Prospect Hospice Limited

Prospect Hospice

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service responsive?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

We undertook an unannounced focused inspection of the Prospect Hospice on 20 and 21 February 2018. This inspection was carried out in response to concerns we received related to the service. The concerns centred on the inpatient unit and were focussed on low staffing numbers, out of date staff competencies, increased safety incidents/complaints, low staff morale/wellbeing and allegations of bullying by senior staff.

The inpatient unit at the Prospect Hospice provided care and support for adults living with and dying from advanced and progressive life limiting illnesses. The inpatient unit is a 16-bed inpatient facility which provided respite care, symptom control and care at the very end of life. There were eight individual patient rooms and two four-bedded male and female bays. At the time of our inspection, one of the inpatient rooms had been temporarily converted into a patient gym, which effectively reduced the number of inpatient beds to 15.

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

The inspection team consisted of two inspectors. During the inspection visit, the team:

- Spoke with four patients and four relatives;
- Reviewed 13 patient records;
- Reviewed relevant data, including policies, procedures and meeting minutes;
- Spoke with 23 members of staff; including seven healthcare assistants, nine registered nurses, two doctors, two administration staff, the clinical lead and two head of service leads.
- We also spoke with two directors, the chief executive officer and a trustee of the board.

The Care Quality Commission last inspected the service in November 2016 and rated the provider as good overall.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

We have not rated the service as part of this focussed inspection. We did not inspect all areas related to this key question and only inspected areas of the service based on the concerns that were raised.

•□Staff were not always supported to understand what constituted an incident and it was unclear if they were encouraged to raise concerns.

•□Investigations into staff concerns were not always thorough or objective and action was not always taken to address them.

•□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 provider was not assured all staff working on the inpatient unit had up to date role-specific training or competencies.

•□The inpatient unit had a high number of vacancies.

•□Most staff we spoke with described increased staff fatigue, low morale and increased sickness levels.

•□Medicines management on the ward was not always safe.

•□Patients and their relatives were complimentary about the treatment, care and support they had received.

•□The provider had employed a full-time inpatient unit manager and provided additional training for team leaders.

Is the service effective?

Inspected but not rated

We have not rated the service as part of this focussed inspection. We did not inspect all areas related to this key question and only inspected areas of the service based on the concerns that were raised.

•□Staff did not receive role-specific training on a consistent basis. Most staff had not undertaken refresher training on role-

specific competencies. Following our inspection, the provider had taken action to address the gaps in staff training.

•□The provider did not ensure there was an induction programme which prepared all staff for their roles.

•□Staff did not always receive clinical supervision/one-to-one meetings on a regular basis.

•□Patients were supported in regard to their nutrition and hydration needs. Patient's confirmed assessments in relation to their needs had been carried out and their records showed patients were receiving appropriate care.

Is the service responsive?

Inspected but not rated

We have not rated the service as part of this focussed inspection. We did not inspect all areas related to this key question and only inspected areas of the service based on the concerns that were raised.

•□Patients did not always have their individual needs met as admissions to the unit were regularly delayed.

Is the service well-led?

Inspected but not rated

We have not rated the service as part of this focussed inspection. We did not inspect all areas related to this key question and only inspected areas of the service based on the concerns that were raised.

•□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 senior leadership team and clinical staff disagreed on what the culture was like on the inpatient unit.

•□Senior leadership were not always visible or supportive.

•□All staff, managers and directors we spoke with were passionate about the service they provided and wanted to improve how it was delivered but it was unclear if support was available to develop and drive improvement on the inpatient unit.

•□The board and managers were not always aware of what was happening within the inpatient unit.

•There were quality assurance and clinical governance systems but they were not always effective and were not in a format which drove continuous improvement. •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.	

Prospect Hospice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was carried out to identify whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. The provider was last inspected in November 2016 and achieved a rating of good overall. We did not rate this service as part of this inspection.

Why we inspected – The inspection was prompted by concerns raised with us about the service. The information shared with CQC outlined concerns regarding the management and delivery of the service and potential risks to patients within the inpatient unit. Due to the concerns raised in respect of low staffing numbers, out of date staff competencies, low staff morale and allegations of bullying by senior staff there were perceived risks to patient safety.

At the time of the inspection we identified a risk that the inpatient unit was unable to provide patients with safe care and treatment due to low staffing levels and a lack of assurance all staff had completed the necessary training and role-specific competencies. We have not been assured the provider has mitigated this risk appropriately as the senior leadership team had not reviewed the frequency with which they used agency staff or how frequently admissions were delayed due to staff being at capacity. In addition, not all staff had up to date training and agency staff were not always inducted onto the unit.

We also identified an additional risk to patient safety as there were ineffective systems and processes for recording, monitoring and reviewing significant safety issues, including staffing levels, staff training, agency use, delayed admissions and induction processes. This was recognised by the provider but we did not see evidence assuring us systems were being implemented to improve their processes.

The risks outlined above may have an impact on people using the service and it is likely to be significant. For example, there is a risk patients may not receive safe or high quality care and treatment at all times due to staffing levels not being reviewed and staff not being competent to perform their roles. The issues regarding poor governance may result in deterioration in the standard of patient care, as there were no systems for regularly reviewing and monitoring staffing levels, delayed admissions, training compliance or inductions.

