Severn Hospice Limited

Severn Hospice Apley Site

Inspection report

Severn Hospice -Telford
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Inadequate
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Severn Hospice Apley site is operated by Severn Hospice Limited. The service provides end of life care had 10 inpatient beds and provided services in the community.

The service is registered to provide the following regulated activities:

- Diagnostic and screening.
- Treatment of disease or injury.
- Personal care.

Following this inspection, we told the provider that it must take some actions to comply with regulations. Following this inspection, we told the provider that it must take some action to comply with regulations. We also issued the provider with three requirement notices and a S29 warning notice.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Requires Improvement 	Our rating of this location went down. We rated it as requires improvement because: • Leaders did not operate effective governance processes throughout the service. • The service did not always ensure it followed current COVID-19 guidance in relation to retesting of patients. • The service did not always ensure it followed current COVID-19 guidance in relation to staff understanding of how many people could be in staff communal areas at any one time. • We found the risk register could be confusing due to the incorrect dates in columns. • Staff did not always receive the appropriate training for their role in line with the 'Adult Safeguarding: Roles and Competencies for Health Care Staff, intercollegiate document (August 2018)'. • The service did not ensure that all documentation and risk assessments were completed regarding skin and wound care. • The service did not ensure that all documentation and risk assessments were completed and updated regarding the use of bedrails. • We found service did not have an Infection protection policy in place that related specifically to their service. • We found that the completion rate for mandatory training was low which meant staff may not have the skills or knowledge to complete their role effectively. However: • We found that there was a sufficient stock of PPE and this was stored correctly. Staff were knowledgeable about personal protective equipment (PPE). • Ward areas were clean and had suitable furnishings which were clean and well-maintained.

Summary of findings

- The service had link Infection Prevention Control (IPC) nurses in place and IPC audits were completed identifying any actions that needed to be completed.
- Staff knew how to identify incidents and report them. Incidents were also discussed in team meetings.
- Staff told us that the senior managers were always visible.
- We found that senior managers understood the hospice challenges and identified the required changes that had taken place during the pandemic.
- Leaders had a clear leadership structure in place.

Summary of findings

Contents

Summary of this inspection

Background to Severn Hospice Apley Site

Severn Hospice Apley Site is a service that operates under Severn Hospice Limited. It is a charitable organisation in Telford, Shropshire. The hospice has 10 beds and supports the community across Shropshire and West Midlands. Severn Hospice Apley Site will also accept patient referrals from outside the area.

The hospice provided the following services:

Hospice at Home: The service provides care for patients with cancer and non-malignant progressive disease and their carers during the palliative care phase of their illness at home.

Community Outreach: A service review was undertaken in 2017 and the service now provides clinical support and specialist advice to GP's, district nurses and care homes in identified geographical areas. The Lymphoedema Service: This service provides specialist lymphoedema care and advice in line with British Lymphoedema Association guidance and protocols. Treatment through the acute phase of their condition and periods of exacerbation with the goal being supporting self-management Inpatient Service.

The service provides a 24-hours a day specialist care service which is not disease specific. Care is provided to patients with complex symptoms. The service aims to offer short term care to safeguard bed availability. Complementary and Creative Therapy.

The current registered manager has been registered with the CQC since 2019.

Severn Hospice Apley Site was last inspected on 22 October 2019 and rated as outstanding overall with no compliance actions or requirements.

How we carried out this inspection

We carried out an unannounced, focused inspection at this location in response to concerns we had around safeguarding, infection control, medicines and governance.

We looked at relevant areas within two of the key questions: is the service safe and well led? We did not inspect effective, caring or responsive key questions.

The inspection was carried out by one inspector and a specialist advisor with end of life experience. We spoke with eight staff members on site and 10 staff were interviewed off site using telecommunications.

There were four patients using the service at the time of inspection and each of their care records were reviewed.

During the inspection, we also looked at the training records, policies and procedures and records relating to quality assurance.

