Mount Edgcumbe 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

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

Overall summary

Mount Edgecumbe Hospice is operated by Cornwall Hospice Care Limited. The hospice had eight beds with facilities available to increase this to 14. Cornwall Hospice Care Limited also provided services in Hayle at St Julia's Hospice.

The hospice provided care and treatment for patients aged 18 years or over, with a life-limiting condition.

We inspected this service using our focussed inspection methodology. This unannounced inspection took place on 19 July 2018. We focussed on the safe and well-led domains following concerns raised to us. The concerns were focussed on staffing levels, staff training, low staff morale and allegations of bullying.

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.

There was a registered manager in post, Dawn Tame-Battell. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

During the inspection visit we were unable to speak with patients or their relatives as the staff informed us they were too unwell. We spoke with 10 members of staff, working in various roles in the hospice.

We reviewed four sets of patient records and relevant other documents, including policies, procedures and meeting minutes.

The Care Quality Commission last inspected the service in 2014 and rated the provider as good overall. We have not re-rated the service at this inspection.

We regulate hospice services but we do not currently have a legal duty to **rate** them when they are inspected as a focussed inspection. We highlight good practice and issues service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- A system of annual mandatory training was provided to ensure staff remained suitably skilled for their job,
- Safeguarding processes were in place to ensure patient safety.
- There were established systems to prevent and protect patients from healthcare associated infections.
- There were systems to manage the environment and equipment, which kept patients safe.
- Patients were monitored for deterioration in their condition.
- Staffing was managed to ensure sufficient staff were available.
- Patient records were well-maintained and stored securely.
- Inpatient medicines were managed safely.
- Incidents were recorded and reviewed to provide learning and prevent reoccurrence.
- External professionals, patients and their representatives had access to a 24-hour support and advice line from the hospice. This also provided a support to patients following their discharge.
- The leadership structure within the organisation was clear and staff were aware of who they reported to.
- Staff were familiar with the organisation's strategy, vision and values, and were provided with the opportunity to be involved in the development of these.
- The leadership team had taken action to address low morale and allegations of bullying with the provision of meetings and the reintroduction of the staff forum.
- The organisation had taken steps to improve the accessibility of trustees and executives to staff. The number of visits to clinical areas had increased and additional staff meetings were held.

However, we also found the following issues that the service provider needs to improve:

- The system for monitoring staff training did not ensure all mandatory or any additional training had been completed. Safeguarding children training was not provided and not all staff had completed safeguarding adults training. This included volunteers, clinical staff, board members and trustees. Training had not been provided to all staff who were required to investigate incidents.
- Staffing levels were not related to patient dependency.
- The harm level of incidents was not assessed to ensure a consistent response.
- Staff were not familiar with relevant national guidance and recommendations to ensure they were providing up-to-date care and treatment.

Following this inspection, we told the provider it must take some actions to comply with the regulations and it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice for Mount Edgecumbe Hospice. Details are at the end of the report.

Amanda Stanford

Deputy Chief Inspector of Hospitals (South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospices for adults		The hospice provided care and treatment to patients 18 years and older with a life limiting condition. The hospice was managed by Cornwall Hospice Care Limited who also provided services at a hospice located in Hayle. Staff were mainly based at this hospice but could work across both sites when required. We regulate hospice services but we do not currently have a legal duty to **rate** them when they are inspected as a focussed inspection. We highlight good practice and issues service providers need to improve and take regulatory action as necessary. We inspected the safe and well led domains as part of this focussed inspection.

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Background to Mount Edgcumbe Hospice

Mount Edgcumbe Hospice is operated by Cornwall Hospice Care Limited. The service opened in 1980. The hospice primarily serves the communities of Cornwall and provides inpatient services to people who are living with a life-limiting condition.

The current registered manager has been in post since 2015.

The hospice is also developing community services within neighbourhood hubs.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors, and a specialist advisor with expertise in palliative and end of life care. The inspection team was overseen by Mary Cridge, Head of Hospital Inspections.

Information about Mount Edgcumbe Hospice

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

- Treatment of disease, disorder or injury.

There were no special reviews or investigations of the hospice ongoing by the CQC at any time during the 12 months before this inspection. The service was last inspected in 2014 and was rated good.

Activity (April 2017 to April 2018)

In the reporting period April 2017 to April 2018:

- There were 177 inpatient episodes of care recorded at Mount Edgecumbe Hospice.
- The average length of stay for patients at the hospice was 13 days, with 40% of patients being discharged to a home environment and 60% who died at the hospice.
- There were 43 outpatient total attendances in the reporting period; we did not inspect outpatient clinics at this inspection. There were 904 appointments with the lymphoedema specialist service. There were 86 patients who attended for care and treatment as day cases.

Track record on safety over the previous twelve months:

- No never events.
- Clinical incidents: No no harm, 38 low harm, no moderate or severe harm, no death.
- No serious injuries.
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),Meticillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (C.diff) or E-Coli
- No complaints.

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?