The provider was in breach of regulations 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result the CQC have issued a warning notice in relation to both breaches.

This inspection took place on 20 and 21 February 2018 and was unannounced. We did not give any notice to the registered manager that the inspection would be taking place.

We visited the location of the inpatient unit to:

- Speak to all levels of staff including the senior leadership team;
- Speak to patients, relatives and carers;
- Review care records;
- Review relevant data, including policies, procedures and meeting minutes.

The membership of the inspection team included two inspectors. As this inspection was unannounced we were unable to gather or review any information beforehand. During the inspection we spoke with patients, their relatives, friends and other visitors, we interviewed staff and reviewed 13 service user records.

We spoke with four patients and four relatives/friends/carers, 23 members of staff, two directors, the chief executive officer and a trustee of the board.

Inspected but not rated

Is the service safe?

Our findings

We have inspected this key question in order to address concerns raised with us about the service. This was a focussed inspection so all areas of the service relating to safe were not inspected. Our inspection focused on the following:

1. How people were protected from bullying, harassment, avoidable harm and abuse that may breach their human rights.

2. How the service ensured there were sufficient numbers of staff to keep people safe and meet their needs.

3. How people's medicines were managed so that they received them safely.

Incident reporting, learning and improvement

Staff were not always supported to understand what constituted an incident and it was unclear if they were encouraged to raise concerns. The intelligence which prompted our inspection highlighted concerns that safety incidents had increased due to low staffing levels on the inpatient unit but we found no evidence to substantiate this. We reviewed data which showed there had been 36 safety incidents between 1 August 2017 and 31 January 2018. The 36 incidents concerned both patients and staff. The incidents related to clinical incidents (2), incidents concerning hot beverages/food (2), cuts (1), manual handling (8), other (8), slip/trip/fall (12), collisions with objects (1) and violence and aggression shown by patients (2). However, we saw no evidence relating to other significant safety incidents, for example, occasions when there had been insufficient staffing on the unit. We saw data which showed there had been nine occasions, between 1 January 2018 and 20 February 2018, when the inpatient unit was insufficiently staffed. Most of the 23 staff we spoke with said they were concerned about staffing issues but none of the nine occasions had been reported as safety incidents. It was unclear as to whether staff were encouraged to report safety incidents relating to staffing or if they were unaware that insufficient staffing constituted a safety incident. This meant the provider was unable to investigate these matters or take action to reduce the risk to patients when there were insufficient numbers of staff to provide them with safe care and treatment.

Investigations into staff concerns were not always thorough or objective and action was not always taken to address them. We spoke with nine nurses and seven healthcare assistants, all of whom said they felt staffing levels were not always sufficient to provide safe and high quality care and treatment to patients. We were told by the registered nurses and healthcare assistants we spoke with that they had escalated their concerns to their line managers, who had subsequently escalated them to the relevant members of the senior leadership team. When questioned, the relevant members of the senior leadership team did not share their staff's concerns and expressed the view there may be efficiency issues within certain groups of staff working on the inpatient unit. This suggested staff and senior management held different opinions on the subject. There did not appear to be any formal investigation into the escalated concerns regarding insufficient staffing levels or efficiency issues and staff had not been provided with feedback on the outcome of their concerns. Members of the senior leadership team said that no action had been taken to address the

concerns as they felt there was no evidence supporting the concerns of low staffing levels. We were provided with data, following our inspection, which indicated that the new staffing ratios were met, with the exception of one occasion in the two-month period under review. They also explained that staffing levels had been reduced when the number of beds being utilised regularly had been reduced and at all times they had been able to maintain safe and appropriate staffing ratios. Although, as discussed above, staffing shortages based on the data available at the time of our inspection had not being reported through the incident reporting system.

Staffing

Staffing levels had been assessed and were being monitored daily to ensure they were flexible and sufficient to meet patient's individual needs and safety. The staffing establishment on the inpatient unit had been reviewed in December 2017, as a result of a reduction in patient occupancy over the previous five months. There had been an improvement in coordinating discharges, which had increased patients' choices over where to receive services and resulted in a reduction in their length of stay which meant beds had become more available. Greater emphasis was being placed upon ensuring admissions were more tailored to people's choices, and Prospect@Home services continued to provide support to patients in their own homes. A review of the inpatient admission and discharge process had been carried out, which introduced eligibility criteria, referral triaging process and a dedicated discharge team. These actions resulted in more appropriate admissions and speedier discharges. Consequently, the staffing establishment on the inpatient unit had been reduced to provide registered nurse and healthcare assistant cover for 12 out of 16 beds, although the four additional inpatient beds remained open. As part of the review, bank and agency staff were to be used to fill additional staffing requirements in the event more than 12 patients were admitted or where people required a higher level of care. The registered manager explained that most of the bank staff used by the Service were also permanent members of staff who had both regular and bank hours, which provided for additional flexibility and good continuity of care.

Prior to December 2017, the staffing numbers were set to 16 beds. However, this was reviewed in December 2017 to reflect the reduced occupancy of 12 beds maximum and therefore,
Staffing during the day shift, had been reduced from five registered nurses to four and healthcare assistants (HCA) had been reduced from four to three. During night shifts registered nurses had been reduced from three to two/three and HCAs from two to one/two depending on the number of patients. These figures were not reduced if the number of patients on the unit during these shifts were less than 12.