The inspection was overseen by Fiona Allinson, Head of Hospitals Inspection

Summary of this inspection

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service must ensure that all documentation and risk assessments are completed regarding skin care, wound care and bedrails. Regulation 12 (1) (f).
- The service must ensure that they consistently follow national guidance for COVID-19 and Infection Prevention Control. Regulation 12(1) (h).
- The service must ensure that service users are protected from abuse and improper treatment. Regulation 13(1): Safeguarding service users from abuse and improper treatment.
- The service must ensure that systems and processes are established and operated effectively. Regulation 17 (1) Good Governance.
- The service must ensure all staff are up to date with mandatory training and effective governance systems are in place around the recording of this. Regulation 18(2)(a): Staffing.

Action the service SHOULD take to improve:

We told the service that it should take action because it was not doing something required by a regulation, but it would be disproportioned to find a breach of regulation overall.

- The service should ensure that they follow current guidance in relation to retesting of patients for COVID – 19.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospice services for adults	Inadequate	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Overall	Inadequate	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement

Requires Improvement

Hospice services for adults

Safe	Inadequate
Well-led	Requires Improvement

Are Hospice services for adults safe?

Inadequate

Our rating of safe went down. We rated it as inadequate because:

Mandatory training

The service had not provided essential mandatory training in key skills to all staff and not made sure everyone completed it.

Staff had not kept up to date with their mandatory training as most of this face to face training had been cancelled due to the pandemic. Leaders told us they had made arrangements for training to be made available via e-learning. However, staff told us they had until September 2021 to complete this training. Leaders told us no risk assessments had been carried out in relation to the lack of mandatory training during the pandemic. This meant the risks associated with staff not completing this training had not been formally assessed and planned for.

Hospice data showed that resuscitation training rates were very low. The registered nurses had a compliance rate of 20% for resuscitation level one, and 25% for resuscitation adults' level two. Nursing assistants had a compliance rate of 29% for resuscitation level one, and 21% for resuscitation adults' level two.

Leaders told us earlier in the pandemic that Basic Life Support (BLS), face to face training had been booked with an external trainer. However, due to COVID -19 related reasons this had not taken place. Basic Life Support was now available via e-learning, but figures remained low.

Hospice data showed that compliance rates for syringe driver training was also very low at 40%. Syringe drivers are used to administer medicines at a constant rate throughout the day and night, to aid symptom control.

Hospice data showed poor compliance levels for moving and handling training, registered nurses had a compliance rate of 35% for moving and handling theory level one, and 25% for moving and handling theory level two. Nursing assistants had a compliance rate of 36% for moving and handling theory level one, and 43% for moving and handling theory level two Social workers, catering staff and housekeeping staff had a compliance rate of 0% for fire safety level one. This lack of knowledge for some staff may place people at risk of potential harm.

Staff received some 'bite size' training during the pandemic from the education lead, these included diabetes in End of Life (EOL) care, nausea and vomiting, nasogastric and parental feeding, pain, shortness of breath, and venous thrombosis in palliative care.

Safeguarding

Requires Improvement

Hospice services for adults

Nursing and medical staff did not receive the correct level on safeguarding adults from abuse in line with national guidance. Safeguarding concerns were not always reported to the relevant authorities in a timely manner.

Staff did not always receive the appropriate training for their role in line with the 'Adult Safeguarding: Roles and Competencies for Health Care Staff, intercollegiate document (August 2018)'.

Clinical staff were not trained to the appropriate levels in safeguarding. None of the clinical staff employed by the hospice had a level three adults safeguarding qualification. This was not in line with the 'Adult Safeguarding :Roles and Competencies for Health Care Staff, intercollegiate document (August 2018)' in that level three is applicable to registered health care staff who engage in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns. There were no safeguarding supervision nurses in place. There was no named professional available at the hospice with a level four safeguarding qualification.

The hospice employed a team of full time and part time social workers from 9am to 5.30pm Monday to Friday. The hospice social work team leader was available during weekdays for safeguarding advice and support. Outside these hours we were told clinical staff were responsible for making any safeguarding referrals and they would ring the local authority safeguarding teams for advice.

We were unable to ascertain if the social workers current level three qualifications in safeguarding children and adults were still valid as we were not provided with the date of completion and expiry. Following the inspection on the 20 April 2021, we asked for details of which social workers had level three safeguarding training, if the level three qualification was for children or adults, the date they completed these and when they were due to expire. Leaders responded that as an organisation, they deemed it appropriate for their safeguarding lead to have level three for both and as face to face training was disrupted last year, the lead had secured training this year through the online NHS portal which will be due for renewal in January 2023.