We have not rated the service as part of this focussed inspection.

- A system of annual mandatory training was provided to ensure staff remained suitably skilled.
- Safeguarding processes ensured patients' safety.
- There were systems to protect patients from healthcare associated infections.
- Systems to manage the environment and equipment kept patients safe.
- Patients were monitored for deterioration in their condition.
- Sufficient staff were available to care for patients during the inspection.
- Patient records were well-maintained and stored securely.
- Inpatient medicines were managed safely.
- Incidents were recorded and reviewed to provide learning and prevent reoccurrence.

However:

- Safeguarding children training was not provided.
- Staffing levels were not related to patient dependency. Filling shifts at short notice was challenging for the ward and impacted on the work being undertaken.
- Reported incidents were not assessed for severity. This did not ensure a consistent response

Are services effective?

We did not inspect the effective domain as part of this focussed inspection, as we only inspected areas raised within the concern.

Are services caring?

We did not inspect the effective domain as part of this focussed inspection, as we only inspected areas raised within the concern.

Are services responsive?

We did not inspect the effective domain as part of this focussed inspection, as we only inspected areas raised within the concern.

Are services well-led?

We have not rated the service as part of this focussed inspection.

- The leadership structure within the organisation was clear and staff were aware of who they reported to.

Summary of this inspection

- Staff were familiar with the organisation's strategy, vision and values, and were provided with the opportunity to be involved in the development of these.
- The executive team had taken action to address low morale and allegations of bullying with the provision of meetings and the reintroduction of the staff forum.
- The organisation had taken steps to improve the accessibility of trustees and executives to staff. Increased numbers of visits to clinical areas were being made and additional staff meetings were held.

Hospices for adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are long term conditions safe?

- A system of annual mandatory training was provided to ensure staff remained suitably skilled.
- Safeguarding processes ensured patient safety.
- There were systems to protect patients from healthcare associated infections.
- Processes to manage the environment and equipment kept patients safe.
- Patients were monitored for deterioration in their condition.
- Sufficient staff were available during the inspection.
- Patient records were well-maintained and stored securely.
- Systems were in place to manage inpatient medicines safely.
- Incidents were recorded and reviewed to provide learning and prevent reoccurrence.

However:

- Safeguarding children training was not provided.
- Staffing levels were not assessed or related to patient dependency. Filling shifts at short notice was challenging for the ward and impacted on the work being undertaken.
- Reported incidents were not assessed for severity. This did not ensure a consistent response.

Mandatory training

- Staff undertook a system of annual mandatory training to ensure they remained suitably skilled. Staff were alerted when training was due to ensure they remained updated. Mandatory training included immediate life support, fire safety, moving and handling, infection prevention, safeguarding vulnerable adults, information governance, Mental Capacity Act and Deprivation of Liberty Safeguards. The mandatory training did not include any training for meeting dementia or learning disability needs despite staff sometimes caring for patients living with these conditions. While not part of the mandatory package, training to support patients with mental health needs was provided to staff.
  - The education lead confirmed some mandatory training had not been completed due to staffing issues. The provider had a mandatory training target of 80%. Mandatory training compliance was 83% overall.
- Staff had link roles to develop their learning and be a point of reference for other staff. These link roles included infection control and safeguarding. Link roles enabled nurses to undertake extended learning and access resources to cascade to other staff on the ward. When staff left and the link training for that specific area was not available, the training was sourced externally. For example, glucometer training was available from the local acute hospital trust. A glucometer is a device for measuring blood sugar.
- Staff undertook an induction when starting work to ensure they had the skills needed to do their job. Staff confirmed the induction followed a booklet format which identified each area of familiarisation required and was signed off when completed as competent. Staff told us they thought the induction was a sufficient preparation for employment.

Safeguarding

- The safeguarding processes ensured patient safety. A safeguarding adult policy and flowchart were accessible in the ward office. This detailed the actions to be taken and who to contact if there were adult safeguarding issues identified. No safeguarding alerts had been raised since the last inspection in 2016. Staff told us when they had safeguarding concerns they first discussed them with the nurse in charge and the head of care. Any alerts were made to the local authority and the flowchart was used to ensure the process was correctly followed.

- The director of patient services was the safeguarding lead for the service. Of the 49 staff employed, 94% (46) had completed level two safeguarding training for adults as part of their induction and ongoing mandatory training. Staff confirmed training had been completed and they had sufficient knowledge and confidence to raise a concern if needed. Housekeeping and catering staff had also received training and demonstrated an understanding of the process to follow.
- Safeguarding children training was not provided. Children could visit the hospice for extended periods of time and stay overnight. Staff were not trained to recognise or report safeguarding concerns in these children.
- Female genital mutilation (FGM) was included as part of the safeguarding training. Staff confirmed the training had also included sexual exploitation.
- There was no specific chaperone training provided. Staff told us patients could request a chaperone and it would be provided.