According to the data provided at the time of our inspection, there had been nine occasions, between 1 January and 20 February 2018, where the staffing levels on the inpatient unit had been described "as not enough staff", even when there were fewer than 12 patients admitted on the unit. Updated data has since been provided, which highlighted there had only been four occasions when staffing had been below the expected levels, although the accuracy of this data was unclear. On two of the nine occasions, the staffing establishment was down by two and on another two occasions it was down by three. The unit had standard staffing levels which required seven staff to be on duty during early and late shifts and four during night shifts. However, on the occasions when the unit was down by two the unit required there be a combined total of 18 staff on duty during the day, late and night shifts but the actual staffing levels showed there had only been 16. On the occasions when the unit was down by three the unit required there be a combined total of 19 and 21 staff on duty during the day, late and night shifts but the actual staffing levels were only 16 and 18 respectively. It was not clear, from the data we reviewed, whether the senior managers were tracking if the inpatient unit was down on registered nurses or healthcare assistants during a shift. On seven of the nine occasions, when staffing was insufficient, there had been less than 12 admitted patients. According to the data reviewed, bank and/or agency staff had been booked on each of the nine occasions but the staffing

levels were still considered insufficient for the number of patients admitted.

Most staff felt that staffing levels were not always safe due to their perception that at times there was an insufficient number of registered nurses present on the unit.. They also felt the staffing levels prevented them from providing the high level of palliative and end of life care expected. For example, we were told of an occasion when there had only been two registered nurses on the unit during a morning shift. This caused safety issues as both registered nurses were required to complete a medicine round which meant their presence on the unit was reduced and they were not delivering any patient care.. The registered nurses were put under further pressure as the medicine round was repeatedly interrupted due to patient requests for breakthrough pain relief. This meant medicines were not administered at the correct times and there were delays in patients receiving pain relief. We were told patients did not suffer any direct harm as a result of this incident but it highlighted the potential risk to patient safety and substandard care and treatment. This incident was not reported but was corroborated by three members of staff.

The provider had no assurance all staff working on the inpatient unit were up to date with role-specific training or competencies. Training records for staff on the inpatient unit were limited as the provider could only provide us with ten completed individual registered nurse staff competencies for syringe driver, intravenous medicine administration and male catheter insertion training, after we had asked for data relating to staff training requirements. This was a risk as there were more than ten registered nurses employed to work on the inpatient unit and who undertook these clinical procedures.

The inpatient unit had a high number of vacancies. There were over five whole time equivalent (WTE) registered nurse vacancies on the inpatient unit. Recruitment was underway but the provider was experiencing difficulty finding suitable candidates. The number of vacancies was impacting on the unit's ability to meet the baseline staff level requirements which, as explained above, increased the unit's reliance on bank and agency staff to fill shifts.

We saw data which showed bank and agency staff (registered nurses/healthcare assistants) had been used consistently between January and February 2018, despite there being no occasions when there had been more than 12 admitted patients. The Provider explained that many of the bank staff working for the Service were actually also on permanent contracts and all were regular contracted members of staff. Agency staff were used when bank staff were unavailable. For example, in January 2018, agency registered nurses had been used on 5 occasions and HCAs had each been used on 9 occasions. From 1 to 20 February 2018, agency registered nurses had been used on 32 occasions and HCAs had been used to fill 15 shifts. This presented a potential safety and quality issue as not all of the agency nurses were trained in palliative and end of life care which increased the risk of patients receiving unsafe and/or substandard care and treatment. However, we did not see any evidence showing there had been an increase in safety incidents as a result of increased bank and agency staff use.

The induction process for agency nurses did not include any training on medicines management or include a checking process to ensure agency registered nurses had completed the relevant competencies for medicine management. This increased the risk to patient safety as it was not known if agency staff had the required competencies to provide safe and high quality care to palliative and end of life patients.

Most staff we spoke with described increased staff fatigue, low morale and increased sickness levels. Staff sickness levels within patient services, of which the inpatient unit was a part of, was consistently higher than the average across the whole service but was only higher than the provider target during quarter three of 2017/18. For example, the provider target was 4% and the average sickness rate across all three quarters for the whole service was 2.6%, 2.8% and 3.9%. The sickness rate for patient services, of which the inpatient unit

was a part of, was 3.1%, 3.6% and 5.1% respectively. We also reviewed the results from the provider's staff survey from 2017 which showed 37% of clinical staff felt their workload was unreasonable. The results of the survey were based on results from 45 clinical staff working within patient services. Whilst this equates to just over one-third of the clinical workforce, the provider had recognised the need to take action and had identified the benefit of having a full-time inpatient unit manager and additional training for team leaders, both of whom were in place by the time of the inspection. The registered manager explained that there had been vacancies to fill on the unit and that at the time of the inspection they had been actively recruiting nurses.

Staff also expressed frustration that they were not able to provide the level of compassionate care that they aspired to or be as responsive to the needs of patients and relatives. During our visit we saw no evidence that care was compromised by staffing levels; patients and their relatives were complimentary about the treatment, care and support they had received.