We were unable to ascertain safeguarding adult and children training compliance levels for trustees. We were told there was no requirement for trustees to complete their level one safeguarding training in adults or children. This not in line with the intercollegiate document in that level one is the minimum level required for all staff working in health settings including board level executives and non-executives. Following the inspection, we asked for details of mandatory training compliance for trustees; we were not provided with this. We were told trustees had been given access to the NHS system and would be undertaking the elements of mandatory training relevant to them such as safeguarding and health and safety.

Safeguarding mandatory training figures at level one and two for social workers were low. Following the inspection, we were provided with information on mandatory training compliance figures for all non-clinical staff as of the 5 May 2021.This showed only 33% of social workers at the Apley site had completed their safeguarding children level one and only 33% of social workers had completed their safeguarding adults' level one and two training.

Hospice data showed that the registered nurses had a compliance rate of 75% for safeguarding adults' level one and level two training. Nursing assistants had a compliance rate of 71% And catering staff had compliance rate of 33%. The hospice had a compliance rate of 85%. Following the inspection leaders told us that the safeguarding level two training figures they provided at the time of the inspection were incorrect and there was an overall compliance rate of 98%. However, a breakdown of individual staff groups and locations was not provided.

Requires Improvement

Hospice services for adults

At the time of the inspection, leaders provided us with safeguarding training figures for registered nurses and nursing assistants. Compliance for registered nurses for safeguarding children level one was 75%, for safeguarding adults Deprivation of Liberty safeguards (DoLS) (includes completed safeguarding adults' level one and two) was 75%, safeguarding adults Mental Capacity Act (includes completing safeguarding adults' level one and two) was 75%. At the time of the inspection, clinical staff were not trained to level three in safeguarding adults.

Nursing and medical staff did not receive the correct level of safeguarding adults and children training. No nursing or medical staff had completed level three training as required in line with national guidance.

Following the inspection, leaders told us due to us concentrating heavily on safeguarding over the last year, it had been decided to enhance the current safeguarding process and invest in safeguarding link nurses on each ward and within the community services who would also be trained to level three in adult safeguarding and will report to the new link lead (in the quality and education department) who in turn will report to the clinical governance team. The aim was to have this is place by September 2021.

Staff could give examples of when they would make a safeguarding referral.

Five staff were able to give examples of when they would raise a safeguarding referral, however staff had not raised any safeguarding referrals recently.

Hospice data showed that the chaplain had 100% compliance for safeguarding children level one, safeguarding adults' level one and two.

At the time of the inspection (20 April 2021) leaders were not aware of the correct documentation to submit safeguarding notifications to the CQC. We raised this at the time and were told this had now been rectified

We found the service did not always send safeguarding referrals to the local authority in a timely manner. For example, one patient disclosed safeguarding information to the service on 19 April 2021, but this was not reported to the local authority until 23 April 2021. This delay potentially placed other people at risk of abuse and avoidable harm.

Cleanliness, infection control and hygiene

Staff used infection control measures when caring for patients on wards and transporting patients after death. However, we found not all staff were trained in the management of infection control and the policy provided to us was not specific to the hospice.

There has been an outbreak of COVID-19 within the hospice, we saw leaders had sent out an email to all staff around their conclusion following a meeting Public Heath England.

Hospice data showed low rates of compliance with infection prevention and control training. Registered nurses had a compliance rate of 70% for infection prevention and control level one, and 70% for infection prevention and control level two. Nursing assistants had a compliance rate of 64% for infection prevention and control level one, and 64% for infection prevention and control level two. Social workers and housekeeping staff had a compliance rate of 0% for infection prevention and control level one or infection prevention & control level two. A lack of training across the staff team presented a risk that the service was not effective in managing the risk of infection, and this may then place people at risk of potential harm.

The service had not followed national guidance to ensure staff understood how many people could be in staff communal areas at any one time, and there were no visible signs to highlight this. The COVID-19 risk assessment also did not demonstrate that staff numbers in staff areas had been assessed and planned for to ensure these risks associated with COVID-19 were assessed and planned for.

We found that the service did not have a policy in place to monitor staff compliance with COVID-19 lateral flow tests to effectively monitor staffs' COVID-19 status. However, staff who tested positive for COVID-19 knew they needed to share these results with the service and appropriate action was taken in response to positive tests.