Cleanliness, infection control and hygiene

- Systems protected patients from and prevented healthcare associated infections. Staff could access the infection prevention and control policy on line. The head of care was the lead for infection prevention and control for the hospital.
- Good standards of hygiene were maintained. Housekeeping staff were clear in their responsibilities and there were procedures to reduce the risk of cross-infection. The flooring used enabled the staff to mop to maintain a suitable level of hygiene and reduce the risk of cross infection. Housekeeping staff explained they cleaned all areas, except for spillages of bodily fluids: these were cleaned by the nursing staff. We saw completed cleaning rotas and observed housekeeping staff working throughout the day.
- There were vacancies in the housekeeping department. Staff worked additional shifts to provide cover.
- Personal protective equipment was available to all staff and visitors. We saw staff wore the protective aprons and gloves when needed.
- There were effective arrangements for patients who had died. Systems ensured these patients left the hospice in a timely and dignified way and any risks of cross-infection were appropriately managed.
- Mandatory training data for infection control stated only one member of clinical staff was not up-to-date.
- Hand hygiene audits were completed quarterly and each scored between 96 and 100%. Audits were completed across the ward, and included a range of staff. In each audit a range of staff were observed. Alcohol hand gel was available outside each room and staff were observed to use this regularly. Handwashing facilities were available for staff, patients and visitors to the wards.
- Clinical waste disposal systems were used which included sharps bins for the safe disposal of used needles and other equipment.

Environment and equipment

- Systems for managing the environment and equipment kept patients safe. Staff confirmed there was an ongoing maintenance plan and any areas of repair needing immediate attention were addressed promptly. The maintenance team were evident on the ward undertaking ongoing repairs.
- Medical equipment was checked and serviced in line with manufacturers' guidance. Daily and weekly equipment safety checks were undertaken in line with local policies. These included checks of resuscitation equipment and blood monitoring equipment.
- Syringe drivers were all made by the same manufacturer to ensure staff were familiar with the devices. They were serviced annually and maintained when needed.
- Each room was pleasant, comfortable and had bathroom facilities. There were two, four-bedded bays which were only occupied by one patient at any time. A large bathroom was available with a jacuzzi bath and hoists to enable all patients to have a bath with some support. Each room had TV facilities and a further day room was available should patients want company. All patients had access to a free guest internet service.
- Call bells were accessible for patients to alert staff. When used the call bells alerted staff to a panel to indicate which room was raising a call. When staff were working in the rooms with the door closed, they used the call bell, to summons other staff members if they required assistance.
- Rooms did not have access to piped oxygen, cylinders were used. Cylinders were stored securely and correctly in all areas and there was an external secure store.
- There were no specific rooms for patients living with mental health needs or dementia. There was a

dementia link nurse who could provide further support to staff and staff confirmed anybody with extra needs was placed in a room nearest the office to enable extra observation and reassurance.
- Resuscitation equipment was available. The trolley was checked daily and an overall check was completed weekly. All portable electrical equipment had been serviced within the last year.
- Hoists were available for the safe moving and handling of patients. We saw that when not in use they were cleaned and stored safely. Staff told us they had a good relationship with the local equipment loan store and could access equipment quickly and easily.
- Rooms accessible to staff only had a secure key pad entry. The rooms which held medicines and cleaning equipment were secured to prevent patient harm.

Assessing and responding to patient risk

- Review processes ensured patients were suitable for treatment at this location. A 24-hour advice line, which was staffed by a non-medical team member or nursing staff, was available. The advice line was the single point of access for referrals from the local trust and GPs. The staff member gathered information and requested support as needed from hospice medical staff. In some cases, the advice and guidance provided prevented admissions and other appropriate action was implemented instead. In other cases, it enabled admissions to take place quickly and easily.
- There was no clear system or written procedure for informing the local hospital trust of available beds. Several staff spoke of different routes that informed the trust. On the day of our inspection nobody had informed the trust there were four empty beds available. This meant that potentially patients could be waiting for hospice care in the acute trust.
- Patients were monitored for deterioration in condition. An assessment tool was used to calculate how often the nurses needed to visit the patient as a matter of routine. During those visits they would ask about the patient's level of pain, change the patient's position to maintain skin integrity, help with fluids and ensure a call bell was in reach. The staff could reassess at any time and change the timescale in line with the patient's needs. Records showed all monitoring was completed.
- Resuscitation processes were clear for staff and training had been provided
- Pressure area care was assessed and monitored to prevent skin damage. Pressure area care assessments were completed and appropriate plans put in place to reduce the risk of skin deterioration. Pressure relieving equipment was available and mobilisation was supported for patients where appropriate. Any assistance needed to change position in bed was provided.
- There were systems to support patients after discharge. A telephone contact line was available for all patients discharged. This enabled them to ring the hospice, both day and night, with any concerns.

