislation, standards and evidence-based guidance, including NICE and other expert professional bodies. We requested, but did not receive, evidence that national guidance was incorporated into systems, processes and policies. For example, the 'Five priorities for care of the dying person'; National Institute for Health and Care Excellence (NICE) Quality Statement (QS) 144 Care of dying adults in the last days of life (March, 2017); NICE National Guidance 31 Care of dying adults in the last days of life (December, 2015), NICE QS13 End of life care for adults (November, 2011) and Ambitions for Palliative and End of Life Care, a national framework for local action 2015-2020. When we spoke to senior members of staff they were not aware of the five priorities for care of the dying person and told us they thought these were a good idea and something they would look into.

As there was no audit process or outcomes in relation to the care of the dying, we could not be assured national guidance was being used effectively to manage patients' care in the last days and hours of life. We also found that patients did not have a clear personalised care plan which reflected their complex needs and wishes.

Not all patients cared for by the hospice had Advance Care Plan to which the hospice had access to. The advanced care plans could be completed with the GP, District Nurse or the hospice. We found that advance care planning documentation was not always completed. This meant patients care needs and preferences at the end of their life may not be met by the staff.

Of the seven sets of notes we reviewed, only two patients had advanced care plans.

Nutrition and hydration

Although the service was committed to providing good quality meals, we found the individual nutritional and special needs of patients were not always identified and recorded. In order to support patients, the service used special feeding and hydration techniques when necessary. An inpatient nutritional audit was completed in March 2019, but there was no evidence the information was used to tailor meals to individual needs. The audit was of six patients and included patients who needed assistance with eating and drinking. There were minimal actions recorded from the audit and there was no follow up date to review and ensure the actions identified from the audit had been completed. The provider had not collected any feedback from patients about the quality and choice of meals and drinks available.

The general menu offered to patients had a very limited selection and did not meet the needs of patients who for example, had a sore mouth or difficulty in swallowing food. There was no evidence that soft diets for patients were considered and fortified foods for patients with poor nutritional intake were not available. There was no provision made for patients with special needs. For

example, some patients may benefit from finger foods being available throughout the day. The provider was aware that this was an area for improvement. A new link nurse had been appointed and was keen to improve nutrition for patients. They had arranged a meeting with the dietitian and chef to look at issues such as fortified and soft options of food for patients.

The kitchen was locked at night and night staff had access to the keys. Staff could prepare soup, sandwiches and drinks for the patients if required.

Hydration was managed according to patient wishes. Following assessment of a patient, and if the patient wanted or had planned for, intravenous or subcutaneous fluids could be prescribed and administered.

Pain relief

Staff did not always record that they regularly assessed and monitored patients to see if they were in pain. The provider used a pain score to assess the level of pain. Patients were asked to grade the pain they experienced on a scale of one to ten. We found there was no recorded evaluation of the effectiveness of pain relief given, including when given for breakthrough pain. However, patients we spoke to were positive about the way their pain was managed. We observed staff asking patients about their level pain on medicine rounds.

We observed the clinical specialist nurses talking to patients about pain management and symptom control.

Staff prescribed and administered pain relief accurately. Anticipatory medicines were prescribed for patients on the inpatient unit and 'just in case' medicines in the community for symptom control. This meant patients would not have to wait for medicines to be prescribed when experiencing a symptom for the first time. For example, medicine for nausea and stronger pain relief. We found anticipatory medicines were prescribed and given as needed.

The provider was also improving the safe use of transcutaneous electrical nerve stimulation (TENS), which is a method of pain relief involving the use of a mild electrical current, through improved competency for registered nurses and consent from patients.

Patient outcomes

Managers did not always monitor the effectiveness of care and treatment to use findings to improve them. A patient discharge audit had been undertaken between January and March 2019. This audit looked at the average length of stay for discharged patients, geographical location, eligibility for funding, level of support required to help individuals manage after discharge and whether they had a mental capacity assessment. The data collected was used to implement actions and improve outcomes for the next quarter. This was the first audit and we were told this would be used to measure against future audits.

There was no participation in relevant quality improvement initiatives. There was no programme of multidisciplinary audits to check care and treatment was being provided in accordance with national guidelines. For example, patient outcomes against the ambitions of the Five priorities for care of the dying person. Senior members of staff we spoke with about this told us they were unaware of such an audit, it was something they were interested in, and it would be something they would look into.

An audit of records was undertaken in December 2018 to assess compliance recently. However, the audit concentrated on grammar, spelling and not quality issues for example, timely completion of risk assessments and evaluation of care given. Staff members we spoke with confirmed there was further work to do to capture the right data to improve patient outcomes.

The provider used outcome measures such as the outcome assessment and complexity collaborative(OACC) for patient care. However, they did not evaluate results to understand the breadth of the service being provided. Monitoring patient outcomes was important to know if the care given is what the person and their family wanted and to ensure it was the most appropriate care possible and how it made a positive difference to their lives. The provider did not participate in the National Audit of Care at the End of Life (NACEL). The provider told us they were considering registering to be part of the audit.

The organisation held monthly quality improvement and clinical audit meetings. These were attended by all clinical leads and a senior manager. We found minutes of

these meetings which covered what audits were due, and ensuring tools were ready to complete audits. We saw audit papers, with action plans, but these plans had no timescales or responsible person. We found results of audits were not discussed at the meetings, and action plans were not followed through or monitored. We found no evidence that audits were used to improve outcomes for patients.