Leaders told us they retested patients weekly who remained positive for COVID-19 after 14 days, until they received a negative result. This was not in line with current guidance which states people who test positive with a PCR test, should not be tested again for 90 days, unless they develop new symptoms. If that happens, they should be tested immediately using a PCR.

We found that there were sufficient stock of PPE and this was stored correctly. Staff were knowledgeable about personal protective equipment (PPE); all staff were wearing personal protective equipment at the time of the inspection.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas of the site were cleaned regularly.

We found there was no concerns with the procedure for transporting patients after death.

The service had lead Infection Prevention Control (IPC) nurses in place. They completed IPC audits which identified any actions requiring improvement. These were shared with the management team.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service had enough suitable equipment to help them safely care for patient's safely. We found that equipment was tested and stored securely. Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments or remove and minimise risks.

We found that staff were using a recognised risk assessment tool for the use of bed rails, however this did not always reflect current risks. Care records showed that one person had been found with their legs over the rails and their risk assessment had not been updated to reflect the risks associated with this behaviour. We did not find any harm as a result of this.

The hospice had a risk management policy and procedure in place, last reviewed in April 2021.

It was reported between November 2020 and March 2021, there were 14 falls, these were all no or low harm to the patients.

We reviewed four patients records and found there was no concerns around pressure ulcer risk assessments.

Information about pressure areas was included in the service's quality account 2020/21. This included data about the number of people admitted with pressure areas and those acquired while at the service. There had been 44 patients admitted with a pressure area and three had been acquired whilst at the service.

Records

Staff did not maintain detailed records of patients care and treatment. Records were not always clear or up to date.

Staff could access patient records easily, however we found these were not always comprehensive. For example, one person's records reflected that staff had identified concerns with the patient's skin, but action was not taken for more than six days.

We found three of the four patients at the hospice had wounds. However, no adequate care plans were in place around how the wounds should be managed.

We found there was no records that accurately described wounds referred to in care plans. This meant staff could not monitor for signs of deterioration and they may not treat wounds consistently as no plans for specific dressings were identified, or guidance about when to change the dressings. There were some body maps, but no detail of size and grade of wound.

We found that staff were using topical skin creams that were not prescribed or documented

patients' care plans. This meant there was no evidence of why the patients needed to use these

creams.

Medicines

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Supplies of medicines was provided by the local NHS Trust which included a medicine top up service every week. Although the top up service had been suspended for six months during the COVID-19 pandemic, staff ensured there was no disruption to the availability of medicines.

Medicine guidelines and policies were available which had been approved by the Governance Committee. Medicines were prescribed by doctors and administered and recorded by nursing staff. Medicine records seen showed that medicine administration was recorded following policy.

A pharmacist was available 15 hours a week to support the team on the safe and effective use of medicines.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines.

The pharmacist routinely checked prescription charts for accuracy and safety as well as ensuring there was individual monitoring for each patient. The pharmacist provided advice and answered queries relating to dose calculations for syringe drivers and the overall safe administration of medicines.

Patient information leaflets were available regarding the prescribing of 'off licence' medicines to provide reassurance and information to patients and their careers. Medicine information and transfer of care was shared with the patient's primary care teams to ensure that up to date information was shared across the system, including GPs, community teams and the end of life group.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy.

Medicines were stored in dedicated secure storage areas with access restricted to authorised staff. We checked storage arrangements and found medicines were stored safely and securely.

Controlled drugs (CD) were stored securely and safely following current national guidance for the safe storage of CDs. Record keeping and destruction was undertaken following policy. The pharmacist routinely checked CD records to ensure they were correct, however there had been no internal CD audits undertaken since 2019. CD checks, calculations and preparations were all undertaken in a quiet and secure area with no interruptions or distractions to ensure medicine safety.

The pharmacist was responsible for ordering and managing prescribing documents for the Non-Medical Prescribers.

Staff followed current national practice/guidance to check patients had the correct medicines.

Medicines reconciliation to ensure patients medicines were up to date was undertaken by a doctor which followed policy approved by the governance committee. Medicine reconciliation was moving to an electronic recording system to ensure consistency and enable internal audits to be undertaken more easily.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

The pharmacist reviewed any medicine incidents to ensure learning could be undertaken from an individual and corporate perspective. There had been no recent reported medicine safety incidents, however there had been a reduction in internal audits into prescribing due to the COVID-19 pandemic.