Nurse staffing

- There were sufficient staff available to meet the care needs of the patients during our inspection. There was one full time trained nurse vacancy, which was being covered by other staff and bank staff. Patient admissions were reliant on staff numbers and there was a limited capacity to provide extra staff. While the service had a bank of staff to cover shifts as and when required, the specialist nature of the service meant the numbers of bank staff were limited and restricted the use of agency staff.
- The hospice was staffed for eight beds, although 14 beds were available. There were three registered nurses and two health care assistants each morning and two registered nurses and two health care assistants in the afternoon. Overnight there were two registered nurses and one health care assistant. On the day of our inspection there was also a student nurse from the local acute trust.
- Staffing levels were not assessed or related to patient dependency. On the day of our inspection there were four patients on the ward and the same staffing levels applied had the eight beds been occupied or patients had increased acuity of need. Many staff told us staffing levels were set historically and had not been reviewed.
- The registered manager considered there were sufficient staff to provide a quality service to patients. The review of staffing had taken place in 2015 using the Royal College of Nursing's (RCN) staffing tool, which used older people with frailty as a measure. The Chief Executive told us there were resources available to support additional staff being rostered if necessary. We requested, but were not provided with, written evidence of this staffing assessment.

- There was no tool used to assess how many staff were needed in relation to patient dependency levels. Senior staff confirmed that should a patient being considered for admission have complex needs, which could not be met by current staffing levels, they would not be admitted.
- Staff turnover at Mount Edgecumbe from September 2017 to August 2018 was one ward sister, three qualified nurses and two housekeeping staff. The reasons for the staff turnover included retirement and promotion. There were full-time vacancies for therapy and nursing staff. The therapy staff provided cover across both hospices in the organisation due to vacancies.
- The hospice had a bank of staff who were available on an 'as and when' basis. Should those staff not be available the hospice would use agency staff. Since August 2017 there had been 60 hours covered by agency staff and 997 hours covered by bank staff. Bank and agency staff had received an induction and every effort was made to ensure that a consistent group of staff were used. There were limited numbers of agency staff who worked at the hospice due to the specialist nature of the work. Staff sickness across the two hospices the provider ran was 4%.
- Therapy staff attended the multidisciplinary meetings and worked with nursing and medical staff to provide the person-centred care needed.
- There had been discussions regarding opening additional beds at Mount Edgecumbe hospice. Staff told us this was planned without the provision of additional staffing resources. Staff were anxious about this and how the quality of patient care would be affected.

Medical staffing

- Medical staffing was provided 24 hours a day with a 'consultant of the day' rota. There was a clinical fellow level doctor working for the five weekdays supported by a GP registrar. There was three routine consultant ward rounds in the working week and access to the consultant of the day at other times. Staff confirmed there was sufficient medical staff to meet the patient's need. Since April 2018 the four consultants employed by the hospice had been working as an integrated team with the consultant from the hospital trust. This ensured a one in five consultant rota. This meant a consultant was on-call and had input in the two services.
- The middle grade doctors included doctors training in general practice or doctors from the local acute trust. These doctors were also available to see patients, liaise with local GPs and respond to questions from the help line. The medical staffing arrangements were under review.
- The medical staff were supported by the clinical director who was also a consultant on the rota.

Records

- Patient records were well-maintained and stored securely. Each patient had two sets of records. The medical records, including results from investigations, and the ongoing doctor and nurses' records. These were stored securely in a locked cupboard with access restricted to medical and nursing staff. The ongoing monitoring records were kept with the patient to enable staff to review and record observations.
- Records we reviewed during the inspection provided an audit trail of the care provided. Care rounds had recently been implemented as a formal system to provide an auditable means of recording the care provided. We reviewed five sets of records and found them to be completed and readable. Records reflected the person's specific requests and included details of spiritual care. We saw there was a focus on what the patient could do, and not what they could not do.
- However, not all nursing records had been written clearly and completed as required in the past. Audits of the nursing records had taken place across the two hospice locations for the admission period April and May 2017, looking at 10 sets of patient records. Results showed only 50% were written clearly, only 60% were dated and only 50% were dated and timed. Recommendations were made and a re-audit planned for six months later. There was no record to show this had been undertaken. There was no action plan, no corresponding addition to the risk register and no system to monitor the progress needed.
- There was no clear audit trail of changes made to medical care and treatment. Medical records were audited in December 2017 and January 2018 and results varied. The audits had found 80% were written clearly, only 50% were signed and only 20% had alterations dated, timed and signed. There was no action plan, no corresponding addition to the risk register and no system to monitor the progress needed.

- Records did not leave the hospice and were stored and archived securely. Discharge letters were used to inform the patient's GP and care services in the community of the care each patient needed on discharge. A copy of that letter remained in the patient's record. The only record which left the hospice was the patient's treatment escalation plan, which identified the patient's requests for care and treatment. All patient notes were identified during transport by use of an orange bag.
- Electronic record systems did not communicate effectively to the electronic systems in the community and local trust. Any exchange of information from the electronic system had to be managed verbally and in written form which provided a risk that information could be missed.