Medicines

Medicines management on the ward was not always safe. We saw data which showed there had been 53 medicine errors between August 2017 and February 2018. Managers had taken action in response to the medicine errors in an effort to reduce them. A review of the medicine round was undertaken in January 2018 and the process had been changed in the hope that it would improve safety. Patient beds and rooms were now grouped together so that the medicines for certain patients were administered in the same place. This was done to increase space for nurses while completing medicine rounds and reduce the amount of interruptions. The process had been implemented in January 2018 but feedback on how well it was working was being sought and was not available at the time of the inspection. However, data showed there had been more medicine errors in January (13) and February (12) 2018 than there had been in any of the preceding months.

Inspected but not rated

Is the service effective?

Our findings

We have inspected this key question in order to address concerns raised with us about the service. This was a focussed inspection so all areas of the service relating to effective were not inspected. Our inspection focused on the following:

1. How people received effective care, which was based on best practice, from staff who had the knowledge and skills they needed to carry out their roles and responsibilities.

2. How people were supported to eat and drink enough and maintain a balanced diet.

Competent Staff

Staff did not receive training on a consistent basis and the majority had out of date role-specific competencies. Intelligence received before the inspection highlighted staff competencies as a concern as it was claimed they were out of date. This was confirmed during the inspection as the most recent training records held by the provider for the majority of staff were from 2014/15. We also saw correspondence between senior managers confirming they were aware staff were practicing with competencies that were out of date. We did not observe any inappropriate or unsafe practice during the inspection and we also saw evidence that ten registered nurses had recently undertaken refresher training on the use of syringe drivers, male catheter insertion and IV medicine administration. There were more than ten registered nurses carrying out these clinical procedures on patients but there was no evidence to confirm they had completed the required refresher training to do so.

The provider could not provide evidence demonstrating all staff continued to meet the professional standards which were a condition of their ability to practice or a requirement of their role. There was no formalised training matrix or competencies which staff were required to complete and it was unclear as to what training staff had to complete on induction or thereafter. This increased the risk that patients were not receiving effective care as the provider could not demonstrate all staff were competent to carry out all clinical procedures. This was further evidenced by registered nurse competencies being included as a high risk on the patient services' risk register. Senior staff confirmed to us the training records did not provide them with assurance that all registered nurses were up to date with their role-specific competencies. Members of the senior leadership team told us they recognised improvements needed to be made and were taking actions to implement formalised systems. Effort was being made to seek a training provider and to hire a practice educator but at the time of the inspection, there were no formal training systems in respect of role-specific competencies. Following the inspection it was confirmed that a practice educator had started work and a training provider had been found. The practice educator was responsible for ensuring that all staff competencies were fully up to date.

The provider did not ensure there was an induction programme which prepared all staff for their roles. We were provided with information which outlined actions agency staff were required to complete. They were to be given an initial tour of the inpatient unit, assigned a buddy, informed of fire evacuation procedures,

provided with a swipe key for the drugs room and provided with electronic patient records system training. However, this was an informal process, there were no records demonstrating these actions were routinely completed and staff of all levels confirmed the actions were not always completed prior to agency staff working on the unit. We saw evidence the provider was using one agency who could provide nurses who had medicines and syringe driver competencies but there was no evidence showing which of the agency nurses had them or if this was confirmed.

Training on the electronic patient record system could only be completed if agency registered nurses and healthcare assistants (HCAs) were covering day shifts, meaning the agency staff covering night shifts, if visiting the unit for the first time, were untrained in its use. The provider explained that when this occurred, permanent staff were responsible for completing the electronic records. Alternatively, records were made on paper, which were then scanned into the electronic system. The nurse in charge was responsible for the oversight of this process. Therefore, there were assurances that all agency staff were recording information into patient records appropriately.

Staff were to receive one-to-one meetings on a monthly basis with their team leaders. There had been a period of time when these were not carried out but they were re-implemented in January 2018, following the appointment of a new in-patient unit manager. We were told team leaders were finding it difficult to schedule monthly meetings to carry out formal management supervisions of staff or to release groups of staff to attend clinical supervision (every 6-8 weeks) due to staff being needed to treat and care for patients on the unit. It was difficult to schedule supervision and appraisals but staff were having regular informal "catch-ups" with their team leaders. Staff confirmed they had not been receiving scheduled formal clinical supervision or more regular monthly one-to-one meetings. However, we saw evidence that monthly one-to-one meetings had been re-introduced as of January 2018, that staff had been advised they would be enabled to attend 6-8 weekly clinical supervision, and that staff were receiving annual and six-monthly reviews. Systems for monitoring and reviewing staff's learning, development or required training over an extended period were recently introduced but they required improvement, which the provider was taking steps to address.

Nutrition and Hydration

Patients were supported in regard to their nutrition and hydration needs. We spoke with four patients and four relatives who all felt they or their loved ones had been supported with their nutrition and hydration needs throughout their admission. They said staff always asked them or their loved ones if they were hungry or thirsty and provided food and drink promptly. None of the patients we spoke with required assistance to eat or drink but felt this would be provided if required. We reviewed 13 sets of patient records all of which included information regarding their nutrition and hydration requirements. Patients and their relatives/loved ones said they recall assessments being carried out upon their admission.

Inspected but not rated

Is the service responsive?