Competent staff

The service did not always record the training and supervision undertaken to demonstrate staff were competent for their roles. At our focused inspection in February 2018 we found staff did not receive role-specific training on a consistent basis. Most staff had not undertaken refresher training on role specific competencies. Following that 2018 inspection, the provider had acted to address the gaps in staff training. Staff told us that whilst they had benefitted from the training they had felt overwhelmed with the extra training .

At this inspection we had concerns about the records of education and skills undertaken by the clinical nurse specialists (CNSs) working in the community. Staff told us there was a competency framework for them and that they had completed this. However, when we reviewed the provider's training records, none of the CNSs had any records documenting further education undertaken, such as degree or master's level degree in the field of end of life care. A bank CNS had a level two certificate in end of life care. The service had six non-medical prescribers and two were undertaking the course; this was also not documented.

The CNS team were experiencing high levels of short- and long-term sickness and also had two full time vacancies. Band five staff nurses in the community, who supported the CNSs, had their own caseload as demand for services was so high. A senior member of staff told us that staff were very experienced and trained to an appropriate level, but we could find no documented evidence of full training undertaken. Also, we were unable to establish who had oversight of the competency framework and its completion. The provider had identified that band five registered nurses should not have their own caseload. However, band five registered nurses had caseloads and we were concerned whether they received the supervision support they required as the provider could not provide evidence of this.

There was a structured induction programme that all staff and volunteers completed when they started work at the hospice. At the last inspection in August 2018, we found the provider did not ensure there was an induction programme which prepared all staff for their roles. At this inspection we found an improvement as all new staff, including volunteers, received an induction programme and this was documented. Staff and volunteers told us they had undergone a comprehensive induction and had felt well supported.

Staff received clinical supervision/one-to-one meetings on a regular basis. Following the August 2018 inspection, we issued a requirement notice for their provider to address these shortfalls. The action plan we received following this inspection said they had addressed these areas of concern. At this inspection we found staff were receiving some clinical supervision. The matron received clinical supervision from the clinical psychologist every six to eight weeks.

Therapy staff we spoke with told us they had yearly appraisals and one-to-ones with their manager. Staff had been asked to identify goals they wanted to achieve by the end of the financial year. At the time of the inspection each member of therapy staff had been asked to create timelines and milestones to help ensure goals could be met. Staff also told us they had access to additional training modules, such as medicines management.

Nursing professional registration was recorded on the training records. We found six registered nurses whose current professional registration was not recorded by the provider. However, assurances were received post the inspection, that all registered nurses had a valid and current registration to practice.

Volunteers, where required were trained and supported for the role they undertook. During our inspection we spoke to six volunteers, two clinical and four non-clinical staff. They had received an induction through the provider which they felt had prepared them well for the role. The volunteers spoke very positively about their experiences in working for the provider and

told us they felt like part of the wider team, and further told us that communication was good from managers. Volunteers also had a quarterly meeting, and this was an open forum to discuss any issues.

Multidisciplinary working

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

Effective multidisciplinary working was evident. We found good multi-disciplinary working between the departments. Staff delivered and reviewed care in a coordinated way. Staff felt confident in seeking support from members of the department. Nursing staff spoke very positively about the volunteers who attended to help with patients in the inpatient unit and in the day therapies rooms and supported the carers café.

Information was shared with the patients GP on discharge. Discharge letters were automatically sent to the patients GP when discharged from department. If patients were part of a follow up clinic then a letter would be sent to the patients GP. This information would also be shared with social or care workers where appropriate.

There was a clear process for the transfer of care from hospital to the hospice. The provider had a team based at the local hospital which covered most end of life patients. They had clear pathways to aid them to ensure patients were sent to local hospices where appropriate.

Seven-day services

There were services available 24 hours a day with enough access to support patient care.

Nurses and medical staff provided cover 24-hours-a-day, seven days-a-week. This was either on site or on-call. Junior and middle-grade doctors told us the consultants were always accessible and gave them good support and would attend during on calls as required. Cover was also available from clinical nurse specialists, Prospect@Home and therapy team staff.

Pharmacy services were available either in the department, accessible by telephone or on call. Staff told us should they need specific medicines, not stocked in the department, the pharmacy arrangement with the local acute trust responded in a timely way.

Health promotion

The hospice offered support to people to live well until the end of their life, through self-management, reablement and appropriate therapies. The service's therapy team included physiotherapists and occupational therapists, as well as offering access to a lymphoedema nurse five days a week and a dietitian one day a week. The purpose of the day therapy unit was to help patients stay independent, feel supported and build confidence in readiness for the challenges they may face ahead.

The unit offered an 'open programme' to new patients. It offered a range of courses designed to help patients cope better with their illness. Developed by the therapy team, it was designed to give practical advice and information to build skills and confidence. This was an eight-week course, with subjects including: living with breathlessness; managing fatigue; managing stress; nutrition workshop; adapted Tai Chi and a sleep workshop. Staff gave us examples of changes made to the programme following patient feedback. For example, patients told staff that the session on fatigue was too long, so adjustments were made to reduce the length of the session.