Medicines

- In-patient medicines were managed safely with policies for general medicines and controlled drugs. These were due review in April 2018, but had not taken place.
- Medicines were prescribed on prescription and administration charts. Allergies were recorded in the patient care record and on patients' individual drug charts.
- Stock medicines were monitored to ensure there were enough available and ordering processes were clear. Night staff ordered the required stock which was delivered the following day.
- Medicines were stored correctly. Patients each had a box by their beds and all routine medicines were dispensed from there. Controlled drugs were stored in line with legislation. We saw the temperature of areas used to store medicines was recorded, and was within safe limits. Parenteral fluids were stored correctly and monitored for temperature and expiry.
- Pharmacy support was available and stock levels and medicine reconciliation reviews by two pharmacy staff took place each week. Any areas of risk or note were recorded on the prescription chart and amended by the doctor. The pharmacist attended the multidisciplinary meetings to ensure medicine changes were correctly managed.
- Administration of medicines and intravenous fluids to patients was managed safely. All intravenous fluids, medicines and syringe drivers were checked and administered by two registered nurses.
- Disposal of medicines was managed safely. All medicines were kept for seven days after the patient's discharge and then disposed of by the pharmacist. Controlled drugs were neutralised correctly before disposal. Destruction records were well maintained. The director of patient services was the accountable officer for controlled drugs and had overall responsibility for ensuring appropriate destruction of controlled drugs. Staff explained a safe disposal process.
- Prescription pads (FP 10) were well-managed to ensure an audit trail of prescriptions used. A system of recording serial numbers was used to identify if any were missing.
- Training was provided for staff for specialist medicine administration but not all staff had the required competencies to administer chemotherapy. This meant that appropriate staff were rostered to be on duty if patients required these medicines.
- All appropriate staff had undertaken syringe driver competence training and were updated annually. Staff also received anaphylaxis (severe allergic reaction) training to enable them to recognise and respond appropriately to any allergic reactions. When new staff started at the hospice, unless written evidence of competence in all areas of medicine management was available, full competence assessments were undertaken.
- Medicine audits were not undertaken. Any medicine errors were investigated and learning fed back to staff through safety alerts. All errors, including omissions, were recorded and learning was shared with all staff. However, this learning was not shared with the other hospice in the organisation. Since April 2018 there were nine recorded medicine errors, all of which had been investigated and had appropriate action taken to prevent reoccurrence.
- The hospice had a blood transfusion policy and provided training for staff for the issuing of blood. Staff were fully aware of how to manage the process safely and described the process to us.
- Medicines on discharge were well-managed to ensure patients had what they needed. Each patient was given a yellow card on discharge which had all their medicines and any instructions needed. Staff took time with the patient prior to discharge to go through the card and explain all the medicines and how to take them.

Incidents

- Incidents were recorded and reviewed to provide learning and prevent reoccurrence. An overview of

incidents was discussed at clinical meetings. Incident reports were hand-written and included a check sheet to enable auditing. This was a new system recently implemented. From April 2017 to April 2018 there were 58 incidents reported, of which 21 were falls, 25 were pressure damage and 12 were medicines issues.

- An incident policy was available, which highlighted to staff the approach to incident reporting and the responsibilities of staff in incident investigation. However, the severity of the harm level of incident was not assessed to ensure a consistent response. This also meant themes and trends could not be identified and used to improve the service.
- Incident investigations were overseen by the head of care with the investigation delegated to the appropriate head of department. The head of department was responsible for completing the investigation and putting together a response. The head of care reviewed all responses. No training had been provided for the heads of department in either root cause analysis investigation or in incident investigation. This meant there was a risk of inconsistent investigation and outcomes.
- Staff confirmed they were encouraged to report incidents. This included if working below what was considered standard staffing levels. However, we checked the incident reports and did not see this staffing levels had been reported when the shifts had not been filled.
- In the last 12 months there had been no never events. Never events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Staff had a clear understanding of the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Are long term conditions effective?
(for example, treatment is effective)

We did not inspect this domain as part of the focussed inspection.

Are long term conditions caring?

We did not inspect this domain as part of the focussed inspection.

Are long term conditions responsive to people's needs?
(for example, to feedback?)

We did not inspect this domain as part of the focussed inspection.

Are long term conditions well-led?

- External professionals had access to a 24-hour support and advice line from the hospice. Patients and their representatives were advised to telephone the hospice directly following their discharge. This enabled a system of support to patients following their discharge.
- The leadership structure within the organisation was clear and staff were aware of who they reported to.
- Staff were familiar with the organisation's strategy, vision and values, and were provided with the opportunity to be involved in the development of these.
- The executive team had acted to address low morale and allegations of bullying with the provision of meetings and the reintroduction of the staff forum.
- The organisation had taken steps to improve the accessibility of trustees and executives to staff. Increased numbers of visits to clinical areas were being made and additional staff meetings were held.