Our findings

We have inspected this key question in order to address concerns raised with us about the service. This was a focussed inspection so all areas of the service relating to responsive were not inspected. Our inspection focused on the following:

1. How people received personalised care that was responsive to their needs.

2. How the service routinely listened and learned from people's experiences, concerns and complaints.

Access to the right care at the right time

Patients did not always have their individual needs met. We reviewed data which showed 26 admissions had been delayed, between November 2017 and February 2018, due to there not being enough staff on the inpatient unit to provide safe care to patients. Delays had occured even when there had been less than 12 admitted patients. We were told an admission was delayed during our inspection, on 21 February 2018, due to this reason. If the patient had been admitted there would only have been 11 patients admitted on the unit. This demonstrated the provider was carrying out risk assessments in relation to whether they can safely provide care to their patients but also showed the unit was unable to provide sufficient staffing establishment, on a consistent basis, to meet patients' care and treatment needs. We have since been told, the delayed admission on 21 February 2018, was due to them not wanting to be admitted. None of the delayed admissions had been reported as incidents or prompted a review of the staffing establishment based on acuity of the patients. Given the type of patient the provider cares for, this was significant, as treatment was potentially delayed and patients were potentially unable to receive care in their place of choice.

Learning from complaints and concerns

The intelligence received, which triggered the inspection, said there had been an increase in complaints regarding service user's nutritional, hydration and hygiene needs due to staff being unable to cope when staffing numbers were low. We were provided with a summary of six complaints which had been received between July 2017 and February 2018. These complaints concerned staff insensitivity (1), moving and handling (1), delivery of information (1), broken possessions (1), nutrition and hydration information availability (1) and the standards of care (1). There was only one complaint in regard to nutrition and hydration but it related to the amount of information available and not the care delivered. There was one complaint regarding the standards of care provided on the inpatient unit but we were not provided with the specific details. We saw no evidence that complaints regarding nutrition, hydration and hygiene were increasing as the unit had only received six complaints and of those, only one related indirectly to nutrition, hydration and hygiene care. The concerns raised were therefore unsubstantiated.

Inspected but not rated

Is the service well-led?

Our findings

We have inspected this key question in order to address concerns raised with us about the service. This was a focussed inspection so all areas of the service relating to well led were not inspected. Our inspection focused on the following:

1. How the service promoted a positive culture that was person-centred, open, inclusive and empowering.

2. How the service demonstrated good management and leadership.

3. How the service delivered high quality care.

Culture

We received intelligence which highlighted concerns regarding leadership, low staff morale and bullying of staff. During the inspection we found evidence which corroborated all of these issues.

The provider had a clear set of values which staff were expected to demonstrate. The values included respect, honesty, compassion and inclusiveness. Staff on the inpatient unit were aware of what they were and felt they all demonstrated them in their role. During the inspection, we saw all inpatient staff demonstrating these values when caring for patients and each other.

The senior leadership team and inpatient staff disagreed on what the culture was like on the inpatient unit. Both expressed different views on staff attitude, values and behaviours. Some members of the senior leadership team felt there was a negative culture on the inpatient unit and explained there were staff who had demonstrated bullying behaviours which were not in line with the provider's values. Whereas staff felt there had been a positive culture which promoted the values and teamwork. The majority of staff had not witnessed any bullying among themselves but some felt bullying behaviours had been demonstrated by members of the senior leadership team. Staff and senior managers agreed that morale among staff had become low in recent times.

Members of the senior leadership team told us the culture on the inpatient unit was negative and some staff were demonstrating behaviours which amounted to bullying. Complaints of bullying had been raised by two registered nurses, which related to staff on the inpatient unit. We were told by the members of the senior leadership team that verbal allegations of bullying had also been made by "two/three volunteers". Initially, action was taken by the human resources department to substantiate and investigate the allegations but they were never made formal and therefore never fully investigated. There was no evidence that any informal or formal action had been taken by the leadership team to address the behaviours of the individuals the allegations were made against. We did not see any written evidence of the allegations and were told none of the complaints had been made formal. There was limited evidence demonstrating there was a negative culture on the inpatient unit or staff demonstrating bullying behaviours but the staff survey from 2017 showed that 9% of clinical staff within patient services felt they had been bullied over the

previous year.

In response to the allegations of bullying by staff, a director planned four identical workshops to promote a positive culture on the inpatient unit and address bullying behaviours. Following completion of the design of the workshops comment was requested from the human resources department. Attendance at the workshops was mandatory for all staff including registered nurses, healthcare assistants, administrative staff, volunteers and managers. The director delivered the workshops with support from other members of the senior leadership team. The support requested by the director amounted to recording comments made by staff on display boards. The workshops included examples of positive and negative behaviours demonstrated on the unit, feedback from external parties, presentations on the hospice values and concluded with an invitation to staff to sign a pledge promoting a positive culture on the unit. The majority of staff we spoke with told us they felt pressured into signing the pledge and some told us they had pretended to sign it. These staff had felt that the invitation was actually a requirement. Some members of the senior leadership team felt three of the workshops were productive but the final one was not. This view was not held by all, with one director describing the workshops as poorly handled and received. Some directors said they would not have changed the way in which the allegations had been addressed or how the workshops were delivered. It was confirmed by the director who delivered the workshops that staff were invited to come on a journey with the hospice or find another job. Some staff told us the director had invited them to sign the pledge or find another job. The journey staff were invited on was intended to improve the culture and to address any bullying behaviours. The director told us approaches had been made to thank them for highlighting the bullying on the unit; however, none of the staff we spoke with expressed this view.