The unit also offered a 16-week course, designed to help support patients through their illness, to maintain independence and to boost sense of wellbeing. This included taking part in some of therapeutic and social activities, to help to lift each patient's confidence and self-esteem, and reduce stress and anxiety. The therapies team worked with patients to set goals together.

Consent, Mental Capacity Act and Deprivation of Liberty (DoLS)

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.

The Prospect team based at the local acute hospital clearly understood the requirements for patients to consent to their care. All patients referred to their service had to be consented by the NHS hospital staff before they could be referred to the service. Consent of patients was clearly identified on the notice board in the locked room where staff were based. We reviewed all the inpatients

treatment escalation and resuscitation plans. We found they were generally well completed and mental capacity was always considered and reasons for decisions well documented.

The hospice had identified two recent incidents where DoLS forms had not been completed, both in May 2019. Following these incidents, the organisation notified the local clinical commissioning group. The organisation provided mandatory on-line training to staff and further mandatory face to face sessions had been arranged to take place in the week following the inspection. Plans for improved paperwork were underway, and we were told that new flowcharts were being added to the policy which would then be recirculated.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

A patient discharge audit was completed from January to March 2019 which included a review of mental capacity assessments. The report concluded there had been significant improvement in acknowledgment of mental capacity and appropriate capacity assessments had been carried out. Patients who were assessed as lacking capacity had a best interests meetings and were involved in decisions about their care and treatment. There was an action plan to continue to monitor and gather information on best interest meetings and DoLs outcomes for patients as part of the next cycle of audits to ensure correct processes were being followed.

Are hospice services for adults caring?

Good

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

Compassionate care

Staff cared for patients with compassion. We observed all staff introduce themselves and explain who they were and their role. The tone of voice used was one of respect and care and an understanding of both the patients and relative's situation. Patients we spoke with all spoke positively about the care they had received**.**

Patients felt staff gave them the care they needed, and we observed staff treating patients with empathy and kindness. Staff took the time to interact with people who use the service and those close to them in a respectful and considerate manner.

Feedback from four patients and relatives confirmed that staff treated them well, with kindness, dignity and respect by all staff. The provider conducted patient experience surveys. The latest survey showed a satisfaction rate for the inpatient unit was 94%, Prospect@Home 100%, complimentary therapy 99%, day hospice 95%, clinical nurse specialists 96%, Occupational Therapy 87% and Physiotherapy 98%.

Staff understood and respected the personal, cultural, social and religious needs of people and took these into account in the way they delivered services. The provider ensured care after death, which included honouring spiritual and cultural wishes of the deceased person and their family and carers. Patients were asked if they had any spiritual or religious needs and we saw this documented in the care plans. Staff undertook online learning for spiritual needs of patients and their families. The provider also had a spiritual co-ordinator who had good links with local churches and faith leaders. The inpatient unit had a multi-faith room called the 'Quiet Space'. This room was well furnished and had copies of different religious texts for patients and relatives to use. There was also access to the viewing room where relatives could spend private time with their deceased relative. The provider also had a designated family room where private discussions could be held with relatives.

The service honoured people's wishes for organ and tissue donation. A speciality doctor had compiled a tissue donation flow chart for the hospice and the community. This contained the eligibility and exclusion criteria for donation. Patients and relatives were asked for their opinion on donation when being admitted by the doctor.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs. Emotional support was provided by all staff to patients and relatives. We saw staff sitting with patients

and families providing explanations, listening and supporting patients and relatives. We observed comprehensive assessments conducted in a very caring, considerate manner. They ensured they understood the information and were given the opportunity to answer any questions.

People were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. Staff said that where appropriate they referred or signposted patient's and relatives to other community services, including support groups and voluntary agencies, for emotional and mental health support with their care.

Patients could be referred to the clinical psychologist who visited the hospice for support. We observed staff demonstrated a non-judgemental attitude when supporting patients with a mental health issue. They showed understanding about their condition and talked to them with respect.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. Patients and relatives were given opportunities to ask questions and staff gave them time to do this. We observed staff asking questions and waiting for the answers. Staff offered options and were able to discuss the patients care with them. Relatives and carers were given timely support and a space to have discussions. Patients carers, advocates and representatives including family members and friends were identified, welcomed, and treated as important partners in the delivery of their care.

Staff involved people who used services and those close to them in planning and making shared decisions about their care and treatment. We observed many examples of how staff included patients and those close to them in making decisions about their care. For example, medical staff encouraged patients and those close to them in be involved in decisions about their care. Medical staff said that it was about "what was important" to patients and about patients taking "ownership" of their care.

Are hospice services for adults responsive to people's needs? (for example, to feedback?)

Requires improvement

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

Service delivery to meet the needs of local people.

The service did not always plan and provide care in a way that met the needs of local people and the communities served. At our focused inspection in February 2018 we found patients did not always have their individual needs met as admissions to the unit were regularly delayed. This was due to issues with staffing. We issued a requirement notice for the provider to address this issue. The action plan we received following the inspection said this was addressed. At our August 2018 inspection we found patients were still being delayed admission to the hospice due to staffing.