Leadership

- The Chief Executive Officer (CEO) held day to day responsibility for the running of the organisation and had been in post since 2005. The executive board comprised of the CEO, medical director, director of patient services (also registered manager), director of HR and director of finance. They were supported by the board of trustees who included people from both clinical and business backgrounds.
- The CEO's office was based at Mount Edgecumbe Hospice. The registered manager also had an office at

Mount Edgecumbe and spent most of their working week there. The board meetings alternated between the two hospices which provided the opportunity for clinical staff to meet with the executive team.

Vision and strategy

- The organisation had a strategy which had been developed by the board following discussions between executives and trustees. The strategy had been developed to enable more people to access services in line with national recommendations and developments in hospice care. This had resulted in the development and implementation of neighbourhood hubs. The aim was to make clinics and services for advice and support within local communities more accessible. There was a neighbourhood hub located in Wadebridge, which linked with Mount Edgcumbe Hospice. There were plans to develop further hubs to reduce the travelling times for patients requiring advice and support.
- Information regarding the strategy and how this was planned to be implemented was shared with heads of departments at monthly meetings. There was an expectation the information would be cascaded to all staff following these meetings. Staff views regarding the strategy had been sought. The senior management team reported this had been minimal and considered this was because staff were aware of the strategy and forthcoming changes.
- A series of workshops had been held by an external consultant to develop the organisation's vision and mission statement. Three workshops were held for different roles: senior leadership team, trustees and the staff. The chief executive officer told us the outcomes from each workshop group had held the same values and therefore the final vision, values and missions were unanimously agreed by all staff.

Culture

- There was a culture of low morale and concerns about bullying in the hospice. Before our inspection staff had contacted us to share this information. During the inspection we found evidence which partly supported these issues. Some staff spoke of low morale and said they had concerns in approaching senior leaders with these issues. Documentation also supported this, for example staff appraisal forms. However, not all staff identified concerns and most staff we spoke with said they were proud to work for the organisation and enjoyed their jobs.
- The executive board were aware of the unhappiness among staff, which they said had started following the development of neighbourhood hubs. As a result, a series of meetings known as 'Let's talk' workshops were held. This had helped to familiarise staff with the board of executives and trustees and provided an opportunity for questions to be asked. The workshops were due to be reintroduced in September 2018 led by all senior managers, members of the board and trustees.
- A staff survey had been carried out in 2018 and identified that while staff were proud to work for the organisation there was also a feeling of low morale. The staff survey was the first to be carried out by the organisation and there were plans to repeat it in 2020. The CEO and registered manager explained this was to allow sufficient time to elapse to enable actions and workstreams to embed before repeating the survey. There were no plans to carry out an interim survey.
- Members of the executive team said they were proud of the organisation and the work carried out by the staff. However, they acknowledged staff morale and unhappiness was a concern within the organisation.
- Many staff we spoke with were positive about the changes and how the service was developing.
- The staff forum had been re-started and representatives were available from different areas of the organisation to take issues from staff to meetings for discussions. We were told staff wanting to raise issues were not able to do this anonymously and some staff said they would not feel confident making themselves known as the person raising the issue.
- Staff had access to occupational health for emotional support when necessary. We were told that following the death of a patient staff accessed the service for bereavement support should they require this. Staff could also access counselling through this service.
- We reviewed the annual appraisals for 10 members of staff. Three out of the 10 members of staff had identified low morale among their colleagues. Reasons offered for the low morale included changes taking place within working practices without clear rationale of why the change was required and a lack of training and opportunities for staff. The appraisal records showed two members of staff had requested training for two

years in succession but this had not been provided. We discussed these issues with three members of the executive team who acknowledged the concerns. The training programmes were being reviewed and developed.

Governance

- The organisation had systems and governance processes to monitor the quality and standard of service delivered.
- The medical director and director of patient services both have responsibility for clinical governance within the organisation at executive level. The Medical Director chairs the Clinical Governance Committee and the Quality Assurance Committee, both of which meet monthly.
  - The medical director and director of patient services both provide feedback to the executive team at their regular weekly meetings, and to the Clinical Services Committee, a subcommittee of the Board of Trustees which meets quarterly.The monthly clinical governance and quality assurance meetings reviewed incidents including any falls, pressure damage and infection control issues. This information is also included in the Clinical Services Committee papers and shared with the local commissioners of care. It is also considered in a regional hospice benchmarking process.
- The executive board and trustees were provided with assurance about safe staffing levels by the clinical governance committee. A staffing review had taken place by the registered manager six months prior to the inspection. We asked for documented evidence of this review but did not receive it. The registered manager stated the review had used a national tool to assess the staffing requirements. Additional staffing was sourced if patient dependency increased. This was achieved by either hiring agency staff or by permanent staff undertaking additional shifts.
- The organisation undertook audits to ensure outcomes for patients were positive. The audits were either completed annually, such as infection prevention and control and completion of medical records, or as a response to an identified need. A recent audit had been undertaken as there had been concerns treatment escalation plans (TEP) had not been completed fully or in sufficient detail. Following the audit, staff were provided with guidance on the completion of the forms. This had improved consistency in countersigning the forms. Following a change in protocol of the use of antibiotics led by the local acute hospital, an audit had been undertaken. The completed audit showed the protocol was consistently followed.
- The organisation ensured staff were recruited following robust procedures. Qualifications and character checks were undertaken, with records held in individual personnel files. Applicants were required to sign a declaration regarding the Rehabilitation of Offenders Act and complete a Disclosure and Barring Service check to ensure they were suitable to work with vulnerable adults. Professional registration checks were made to ensure registered nurses and medical staff were suitable for ongoing employment. We reviewed five sets of recruitment records for staff working at Mount Edgecumbe Hospice. These showed systems had been followed when recruiting the staff members and appropriate checks made to ensure the suitability of the person to work with vulnerable adults. We also saw annual checks of the professional registration status of registered nurses working on the ward.
- Annual appraisals were provided for all staff. Records showed these were up to date and provided staff with the opportunity to raise any ongoing work or training issues. The action plans did not appear to be reviewed between appraisals and for some staff the same issues had been raised at subsequent appraisals.
- Staff had been provided with the current Ambitions for Palliative and End of Life Care document. This is a national framework for local action between 2015 and 2020. Staff were not aware of the document and the education lead confirmed she believed some staff had not read it. This meant there was a risk staff would not be following current good practice recommendations.