The pharmacist reviewed medicine alerts and alerted staff if any action needed to be taken. A medicine safety group was also in the process of being set up in order to consider alerts, highlight risks and support ongoing learning for medicine safety. These meetings would be shared with the governance group and nurse meetings.

The Controlled Drug Accountable Officer attended the controlled drug local intelligence networks in order to share any learning relating to CDs.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Requires Improvement

Hospice services for adults

Staff knew what incidents to report and how to report them, they used an electronic reporting system. They told us that they have team meetings where this is discussed, and they knew how they would raise an incident.

We reviewed the meeting minutes of the clinical leads meeting in December 2020 and saw incidents were discussed. For example, we saw incident reporting in relation to pressure ulcers and safeguarding referrals were included alongside an action point.

There was evidence that changes had been made as a result of incidents. For example, the service has set up safety hubs in response to several medication errors and had made changes to how they administered medications.

Are Hospice services for adults well-led?

Requires Improvement

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

Leadership

Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills. The hospice had a clear leadership structure in place.

The relationship between the senior leaders and trustees was positive and had worked together for a long period of time, the senior managers stated that could seek support, guidance from the trustees.

The service had a department structure in place, with an overview which included Chief Executive, Director of Finance and Information / Company Secretary, medical director, director of care and Director of Income Generation. This clearly identified who was responsible for each area.

Senior managers had a good understanding of the challenges there had been during the pandemic and the continuous challenges within the service.

Staff told us that senior managers and managers were always visible and accessible.

Vision and Strategy

We reviewed the Severn Hospice quality account dated 2020/21 and found it detailed the main developments within the service these included extending the role of hospice outreach nurses, extension of the hospice at home service and embedding living well as a concept of care. Priorities noted for 2021 and 2022 included topics such as patient and relative experience, clinical effectiveness, services provided and participation in clinical and service audits.

Governance

Leaders did not always operate effective governance processes throughout the service. However, we recognised that the pandemic has created significant challenges to both leaders and staff.

Requires Improvement

Hospice services for adults

Leaders told us how the COVID-19 pandemic had been the main challenge for them over recent months and how it was important to them to keep everyone safe. Leaders were proud that they were able to continue to offer the service to those patients who needed it.

Hospice policies and procedures did not always reflect up to date national standards and guidance and missed some key information.

Our review of the 'Severn Hospice Safeguarding Vulnerable Adults Policy' V8' found it did not accord with the detail within the Care Act 2014 statutory guidance. For example, it did not define safeguarding in line with the Care Act 2014

The adult safeguarding policy did not direct staff in how they were safeguarding people from harm or understanding of how the Mental Capacity Act 2005 applied to people and how consent was sought and agreed, a major component of safeguarding.

The safeguarding policy did not reflect up to date national guidance or standards that should be used in developing the safeguarding adult's policy and procedures. It did not provide assure of the level of understanding around consent or an up to date understanding of Deprivation of Liberty Safeguards.

The adult safeguarding policy referenced safeguarding leads as "*identified experienced professionals who had completed further training to provide advice and support to staff regardless of the safety issues*". The nominated person identified within the policy, to report safeguarding concerns was the matron, the director of care or senior managers on call who were only trained to level two safeguarding adults training. The policy was not clear on who the hospice social worker was. This was important as leaders told us they would go to the social workers for any safeguarding advice when they were on site. There were no clear timescales for reporting safeguarding concerns within the safeguarding policy.

The hospice did not always have its own policies. For example, it did not have a children's safeguarding policy. The policy the hospice provided us with did not reflect that the service was a hospice, it was not specific to the provider or the capacity in which children would attend. The policy also referred to other trust documents such as the record management policy and staff duties and roles which were not the same.

We asked for a copy of the children's safeguarding policy and were directed to the policy of a local trust. Leaders told us they had directed us to this policy as the hospice care registration was for adults over the age of 17 years. However, having a children's safeguarding policy is important as staff may come into contact with children who are visiting relatives at the service. The hospice social workers also provided a service ('Elephants Never Forget') that worked with children, helping children and families who had a relative with an incurable illness or who have experienced the death of a relative.