At this inspection we found between August 2018 and June 2019, 190 patients were added to the waiting list of which 151 were actually admitted. Of these 114 patients were admitted within one day and the average waiting time to be admitted was 1.3 days with the longest wait of three days. Delayed admissions affected 63 patients, 22 due to shortage of medical and/or nursing staff, 30 due to the inpatient unit being full and eight patients were medically delayed. In total, 39 patients were removed from the waiting list for varied reasons including the patient declining admission, being admitted to the local acute hospital and patients who died at home. Although patients were still experiencing delays, this was an improvement on the inspection in August 2018. At the time of our inspection, only one patient was waiting for admission.

The service worked with others in local organisations to plan care. The provider worked closely with the local clinical commissioning group, the local acute trust, a local independent pharmacist, social services and their own teams to plan care for patients. The provider employed a team of clinical nurse

specialists who worked within a local acute trust Their role was to identify patients who would benefit from palliative care, either in the community or in the hospice admission and support their discharge from hospital.

The hospice was designed to meet the needs of families and relatives of patients. The hospice provided accommodation for families and relatives of patients. They had two purpose-built lodges in the gardens. These were well furnished, and relatives told us they helped them to be near to their loved ones. Relatives were also allowed to stay by the patient's bedside if requested.

The hospice also had a cafeteria run by volunteers. All food was cooked in the hospice kitchens and was available to families, relatives, staff and visitors. The hospice also provided hot and cold drinks for relatives who could help themselves.

Staff had access to translation services to help patients with communication. Staff told us how they could access translation services when required.

Meeting people's individual needs

The service and its environment took account of patients' individual needs. Corridors and doors were wide enough for wheelchair access. All bathrooms had disabled facilities, including the lodge accommodation provided for families. Staff were able to access interpreters for patients whose first language was not English. This could be arranged through an external company over the telephone.

People's privacy and dignity were respected, including during physical or intimate care in nearly all areas we visited. Staff pulled curtains and doors were shut when undertaking care. A member of staff was observed attending to the personal hygiene needs of an end of life patient. They answered the call button immediately and spoke to the patient in a discrete and quiet manner. The curtains were drawn round the patient to ensure privacy and dignity.

All the rooms and bays in the inpatient unit looked out onto the gardens. Patients could be wheeled out, on their beds if needed, to enjoy the outdoors. Parasols and sun cream were provided for the patients. The gardens had wheelchair friendly paths and there was also a remembrance area where relatives could lay commemorative stones in memory of their loved ones. This part of the garden could be accessed from the side of the hospice so that relatives did not have to pass through the hospice.

The inpatient unit had a large conservatory called the garden room. There was a large television on the wall and patients and relatives were encouraged to use the room. It had been used for family parties, weddings and a confirmation.

Nurse call bells and emergency call bells were available in areas where patients were left alone, such as toilets and changing areas. The staff carried bleeps in their pockets to alert them to the needs of the patients and there was a panel at the nurse's station which had an audible alarm. We found they were answered quickly.

The provider had 'Pets as Therapy' dogs who visited the unit once a week. Relatives were also able to bring in patients' pets.

The provider had a network of volunteers who supported patients and relatives at home. They did not provide personal care but provided support and companionship to patients and relatives.

The service made adjustments for patients' religious, cultural and other preferences. The provider's chef had worked with a local Hindu community group who showed them how to cook Hindu vegetarian food. They also catered for Halal and Kosher diets.

The provider was not fully engaged in patients preferred place of death. The provider was able to produce basic information on whether a patient had died in their preferred place of death. However, it was not possible to see if patients wishes had been met, and in many cases the patient's preferred place of death was unknown and had not been obtained or recorded in their notes. The data given to us recorded that from August 2018 to June 2019 showed 62% of patients had died in their preferred place of death, 10% had not, but whether the patient had died in their preferred place of death was unknown for 24% of patients. After the inspection, the provider told us it was neither compulsory, nor possible to obtain this information all of the time. The reasons given were the organisation was not the only provider responsible for obtaining this data and it was sometimes not possible to obtain it.

Requires improvement

Hospice services for adults

Access to care at the right time

People could access the service when they needed it. The service had a 'single point of contact' (SPOC) team which began in May 2017. Their role was to ensure that patients referred to the service received the right at the right time, in the right place. At the time of the inspection there were three band six nurses employed in the SPOC team (an increase of one staff member since April 2019), and three administrators. The team told us that previously all patients had been referred to the clinical nurse specialists, and this meant that there could be delays in providing care to patients.

The SPOC team accepted and managed all patient referrals from the community (from patients, families, and healthcare professionals). The team ensured referred patients meet the referral criteria and had consented to the care. They contacted each patient or carer and to find out what the expectations were of the patient. For all immediate referrals, where the patient was imminently dying, patients or their carers or families were contacted within 24 hours. For urgent referrals, patients, families or carers were contacted within 48 hours, and routine referrals were contacted within three to five days. Data provided by the organisation showed that all immediate referrals were dealt with on time.

The provider had effective processes to manage admission to the service. The provider had an admission policy which aimed to facilitate admission and safe discharge of patients. The local commissioning group had commissioned the provider to provide a 'single point of contact' to the provider's services. On week days, a daily bed meeting was held in the inpatient unit (IPU) which included the IPU nurse in charge, IPU coordinator, specialist doctor on duty, a nominated clinical nurse specialist (CNS) based at the local acute trust and a CNS from the community team. Bed occupancy, staffing, skill mix and current patient dependency levels were reviewed, and potential admissions planned accordingly. At the weekends, potential admissions were discussed between the doctor and CNS on call in agreement with the IPU nurse in charge.