Managing risks, issues and performance

- Consideration had been given prior to opening additional beds in the hospice to ensure that it was safe to admit more patients. The organisation had considered the impact of opening the additional beds on the current staffing levels. The CEO stated the board had been provided with information regarding the existing staffing levels at the hospice and the management of the proposed new beds and review of staffing. The director of patient care had benchmarked the staffing levels against those in other hospices.

Discussions and assurances had been provided by the registered manager. The senior leadership team had been asked to seek views from the staff on the required staffing levels to safely staff the wards with the increased beds. At the time of our inspection no additional beds were being opened while the review was ongoing.

- There was a local risk register and organisational risk register. The board had been concerned the local risk registers were generic and not service specific so a project to develop these had been led by the clinical leads for nursing and medical staff. The risk registers were reviewed every three months by the executive team. The board meeting agenda had been developed to enable more time to be spent on the identified risks and provide assurance the risks were rated appropriately using a red, amber, green (RAG) scale. Significant risks and those which impacted across the organisation were included on the organisational risk register following this meeting. This provided assurances that appropriate action was being taken to mitigate against the risk.

Managing information

- The organisation was not fully compliant with the General Data Protection Regulation (GDPR) 2016 but were working towards full compliance. GDPR became mandatory in May 2018 for all organisations and replaced the Data Protection Act 1998. The organisation was working towards making changes to ensure they complied with the GDPR requirements. The policy and procedure regarding data protection had been reviewed and developed to reflect the GDPR requirements and have confirmed their view that they are now compliant.
- The director for finance was also the information governance lead and had been in post for 18 months. Part of the director's role was to chair the information governance meeting, which met every three months, or sooner if there was an issue to address.
- Confidential and personal information was stored securely. The organisation had provided lockable notes trolleys for the storage of patients' confidential and personal information following the discovery of patient records in an unlocked and unattended office. There had also been an incident within the organisation where a patient's details had been stored on a member of staff's personal electronic device. As a result of these, information governance issues, policies and procedures had been updated and shared with staff to protect confidential and personal information of patients using the service. We asked to see the incident reports and associated investigations for these incidents but were told by senior staff there had not been an incident report completed as action had been taken. This did not ensure a clear record was kept of the events and the associated actions.
- Staff personnel files were stored securely in locked filing cabinets in a locked office when the administration staff were not working.

Engagement

- Staff reported they did not have regular contact with the executive board or the trustees. The executive board had been made aware of this through the staff survey and conversations with senior clinicians. Following each each board meeting one of the executive team and a trustee would visit the clinical areas to meet and talk with staff. The senior management team expressed concerns the staff were not currently engaging with them and attributed this to the low morale and dissatisfaction among some staff.
- The staff forum had been reformed and restructured to give staff representatives an opportunity to form links between the executive team and their colleagues. Issues could be raised by staff and responses from the executive team or other relevant departments were then provided.
- Information was provided to staff regarding the developments of the organisation and how this would affect their roles. A director of care's team meeting was held monthly and attended by the registered manager, clinical director, the head of care and the education lead. Information was cascaded to staff through monthly team meetings. This system had been introduced to address staff concerns that information was not shared fully with them.
- Group meetings known as 'Let's talk workshops' were started in January 2018 and were mandatory for staff to attend. The purpose of the workshops was to inform staff of changes to the running of the hospice services, including the purpose of developing community services. There had been previous concerns that information was not cascaded to all staff effectively and the purpose of the workshops was to provide staff with an opportunity to meet with senior managers and raise any questions, concerns or queries.