The hospice did not have their own infection prevention and control arrangements and responsibilities policy; this variation was noted in the hospice-controlled documents policy V2.

Leaders told us they were assured the infection prevention policies were up to date as they were members of the associated infection prevention control group which meet quarterly and the silver infection prevention control task and finish group.

The policy on the management of 'Slips, Trips and Falls' did not cite any national falls guidance and the interventions mentioned did not refer to a medicines review. The policy did not reference how best to move a patient post fall, or detail what to do if a hip fracture was suspected. This was not in line with the hospice-controlled documents policy which stated that policies were reviewed and revised regularly responding to changes in legislation, standards and good practice. The policy provided did not have a version number or date.

We asked leaders how they were assured all staff have read and understood the policies. Leaders told us all staff had to acknowledge they have read and understood role-relevant updated policies and guidelines each time they log into the computer and it was also incorporated within individual contracts. The clinical governance committee was responsible for reviewing any new and revised clinical policies.

We reviewed some examples of staff meeting minutes dated between October 2020 and March 2021 and found safeguarding and patient safety incidents were not routinely recorded as an agenda item in all of them. However, we did find incidents were discussed in the clinical governance group and the clinical leads meetings. The incident topics discussed in the clinical governance group included the number of incidents concerned with routine care and pressure ulcers in particular.

We reviewed the minutes of the clinical governance meeting dated November 2020. We found them to be comprehensive and detailed.

We found that the service did not have a written policy in place to monitor staff lateral flow tests to ensure that staff were compliant. However, the service used a capacity tracker and used a COVID -19 referral form, positive tests referred through local single point of referral to facilitate test and trace.

On the day of the inspection there was some confusion around the amount of people who should be in the rooms staff access at any one time. There was no signage to indicate the amount of staff able to access the room. Staff told us they were unsure of the amount of people who should be in the room and stated I think it's four or five.

There was a COVID-19 risk assessment in place, but this did not detail the amount of people that should be in a room. Guidance from the Health and Safety Executive (HSE) at to what to include in services' COVID-19 risk assessment recommends limiting the number of people in rooms, for example staggering breaks.

Leaders told us they would retest patients who remained positive for COVID-19 after 14 days weekly until they received a negative result. This was not in line with government guidance on Coronavirus (COVID-19) testing for hospices which notes If anyone tests positive with a Polymerase Chain Reaction (PCR test), they should not be tested again for 90 days, unless they develop new symptoms.

In 2020 all face to face training at the hospice was suspended due to COVID-19 for both clinical and non-clinical staff. Following discussions with the senior management team the decision was made to sign up to e-learning for health to provide the mandatory training staff required.

Leaders told us there was no specific risk assessment carried out on the lack of mandatory training during the pandemic. The annual mandatory training calendar was noted in the risk description assurance section of the clinical risk register that the hospice care remains safe; however, it did not sufficiently detail any mitigations. There was a mandatory training recovery action plan in place, dated January 2021. The recovery action plan had actions backdated to November 2020.

The training recovery action plan noted in November 2020, (seven months after the initial stay at home order in March 2020) all staff were provided with log in details for training. The date for full compliance was agreed as September 2021, this was ten months after staff received their log in details.

We asked leaders why e-learning had not been set up earlier in the pandemic. They told us told us it was because it had taken a few months to set up the e-learning and to gain individual access for staff. Prior to this they told us they had not known what the future held due to COVID-19.

There was a training and development policy in place. The policy was reviewed in April 2021.We saw mandatory training figures were discussed at the meeting of human resource committee. It was difficult to obtain all of the training figures of all staff groups at the hospice. It was not clear if the training figures sent included staff working on the outreach service or at hospice at home as the training figures for registered nurses and medical staff were provided under ward names and locations.

Leaders told us numbers were dropping in relation to clinical supervision. This had been reported to the director care, who we were told had escalated this to the governance team. We reviewed a copy of the latest clinical supervision audit dated 2019. The audit notes clinical support/peer support is available to both clinical and non-clinical staff and whilst it is not mandatory for all clinical staff to access supervision/support, they were very much encouraged to do so.