The provider was in charge of its admission list. Patients were prioritised at the bed meeting through joint consultation and as a multidisciplinary decision. The local acute trust funded two beds within the inpatient unit for their patients if they needed palliative care.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. The provider had 29 complaints from June 2018-19 of which three were about clinical care received. Staff worked to manage concerns before they became formal complaints. Learning from complaints was a standing agenda item for discussion at governance meetings, team meetings and, if safety related, during safety briefings.

Complaints were investigated and used to improve the service. Formal complaints were investigated by senior staff. Staff told us they received feedback to any complaints they were involved with.

Patients were encouraged to report concerns about their care and treatment and provide feedback. None of the patients we spoke to felt they had cause to complain. The provider website also had a section on how to complain.

Patients were encouraged to report concerns about their care and treatment and provide feedback. For example, patients told day therapy unit staff that the open session on fatigue was too long, so adjustments were made to reduce the length of the session. Patients also suggested an adapted Tai Chi session, which now forms part of the 'open programme' on the unit.

Are hospice services for adults well-led?

Requires improvement

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

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care, and there were new members of the senior leadership team. Board assurance was in its infancy. At previous inspections we found the senior leadership team were not always

visible or supportive and a number of senior leadership posts were vacant. Trustees were not fully involved and did not provide adequate challenge or hold the senior leadership team to account.

At this inspection, we found the hospice was led by a chief executive officer (CEO) supported by a new team of five directors covering a range of portfolios including patient service, patient services/inpatient unit, family support team, therapy service, a community nursing team and organisational change. A new director for governance and quality was due to start in July 2019. The service was not clinically led by a medical director as the organisation had found it difficult to recruit. Clinical staff were in post such as a matron and the inpatient had a clinical lead. As a charity, the chief executive was accountable to a board of trustees led by the chair. There were 13 trustees on the board, from a mixture of backgrounds.

The hospice has not had a registered manager in post since prior to the last inspection in August 2018. The registered manager de-registered with CQC in November 2018. The CEO also left the service and had simultaneously held the role as nominated individual. At the time of this inspection and report there were no registered persons. However, the provider had recently appointed to the CEO post and this person was aware of their responsibility to register as the nominated individual. The provider also now had a registered manager in post who was in the process of registering with us. Since our last inspection a matron, a clinical and deputy clinical lead had been appointed to oversee the inpatient unit.

The new CEO had maintained regular contact with CQC since their appointment in September 2018. They provided regular updates on senior appointments, in addition to sending monthly progress reports, as required by the conditions of registration. Staff told us that senior leaders were visible and approachable**.** All staff told us there was improved support and engagement from the executive team, including the chief executive.

There has been a positive step change since our last inspection, with the new leadership team having the key ingredients and commitment to develop a performing team. The CEO, trustees and the senior leadership team have identified areas of improvement and have recognised that there are still a number of areas for development and improvement and are working to develop and strengthen these areas.

The most current staff survey had been conducted in June 2018. The staff survey used by the hospice was a survey recommended for this service type. The 2018 survey reported that 87% of staff were clear about what was expected of them, 50% of staff felt appreciated and a third of staff didn't feel there were opportunities for career and personal development. A staff survey for 2019 was in progress at the time of this inspection.

The CEO has initiated a monthly update newsletter to staff in order to aid communication and staff engagement and feedback. We saw a committed team who wanted to work well together, inclusively for the benefit of people using the service.

We found the quality assurance and governance frameworks were not yet fully developed and that work was in progress to support the development of this and the board assurance framework and the underpinning associated dashboards. We saw positive changes in the organisation and the board since our last inspection. The board were working together more cohesively as a group and there was a feeling of 'being on a journey'. We saw what we felt, was a step change at the service. However, it was important that enough time and attention to quality improvement and board governance and development was given.

People that we saw at differing levels within teams told us that they were on board with the journey of improvement and we were also told that although difficult for some staff, they had recognised that changes were needed. Staff were keen to be involved in quality and safety development and improvement to provide the stability and assurance required to take the service forward.

Trustees were striving to meet their governance responsibilities and have a good understanding of quality and safety of care. Since our last inspection the provider has appointed a director for organisational change who was on a fixed term contact and a director of governance and quality assurance who was taking up the post in July 2019

Also, since our last inspection the trustees had been more engaged with staff, participating in culture workshops

and undertaking trustee buddy visits to departments, these visited were recorded, and feedback to develop and improve services had been provided. In July 2019 the current chair of the board, who had served the maximum term permitted, stepped down and an experienced replacement had been identified.

The leadership team were highly visible in the hospice. Some members of staff told us they felt well-led and connected. They said they felt they were able to escalate issues which would be dealt with, they were respected and listened to. They told us the team had 'gelled and really turned around and was unrecognisable from last year' and that the disconnect between staff and the senior management team had now gone.

The clinical leads wrote bi-weekly reports of issues for escalation to the executive team. This process was popular with the clinical leads as a good channel of communication.

Vision and strategy

The service had a vision for what it wanted to achiever, this was under review and development with the whole staff team. At our inspection in February 2018 we found the provider had a clear set of values which staff were expected to demonstrate but it was unclear if staff were always demonstrating them.