- A newsletter was published within the organisation to provide staff with relevant information. We reviewed a number of the newsletters and saw information included proposed changes to staffing roles and recruitment of new staff, applying the organisation's vision and values, access to training and celebrating staff achievements.
- The senior leadership team prepared a monthly team briefing, this was shared at staff meetings. The briefing included a short summary of items discussed in the most recent board meeting, the financial status of the organisation, clinical and organisational updates, staff statistics, outcomes from the staff survey, media coverage, the organisational risk register and events running within the county.
- A community engagement nurse had recently been employed by the organisation. Their role was to link with external organisations and staff particularly around planning and developing the community / neighbourhood hubs.
- The organisation engaged with other providers of services in the area to provide an accessible service to patients. A partnership had been formed with the local acute trust to provide support to both patients and medical staff at the hospital. Consultants rotated between the hospice and acute trust, which had led to better integration and developed relationships. We were provided with information which showed 90% of patients attended the hospice for care and treatment for cancer. The senior management team was working with the acute trust to increase services for patients with other life-limiting conditions. There had been limited joint work with the community palliative care teams, which were provided by the local mental health trust. The registered manager linked with the hospice for children in Cornwall to provide support to patients, families and staff during transition to adult services.
- The local clinical commissioning group held an end of life strategy board, which the service was part of. This led to positive joint working practices with the commissioners.
- The registered manager shared with us the vision of the organisation to reach harder to access groups of people, such as those experiencing addiction, LGBT (lesbian, gay, bisexual and transgender) and travelling groups. Links had been formed with LGBT and addiction support groups in the local areas but the registered manager stated there was little diversity in Cornwall. There had been no work to reach homeless people who required services.
- There was limited engagement with patients and the wider public regarding the service. Following the death of a patient or an inpatient stay, the patient, their relative or representative was contacted to provide the opportunity for the bereaved to ask any questions or provide feedback. The registered manager said the feedback had been 'overwhelmingly positive'. The friends and family test results received were also positive.
- The lymphoedema service requested feedback from patients regarding their care and treatment. This was based on the friends and family test questionnaire. Outcomes from the survey showed patients were satisfied with the care and treatment provided and they would recommend the service to their friends and family.

Learning, continuous improvement and innovation

- Care pathways had been implemented to ensure patients who suffered a higher level of distress would receive prompt and appropriate care and treatment from external professionals. The organisation had reviewed the care provided to patients experiencing psychological distress. A recognised distress tool had been used to measure the support and clinical care distressed patients required. Use of the tool had been audited and found the staff had managed the care required without seeking assistance from external specialist staff.
- Clinical issues identified in other services, either locally or nationally, were considered to inform how care was provided by the organisation. Policies and procedures were reviewed and developed when necessary to reflect findings. For example, the policy and procedures for prescribing and administered opioid medicines had been reviewed thoroughly and additional guidance provided to staff.
- The organisation was undertaking a mortality review following updated national guidance. This was in progress at the time of our inspection so we were unable to review the findings.
- The organisation was involved with integrated working with external providers to promote early intervention for patients with a life-limiting illness or condition. This was

in line with national guidance and research which showed patients experienced significant benefits in quality of life, planning of care and communication when referrals occurred early in their care pathway.

- The clinical team from Cornwall Hospice Care had received national recognition for their work. In 2017 they were a finalist in the British Medical Journal (BMJ) 'care team of the year' for their work in rolling out anticipatory prescribing guidance in the dying phase to over 1,00 health professionals. In 2018 they were shortlisted for the BMJ 'palliative care team of the year', recognising the joint working in oncology clinics within the acute trust.

Outstanding practice and areas for improvement

Outstanding practice

- The organisation was involved with integrated working with external providers to promote early intervention for patients with a life-limiting illness or condition. This was in line with national guidance and research which showed patients experienced significant benefits in quality of life, planning of care and communication when referrals occurred early in their care pathway.
- The clinical team from Cornwall Hospice Care had received national recognition for their work. In 2017 they were a finalist in the British Medical Journal (BMJ) 'care team of the year' for their work in rolling out anticipatory prescribing guidance in the dying phase to over 1,00 health professionals. In 2018 they were shortlisted for the BMJ 'palliative care team of the year', recognising the joint working in oncology clinics within the acute trust.

Areas for improvement

Action the provider MUST take to improve

- Ensure all staff are trained and competent to safeguard adults and children from abuse.

Action the provider SHOULD take to improve

- Ensure staffing levels are assessed and related to patient dependency.
- Ensure incidents are appropriately assessed to ensure a consistent investigation and response by suitably trained and competent staff.
- Ensure all staff complete mandatory training and assess compliance rates. The provision of additional role-specific training should be reviewed to ensure staff are competent and skilled to carry out their jobs. For example, when providing care to patients living with dementia and mental health care needs.
- Ensure staff are supported to access national guidelines and legislation.
- Ensure all staff feel able and confident to raise concerns and issues.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13(1) Service users must be protected from abuse and improper treatment in accordance with this regulation. 13(2) Systems and processes must be established and operated effectively to prevent abuse of service users. Safeguarding children training was not provided for staff. Children could visit the hospice and stay overnight.