Almost all of the 23 members of staff we spoke with felt the workshops were handled poorly, were inappropriate and disagreed with the content of them. They described the workshops as painting the inpatient unit as a negative and unfriendly environment. The words "toxic environment" had been used to describe the unit. Staff did not recognise the description of the unit and were upset by the way in which they were being spoken about. Staff described feeling "humiliated", "bullied", "put down", "undervalued" and "rubbish". They felt they had not been listened to and had been unable to stand up for themselves. The majority of staff we spoke with felt any questions or challenges were dismissed and the delivery of the workshops was perceived as aggressive. Staff described the inpatient unit as being a good place to work and felt all staff had been doing a good job. Staff told us the morale on the unit had deteriorated as a result of the workshops. Staff said they were shocked when they had been told of the allegations of bullying as they had not witnessed any such behaviour. However, management explained that complaints had been made so felt the issue needed to be addressed. Staff felt the allegations had not been addressed in the correct way as many told us they felt as if everyone had been viewed in the same way. Most staff said they felt bullied during the workshops and felt they had no choice but to sign the pledge. The signed pledge had been displayed in the pantry but was taken down after multiple complaints from staff, as they felt their personal data was being shared without their permission. The pledge contained the names and signatures of staff and could be seen by anyone who had access to the pantry, including staff and volunteers. We were provided with evidence, following the inspection, which showed an indeterminate number of staff felt there were negative behaviours being demonstrated on the inpatient unit.

Following the workshops, staff were invited to provide feedback at drop-in sessions or by anonymous submissions. Staff said the drop-in sessions were not well attended because they did not see the point of them as they felt they had not been listened to during the workshops. At the time of the inspection, seven anonymous complaints, specifically about the workshops and how they were run had been submitted. The complaints included comments about negativity and one-sidedness. Complainants said the workshops made people feel uncomfortable and the delivery had felt rude and dismissive with staff feeling silenced. The complainants described feeling sad, angry, humiliated, undervalued, demotivated, disrespected,

intimidated, unsettled and distressed during and following the workshops. Some felt the meeting had been deliberately conceived to belittle and humiliate. Some complainants felt threatened into signing the pledge. The complaints described the tone of the meeting as being intimidating and threatening with staff feeling unsafe to voice an opinion. Many felt the situation was mismanaged, and little had been made of the excellence, professionalism and dedication of staff. Some attendees were reduced to tears and described coming out of the meeting feeling bullied and reprimanded. Some felt more unsupported than ever and that there was no appreciation of the pressure staff were under. These feelings were shared by most staff we spoke with during the inspection. Whilst we were provided with a range of views about these workshops it does seem clear that they did not achieve their intended purpose.

Leadership

Senior leadership was not visible or supportive at all levels. All the directors worked from an office in the same location as the hospice. Some members of the senior leadership team worked from other locations which some staff felt made them often unavailable in person, although they were contactable by telephone and email. We were told that the senior leadership team generally only worked from other locations once per week. Not all staff were able to identify every member of the senior leadership team and those who could were unable to recall the last time they saw them on the unit. Some staff said each member of the senior leadership team might visit the unit once or twice a year. We were told that the chief executive officer (CEO) does 'CEO on Tour' visits, the most recent of which was in November 2017. We were told that visits to the hospice premises and departments take place on a monthly basis. In addition, two members of the senior leadership team visit the inpatient unit (IPU) monthly in their capacity as witnesses to the destruction of controlled drugs. The director of resources visits the IPU in the course of their business on an almost daily basis and both the CEO and director of patient services visit the IPU several times a week, speaking with staff, showing visitors around and addressing issues. The CEO oversaw all services offered by the provider; however, we only inspected the inpatient unit.

The senior leadership team had an annual programme of visits which were meant to be completed. It was unclear whether these visits to the unit had been completed in 2016/17 or 2017/18. Regular meetings were held to provide staff with a forum to discuss topics, provide updates and raise issues. Members of the senior leadership team expressed frustration that inpatient unit staff rarely attended the meetings even after effort had been made to increase attendance. Staff told us they were aware of the meetings but these were often held at inconvenient times, especially for night staff. The Provider explained that they had received a suggestion to change the meeting times to accommodate inpatient unit shift patterns and this had been implemented but attendance had unfortunately not improved as a result.

The director of patient services and the chief executive officer were both based at the hospice but, once a week, would work from locations other than where the inpatient unit was based. They told us they would also visit the inpatient unit on a regular basis. For example, the director of patient services conducted a weekly visit and did a monthly shift on one of the services. We were told the purpose of the weekly visit was to meet patients and build relationships with staff by speaking to them. The director felt the visits were productive and gave them an opportunity to see how the unit was running. During the unit visit, the director was accompanied by a member of staff.

Staff on the unit felt visits from members of the senior leadership team were infrequent and inconsistent. Staff confirmed that a weekly visit was conducted by a director but the unit was rarely visited at any other time. Staff said some members of the senior leadership team rarely engage in conversation during visits and

described them as being "scary" and "unapproachable". The majority of staff felt leaders lacked listening skills and were abrupt. Many staff felt leaders were unaware of who they were and made no effort to build relationships with them. These feelings were not shared by all staff but by the majority of those we spoke with.