The hospice had a mission statement and a set of values. These were currently under review. Three "Your Prospect" workshops have taken place and were well attended with almost 150 staff, including trustees attending with some clinical staff attending in their own time. We were told that staff engagement looking at the organisation's culture, mission, values and underpinning behaviours has been high and the output from the workshops will be brought together and reviewed at the staff forum. We were told the next steps were to look at embedding the values with staff, incorporating these within 1:1 meetings and linking these into individual's annual performance reviews.

At this inspection we found the provider was working with the whole staff team through a serious of staff workshops, staff forums and culture work to review the organisation vision and mission. As part of this work there were plans to develop organisational values and behaviours. This work was very much in the early stages and the senior leadership team were committed to developing a strategy to underpin this. Staff were engaged in the strategy work and were being consulted for their views, further work was planned for consultation with people who use the service, their carers and other external stakeholders. The strategy should align to local plans in the wider health and social care

Structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services were at different stages throughout the organisation. We found teams had used the Care Quality Commission's key lines of enquiry to underpin its governance. For example, in meetings and minutes and staff one-to-one meetings were structured under: safe, effective, caring, responsive and well-led. Staff told us that this had helped them identify gaps in their processes, for example requiring some updated statements of purpose.

Culture

Managers across the service promoted a positive culture that aimed to support and value staff, there has been improvement, however, this was still an area for improvement. At our inspection in August 2018 we found managers did not promote a positive culture that supported and valued staff. Staff on the inpatient unit felt unsupported by the senior management team and the trustees. Staff morale was mixed. We found that staff complaints and grievances had not been investigated in a timely way. At this inspection we found staff at all levels were committed to ensuring patient care was safe, however, staff satisfaction was variable. The organisation had worked to improve the culture and some staff told us that since our last inspection the culture had improved. After the inspection, the provider told us they had identified an equality and diversity lead who been given an 18-month project to include embedding of the work on culture within the organisation. The culture workshops had helped and that the organisation were on an improvement journey, however, some staff told us they felt undervalued and believed that there was lack of recognition of their input and impact and were emotionally upset in sharing their experiences with us. Additionally, we heard from some staff of a poor culture around speaking up with a fear of the outcome of doing so. Generally, staff gave us a clear message that they wanted to be involved in decisions that affected them.

The culture did not always encourage, openness the organisation. Staff were aware of the Freedom to Speak Up Guardian role. There were three new guardians and the CEO had also been identified as a point of contact for people to raise concerns to. We spoke to staff within these roles who were clear on their role and responsibilities and had worked to develop the speak up policy, staff training and development and to publicise the purpose and function of the role. We found that some staff did not know who the guardians were and although they welcomed this process some staff told us that they would not speak up for fear of reprisal and the lack of confidence that their issues would be listened to. The Freedom to Speak up policy and procedure was approved for issue by the board in April 2019. Some consideration should be given to this policy as the tittle 'The Freedom to Speak up policy 'as this could be misleading for staff. Contained within the policy was reference to 'protected disclosure' which directed staff who wished to make a whistle blowing concern to an external body or legal representative, but the policy did not cover what a protected disclosure was and how this could be raised within the organisation.

Since our last inspection the staff forum had been reviewed and refreshed with new membership, the group met monthly, issues covered included staff safety, well-being and communication. Information contained within the minutes of these meetings showed that staff felt that feedback within the organisation was mixed, all gave positive feedback on the structure and pace of the 'Your Prospect days', however, some people indicated that information was not getting to them from the staff forum.

Not all staff felt supported, respected and valued. During the inspection we looked at the analysis of staff who had left the organisation. From January 2018 to May 2019 88 members of staff had left. Of those, 24 had had exit interviews. Nine members of staff had been unhappy when they left, with issues around ethos and management in the organisation; heavy workload, issues with managers and work-related stress. The analysis had been reported to the board, and an action plan was presented, although this could not be provided at the time of the inspection. Staff we spoke with told us that going forward all exit interviews would be face to face and carried out by a member of the human resources team, with the aim to have accurate and timely information to report upon.

Staff told us they really enjoyed working in the hospice. The volunteers we spoke with told us how proud they were to work for the organisation and felt valued by both employed staff and patients. Volunteers were invited to bi-annual meetings which functioned similarly to a staff forum. A lunch had also been organised for the volunteers, as well as occasional evenings out. Volunteers told us they felt valued and were thanked at the end of each shift. They told us they were not taken for granted.

On the whole there were cooperative, supportive and appreciative relationships among staff. However, teams tended to work in silos and more work could be undertaken to ensure staff and teams worked collaboratively, in order to share responsibility and resolve conflict quickly and constructively.

Daily handovers took place on the inpatient unit, attended by nursing team. In addition to discussing each patient, staff would share education on symptom management and any changes in patient medicines.

The hospice care team managers held monthly staff meetings to share information from the senior managers meetings; however, these were not well attended, and managers were considering how they could improve attendance levels.

Equality and diversity were promoted within and beyond the organisation. Staff, including those with particular protected characteristics under the Equality Act, told us they were treated equitably.

Measures were taken to protect safety of staff who worked alone and as part of dispersed teams in the community. Staff told us they felt well supported and were clear on their roles and responsivities as well as their own personal safety. The provider has a lone working policy which staff were aware of.