The 2019 audit concluded the past year had seen a reduction in individuals accessing clinical supervision/peer support with the main reasons being individuals shielding. A plan of action had been put in place which included staff education /information boards being implemented with facts around clinical supervising and peer support and to send out questionnaires to ascertain why accessing clinical supervision /peer support was not being taken up and to repeat the audit in December 2021. Due to COVID-19 this audit had been rescheduled for April/May 2021.

On the day of the inspection we saw little evidence audit findings were shared at ward level. We asked leaders to provide us with evidence of how any actions of audits completed between April 2019 to April 2021 were escalated and learnt from. Leaders responded that audits were presented through the clinical governance and all actions fed back through senior leads meetings to individual staff. We reviewed a copy of the minutes from the clinical governance group meetings dated 26 January 2021 and found it detailed an audit presentation that took place around the End of Life Care Plan.

Leaders and teams used systems to manage performance. However, we found the clinical risk register had incorrect dates recorded in the number/date column.

There were clinical and corporate risk registers in place, however the clinical risk register (that contained seven risks) had incorrect dates recorded in the number/date added column. For example, we reviewed the Severn Hospice Clinical Risk Register dated 2019 to 2021 and found in the column labelled number/date were the risks relating to COVID-19 disruption (September 2018); following discussion with leaders it was confirmed this was not the date the risk was added to the risk register. Regardless of the risk rating the date for review was mainly recorded as either April 2021 or May 2021.

Leaders attended Executive Clinical leads in Hospice and Palliative Care (ECLiHP) meetings. ECLiHP is a forum for all executive and aspiring clinical leaders engaged in the strategic planning and operational delivery of contemporary hospice care.

The director of care was part of the silver commander team and attended a local NHS trusts silver command meeting.

Requires Improvement

Hospice services for adults

There was a Risk Management Policy and Procedure in place. The policy was last reviewed in August 2019 with a next review date of August 2022.

The hospice clinical leads meetings included the director of care, the therapy lead, the social work lead, the clinical admin lead, the lead chaplain, the day services lead and the hospice at home lead.

COVID-19 was discussed in the Corporate Governance and Human Resource Committee held in April 2021. Infection control was an agenda item in the clinical lead's meetings.

We reviewed the minutes of the Board of Directors from November 2020 and March 2021. Topics discussed included the hospice budget, an update on the strategy, reflections on working through the pandemic, committees and governance, trustee recruitment, reports of the management team.

We reviewed the minutes from the meeting of the Corporate Governance and Human Resources Committee, dated 20 April 2021. The meeting was held via Teams due to the pandemic and was chaired by one of the hospices trustees. Attendees at the meeting included the director of care and the chief executive officer. With the exception of the chair, the job title of the attendees was not described in the minutes.

The corporate risk register was presented for review at the meeting of the Corporate Governance and Human Resources Committee. The chair went through each risk and updates required were discussed.

Leaders told us one of the main challenges faced by the hospice was the pandemic. However, it was felt the hospice had now moved forward, staff were happier, and they were looking at continuing to work on the community building and the first contact for referral service (first contact line where people could speak to someone at the hospice) The hospice had a recently built building to enhance visitor and communal spaces and to allow a larger therapy area.

The hospice had mental health first aiders at each site with 12 in total. Staff also had access to a clinical psychology service where they could access counselling.

Leaders were currently working on an oversight dashboard to aid further oversight of both hospice sites it was hoped these would support to manage any themes, tends of audits and incidents as well as shared learning across sites.

The hospice held regular board meetings and we saw these had taken place regularly. Other meetings included finance meetings, clinical governance, corporate governance, fund raising and promotion, retail, property and estates and communications and marketing. Each committee sends a summary report to the board.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service must ensure that all documentation and risk assessments are completed regarding skin care, wound care and bedrails. Regulation 12 (1) (f). • The service must ensure that they consistently follow national guidance for COVID-19 and Infection Prevention Control. Regulation 12(1) (h).

Regulated activity	Regulation
Diagnostic and screening procedures Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure that systems and processes are established and operated effectively. Regulation 17 (1).

Regulated activity	Regulation
Diagnostic and screening procedures Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • The service must ensure all staff are up to date with mandatory training and effective governance systems are in place around the recording of this. Regulation 18(2)(a).

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • The service must ensure that service users are protected from abuse and improper treatment. Regulation 13(1).