All staff we spoke with were complimentary of the head of patient services and clinical lead. Describing them as knowledgeable, experienced, approachable and supportive. Staff felt both were responsive to staff needs and requests. The clinical lead and head of patient services were also accessible as they worked closely with staff and encouraged them to come forward if they had issues or concerns. Staff felt confident they were being listened to and action would be taken to address issues or concerns. Both worked well together and were introducing measures to improve the way the service was delivered. We were told they both made an effort to arrive on the unit before the night staff had left so they were visible to all staff and were interested in how they were. Night staff said this made them feel supported.

Learning, continuous improvement and innovation

It was unclear if support was available to develop and drive improvement on the inpatient unit. All staff, managers and directors we spoke with were passionate about the service they provided and wanted to improve how it was delivered. However, there was a difference in opinion in how this could be achieved which appeared to be creating barriers. For example, some senior managers felt a change in the culture and behaviours, demonstrated by staff, would lead to service improvements. Staff felt the service would improve with increased staffing and more support from senior managers. Some managers felt there was no evidence to show there were staffing problems and so were not supportive of staff concerns. The majority of staff, we spoke with during the inspection, did not feel there were issues with the culture or behaviours on the inpatient unit and therefore were unsupportive of the senior manager's concerns. However, we saw evidence, following the inspection, which indicated an indeterminate number of staff felt bullying was an issue. As there was a difference in opinion between what managers and staff felt would improve the service, there was a lack of support from both sides in driving and improving care and treatment delivered to patients. However, staff said the head of patient services and clinical lead were supportive and were introducing measures to drive and improve service delivery, including taking initial steps to formalise training programmes and implement regular supervision. Following the inspection, we were told that senior management were having regular conversations with the head of patient services and the clinical lead and supporting them to recruit staff and improve standards on the unit.

Governance

The board and managers were not always aware of what was happening within the inpatient unit. Trustee meetings were held quarterly and we reviewed three sets of minutes from meetings held in August 2017, November 2017 and February 2018. Attendees included the board of trustees, chief executive officer (CEO) and directors. As part of the meeting, a report was submitted to the board outlining significant events which were occurring throughout the provider's services. In the February 2018 minutes, the report provided updates on performance issues occurring on the inpatient unit; however, there was no mention of the seven complaints that had been made about a member of the senior leadership team in January 2018, and no evidence of what actions had been taken to address these. There was also no mention of the 26 delayed admissions, between November 2017 and February 2018, which were a result of there not being enough staff to safely admit. The complaints had been discussed in the patient services committee meetings but not all the trustees were members of the committee. This meant some trustees were not aware of all the significant events which were happening on the inpatient unit and could therefore not raise any questions and hold the senior leadership team to account on these matters.

We discussed the concerns raised with us by staff and the negative feelings expressed by staff on the inpatient unit with a trustee. The trustee was unaware of the strength of feeling staff had about the workshops delivered in November and December 2017 or the specific allegations about behaviour of senior managers during the workshops. The trustee said they thought the intention of the workshops was good and that senior managers have a very difficult job. It came to our attention that attempts had been made by staff to express concerns with trustees but these had failed. The trustee was unaware of the process of escalation. This showed there was a gap in oversight and in information escalation as the processes for escalating matters to trustees, other than through the chief executive officer, was unknown to those who may need to use it.

Trustees and some managers did visit the inpatient unit. We saw evidence that each trustee was expected to visit the provider's services twice each year, however, this included all other services and not just the inpatient unit. Records provided to us show there were trustee visits to the inpatient unit in 2014 and 2017 and staff on the inpatient unit told us some senior managers did attend the inpatient unit regularly.

Some members of the senior leadership team were unsurprised by staff concerns regarding staffing and their feeling that senior management did not listen or understand. The staff survey undertaken in 2017 showed 43% of clinical staff working within patient services felt communication between staff and senior management was ineffective, 38% felt it was unsafe to challenge the way things were done and 25% felt their views were not listened to or valued. This showed there was awareness by senior management that staff did not feel listened to but there was no evidence showing this issue or staff concerns were being addressed effectively.

There were quality assurance and clinical governance systems but they were not always effective and were not in a format which drove continuous improvement. There were a number of monthly meetings which took place within the inpatient unit, involving staff, team leaders and the patient services committee.

Attendance at the staff meetings was variable as some staff found them difficult to attend. This was due to capacity issues and unavailability of night staff. However, all staff working on the inpatient unit were invited to attend. We reviewed six sets of staff meeting minutes, between August 2017 and February 2018, which showed there were shifting agenda items. For example, staffing was on the agendas on three occasions, drugs errors on two occasions and infection control, incidents and falls were each items on one occasion. We did not see any evidence that inpatient unit risks, complaints or clinical audits were discussed routinely during all staff meetings. This was despite the inpatient unit receiving complaints in August 2017 (2), November 2017 (1), December 2017 (1) and February 2018 (1) and there being six risks on the risk register rated as high. There was a lack of discussion around clinical governance generally which did not promote staff awareness of performance issues or inpatient unit risks.