Governance

Although the will was there and the intent at this point in time the service did not have overarching governance systems to systematically improve service quality or safeguarded high standards of

care. At the inspection undertaken in February 2018 we found there were quality assurance and clinical governance systems, but they were not always effective and were not in a format which drove continuous improvement. Following that inspection, we issued the provider with a warning notice to make improvements. The warning notice contained information of our concerns. Following the inspection in February 2018 the provider sent us an improvement plan detailing that they had addressed all areas of concern. At our inspection in August 2018 we found the warning notice had not been met and we judged the provider had not made progress at sufficient pace. The improvement plan was not supported by sound evidence and we found some assurances provided by the organisation were factually inaccurate. Following that inspection, we added conditions to their registration and these included the provider sending us information every month to demonstrate they were monitoring elements of the services being provided to make sure patients were safe.

At this inspection we found the board assurance framework (BAF) was planned by the organisation to be introduced in September 2019. At a strategic planning event with the board of trustees held in May 2019, time was spent working through the BAF and discussing when the organisational and departmental strategies would be reviewed. Utilisation of the trustee's skill set were also reviewed and evaluated at this event. At the time of this inspection we were shown a BAF prototype and some of the underpinning performance dashboards but cannot comment on the quality or accuracy of these as these were still under development. Although improved, there continues to be a lack of managerial oversight of the risks to quality and safety and a lack of scrutiny and challenge at the top of the organisation.

To support the governance, monitoring and quality insight, work was needed to produce an integrated performance report which was sufficiently detailed, accessible, and that clearly identifies where there may be variations and/or a need for change or improvement.

To support governance, risk oversight and quality assurance, the organisation should consider producing data which could provide intelligent insight and forecasting for the future and to drive service and board improvement decisions.

We were concerned that care plans were not person centered, were not holistic and did not involve the person to whom the care was provided. Staff told us records were confusing and that both paper and electronic systems were used, and they were not always assured they were recording patient care and treatment in the correct place.

The service did not undertake any end of life or care of the dying audit focusing on the quality and outcomes of care experienced by those using the service and therefore cannot be assured of the quality of the service or that patient's wishes were known and respected.

The provider sent us regular notifications, as required by the regulations. People's care records were kept securely and confidentially, and in accordance with the legislative requirements. All record systems relevant to the running of the service were well organised and reviewed regularly.

Managing risks, issues and performance

The service did not have embedded systems to fully identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected. At our inspection in August 2018 we found patient safety, quality and sustainability did not receive sufficient coverage in the organisation's board meetings, where the focus was on reputational risk and risks to income generation.

At this inspection we found that there was a prototype board assurance framework however, systems had not been fully established and operated effectively to ensure full assurance and oversight.

Governance was still considered by the provider as a 'work in progress' the board assurance framework was still under development. The clinical audit plan did not accurately reflect work and was not given sufficient priority and pace. Quality Improvement was lacking, and a system had not been established. This meant that the senior leadership team were not able to assess, monitor and improve the quality and safety of the services provided.

Risk registers were used in each department, at patient services level to review and monitor risk. This was a score-based system and escalation was made by the management team as required, however, the risks recorded on the department risk register did not reflect the concerns staff and managers told us about, concerns over culture within the organisation is an example of this.

Although the board assurance framework was still in its infancy we saw evidence that the risk register was part of the agenda for all board of trustee's meetings. It was also discussed risk at safety compliance committee meetings, which were held every two months.

Any member of staff could report an incident; forms were available on the hospice Intranet and completed on paper. Incidents were investigated by the hospice care team manager or head of clinical services. Feedback was given individually.

At our last inspection, undertaken in August 2018 we found that the service did not manage patient safety incidents well. There was no formal incident investigation process to ensure that learning from incidents was identified and cascaded to staff to improve patient safety. Since our last inspection the risk register identifies areas for improving patient safety, such as a falls assessment and screening tool which are being introduced

Pharmacy support was available from the local NHS Trust and a local pharmacist has been commissioned by the provider since our last inspection to oversee medicines management.

Feedback from people who used the service and the public was collated via an online survey; 'I want great care'. Feedback was extremely complimentary and positive about the care and service provided by staff.

The hospice had a positive and collaborative relationship with the local clinical commissioning group and attended a monthly contract meeting with commissioners to discuss performance and funding.

Records we looked at during inspection showed that risk assessments were completed upon admission but not always reviewed at suitable intervals during a patient's stay in the hospice. Care plans and risk reduction measures were implemented as appropriate where risks were identified. This included risks of falls, pressure ulcers, nutritional deficiency. We had noted on three patients records required regular pressure ulcer risk assessments, but these were not recorded. This meant patients may not be receiving the right level of intervention to reduce risk. We also found the nutritional needs of patients were not always met. Patients nutritional needs had been audited in March 2019 but there was no evidence that this was used to provider the nutritional support needed.

Individual risk for people using the service was discussed at handovers and multidisciplinary meetings. We observed a nursing hand over during our inspection and found that risk for people within the inpatient unit was highlighted effectively.

There was at least one doctor on site in the hospice each day with a consultant on site four days a week. The consultant was available 'on-call' when not on site and could provide advice and support to the staff by telephone. The doctors worked to the local NHS hospital palliative care formulary.