Senior management team meetings took place monthly and were attended by all directors, the chairman and chief executive officer. We reviewed three sets of minutes of meetings between November 2017 and January 2018, but the agenda for the meetings appeared to change as the items discussed during each meeting varied. There was a lack of discussion surrounding clinical governance, for example; there was no discussion concerning complaints, clinical audits, incidents or infection prevention and control. Within the three sets of minutes, the provider's risk register was mentioned once but the minutes lacked detail on what was discussed. There were six risks regarding the inpatient unit on the patient services' risk register which were rated as high but none had been discussed. It was unclear if clinical governance systems were in a format which assured the senior management team on the quality and performance of the inpatient unit as clinical governance issues were not always discussed.

Patient services committee meetings took place quarterly and were attended by various trustees and members of the senior leadership team. We reviewed three sets of minutes from the meetings, which took place in July 2017, October 2017 and January 2018. There was a clinical governance agenda item in the minutes from July and October 2017 and January 2018. Within the October 2017 minutes, attendees discussed the risk register, incidents, clinical audits and benchmarking as part of the clinical governance agenda item. However, only incidents were discussed during the July 2017 meeting. None of the above items had been discussed during the January 2018 meeting. We saw that complaints, the risk register, implementation plan, budgets, and education was an agenda item at monthly clinical leads meetings. We saw agendas for the meetings but not any minutes. This showed that some elements of clinical governance were considered during meetings but there was limited evidence to confirm it was discussed systematically and therefore could offer limited assurance to the committee of the quality and performance of the services provided.

Management of risk, issues and performance

The inpatient unit did not have effective recording and data management systems. We asked for data relating to specific staff training requirements. However, the provider was unable to show they monitored or reviewed the frequency with which training should be refreshed or who had responsibility for the oversight of staff training. For example, there were only ten completed individual registered nurse staff competencies for syringe driver, intravenous medicine administration and male catheter insertion training. The provider was unable to produce any evidence relating to whether there were additional competencies registered nursing staff and/or healthcare assistants were required to complete, how many staff were required to complete them, who had not yet completed them or when they were due for renewal. Therefore, the provider could not be assured they had oversight of staff training, as the systems and processes for monitoring compliance were failing.

There were no formalised processes for recording when agency staff commenced and completed an induction process. We requested records relating to the completion of the induction process but the provider was unable to provide us with evidence they had monitored agency staff inductions. Therefore, the provider could not be assured they had oversight of agency staff inductions as there were no systems or processes to ensure they were completed.

There was no formalised system for recording, monitoring or reviewing the use of bank and agency staff. We requested data on frequency and extent to which bank and agency staff had filled shifts but the provider could not evidence that data was routinely collected as part of a monitoring process. There was no evidence to show bank and agency use had been monitored or reviewed since the staffing establishment review, which took place in December 2017. This showed a lack of oversight in how agency staff were being used or impacting on the inpatient unit's performance.

There was no formalised system for recording, monitoring or reviewing when admissions to the inpatient unit were delayed or the reasons for doing so. We asked for data relating to delayed admissions but it was explained to us by senior staff members that this data could only be provided by reviewing individual daily records of admissions. It was also confirmed that delayed admission data was not collected for evaluation. There was no mention of delayed admissions within any of the meeting minutes we reviewed. This meant there was no formal system to evaluate when staffing levels needed to be reviewed and/or increased when referrals for admission was made, which led to admissions being delayed.

Information from investigations and complaints were not always acted on or used to drive quality across the service. As outlined above, seven anonymous complaints from staff had been made. These complaints had

not been investigated. Four of the complaints were made before 11 January 2018 and three others before 30 January 2018. We saw correspondence between members of the senior leadership team which showed they were aware of the complaints and an investigation into the matter was being considered but no significant steps or actions had been taken. During the inspection we found that action had not been taken to seek feedback from staff on the complaints.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person Centred Care (1) The care and treatment of service users must – (a) be appropriate; (b) meet their needs, and (c) reflect their preferences. (3) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include- (b) designing care and treatment with a view to achieving service user's preferences and ensuring their needs are met. The provider did not always meet the needs of patients with palliative or end of life needs or reflect their preference to receive care in a hospice setting. This was evidenced by the 26 delayed admissions, between November 2017 and February 2018, due to staff being at capacity, even when there were less than 12 admitted patients on the inpatient unit.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment

(1) Care and treatment must be provided in a safe way for service users.

(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;

The provider did not ensure staff providing care and treatment to patients had the qualifications, competence, skills and experience to do so safely. They were aware that staff competencies for carrying out specific procedures were out of date.

(g) the proper and safe management of medicines;

The medicine management practices and procedures were not effective. There had been 53 medicine incidents on inpatient unit between August 2017 and February 2018. Changes designed to reduce the amount of incidents had not been effective as there had been an increase in incidents following the change.

Agency nurses were not trained in medicine management processes as part of an induction on to the inpatient unit.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had no training policy which set out role specific staff training requirements, the frequency with which this training should be refreshed or who had responsibility for the oversight of staff training. The provider had no formalised process for recording when agency staff commenced and completed an induction process. The provider had no formalised system for recording, monitoring or reviewing the use of bank and agency staff. The provider had no formalised system for recording, monitoring or reviewing when admissions to the inpatient unit were refused due to staffing levels being at capacity. The provider failed to seek feedback from relevant persons to continually evaluate and improve the services provided. The provider failed to ensure all staff received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

The enforcement action we took:

We issued a warning notice on 20.03.2018. Representations were received on 29.03.2018.