At the time of our inspection there was not a holistic understanding of performance with performance indicators and measures, which sufficiently covered and integrates people's views with information on safety and quality. The provider is aware of this, a lead for quality improvement had been appointed and part of their role will be to work with others in order to develop a system in which tools and information are developed to identify and measure areas for improvement.

Managing information

The service did not always collect, analyse, manage and use information well to support all its activities. At our inspection in February 2018 we found the inpatient unit did not have effective recording and data management systems. Information from investigations and complaints were not always acted on or used to drive quality across the service. At this inspection we looked at the records seven patients that were being cared for as inpatients at the hospice at the time of our inspection. We found nursing records were not always kept appropriately. Records were not always clear, up-to-date and available to all staff providing care. Care plans were brief, vague, not individualised and were a confusing mix of paper and electronic records. Both electronic and paper notes were stored securely. We also checked two records of patients being supported by the Community nursing team. We found that record keeping was of a good standard. Notes were comprehensive, complete and included important information; there were no loose leaves.

Information needed to deliver effective care and treatment were well organised. Treatment protocols and guidelines were either included in proformas or easily accessible from the trust's intranet site.

Requires improvement

Hospice services for adults

Engagement

Leaders and staff actively and openly engaged with people who used the service. They collaborated with partner organisations to help improve services for patients. At our inspection in August 2018 we found that although the former chief executive and trustees had arranged a series of visits to engage with staff on the inpatient unit, many staff continued to feel unsupported by the senior management team, who, they said, were not visible leaders. At this inspection we found the service was taking steps to improve staff engagement. In response to our previous concerns about staff morale and dissatisfaction with management.

The service engaged well with patients, volunteers and the public and local organisations to plan and manage appropriate services and collaborated with partner agencies effectively.

The unit held regular coffee mornings throughout the year which allowed former patients to stay in touch with staff and other patients who had been discharged.

Employees completed an annual staff survey. The results of the 2018 survey were generally positive with staff answering positively to questions asking if the service's vision, mission and valued mattered to them, that the role the worked in was as they expected it to be and their colleagues were committed to doing quality work.

The service ran a patient survey for service users to give their feedback about their experience, we saw the results from these feedbacks were overwhelmingly positive.

There was regular communication with staff via 1;1 and annual appraisal meetings, individual team meetings, the CEO monthly updates, the intranet page and staff forum.

The service had an on-line facility for people to provide feedback about the service, there also was a feedback box for written feedback and also the service had an IPAD in the reception area for people to have their say and to have methods to help improve the quality of the existing services and be involved in the discussion about the development of future services.

The service met regularly with the local Clinical Commissioning Group who reviewed and oversaw the organisation's improvement plan.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure care plans are person centered, holistic and involve the person to whom the care was provided to. Staff told us that patient care records were confusing and that both paper and electronic systems were used, and they were not always assured they were recording patient care and treatment in the correct place. (Regulation 12 (1) (2) (d))
- Ensure quality improvement principles and practices are developed and ensuring they are given pace and prioritisation and must be cascaded and embedded within the organisation to ensure they are effective and are in a format which drive continuous improvement. (Regulation 17 (1) (2) (a))

Action the provider SHOULD take to improve

- Check risk assessments are kept under review for each patient to identify, remove or minimise risks.
- Have an appropriate level of nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm.
- Resolve the confusion about paper and electronic systems for recording nursing notes.
- Check all staff involved in incident reporting are clear on their role and responsibility and are clear on the reporting process and that there is a process of oversight monitoring evidencing lessons learnt to avoid, where possible, reoccurrence of incidents.
- Manage prescription stationary line with the provider's policy and national guidance.
- Share and document lessons learned from patient safety incidents with the whole team and the wider service.
- Provide evidence that care and treatment delivered is based on national guidance and evidence-based practice. The nutritional needs, wishes and choices of people are known and provided to meet individual need.
- Check staff always document pain assessments of patients.
- Monitor the effectiveness of care and treatment and participate in relevant quality improvement initiatives. Care should be planned and delivered in a way that met the needs of local people and the communities served.
- Check training records demonstrate that all staff are competent for their roles.
- Continue to improve waiting times from referral to achievement of preferred place of care and death and document to be in line with good practice.
- Continue work on culture within the organisation to make sure staff feel respected, supported and valued. Also, continue to work on the culture to encourage, openness within the organisation.
- Give consideration to there being clear recorded information for staff on how to raise concerns safely.
- Align the organisational vision and strategy to local plans in the wider health and social care economy, and identify how have services been planned to meet the needs of the relevant population and be in line with national recommendations and direction of travel for hospice care.
- Review board meetings to provide scrutiny and a clear audit trail of the discussions that take place and the key decisions made.
- Look to produce an integrated performance report which is sufficiently detailed, accessible, and clearly identifies where there may be variations and/or a need for change or improvement.
- Have a system for producing data which can provide intelligent insight and forecasting for the future and to drive service and board improvement decisions.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure care plans are person centered, holistic and involve the person to whom the care was provided to. Staff told us that patient care records were confusing and that both paper and electronic systems were used, and they were not always assured they were recording patient care and treatment in the correct place. (Regulation 12 (1) (2) (d))

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider must ensure quality improvement principles and practices are developed and ensuring they are given pace and prioritisation and must be cascaded and embedded within the organisation to ensure they are effective and are in a format which drive continuous improvement.** Regulation 17 (1) (2) (a)