Kate's Home Nursing

# Kate's Home Nursing

## Inspection report

The Cottage, The George Moore Community Centre,
Moore Road, Bourton On The Water
Cheltenham
GL54 2AZ
Tel: 07800830302
www.kateshomenursing.org

Date of inspection visit: 17 November 2021
Date of publication: 08/04/2022

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? | Good |
| Are services effective? | Requires Improvement |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Requires Improvement |

# Summary of findings

## Overall summary

We rated it as requires improvement because:

- The systems of governance, assurance and audit to assess, monitor and improve the quality and safety of the services were not fully clear and did not operate effectively.

However,

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Information about staff training, supervision and appraisal was recorded and monitored as was necessary to ensure staff were competent to carry out their duties.
- Staff provided good care and treatment, ensured patients had enough to eat and drink, and gave them pain relief when they needed it. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **End of life care** | Requires Improvement  | Kate's Home Nursing provides end of life care and hospice nursing at home for patients in the last stages of illness who have expressed a wish to be at home.<br>All palliative nursing care was provided free of charge and paid for from charitable funds. The service received support from official sources but had to raise most of the funds.<br>We inspected the service using our comprehensive inspection methodology. We carried out a short notice announced inspection on 17 November 2021.<br>To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we review services' performance against each key question as outstanding, good, requires improvement or inadequate.<br>The inspection team included two CQC inspectors and a specialist advisor with expertise in end of life care. The inspection team was overseen by an inspection manager and the Head of Hospital Inspection South West.<br>Following this inspection, we told the provider that it *must* take some actions to comply with the regulations and that it *should* make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with requirement notices. Details are at the end of the report. |

# Summary of findings

## Contents

# Summary of this inspection

## Background to Kate's Home Nursing

Kate's Home Nursing is a registered charity set up to provide hospice at home care for patients in the last stages of illness. The team of registered nurses provides specialist palliative care for patients and support for their families.

The service was registered on 24 August 2016 and is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury.

The service has a manager registered with CQC.

**What people who use the service say**

Patients and their families said staff treated them well, treated them with respect, and listened to them. They said the staff were caring and compassionate and responded quickly. They also said staff were supportive and interested in them as individuals.

## How we carried out this inspection

During the inspection visit, the inspection team:

- visited the provider's office base and observed how staff were caring for patients
- spoke with the registered manager and chief executive officer
- spoke with three trustees
- spoke with five other members of staff including a nurse co-ordinator and nurses
- spoke to a community nursing lead
- spoke with seven relatives who had used the service
- observed one handover meeting
- looked at seven care and treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

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 to improve:**

- Maintain and strengthen an effective system of governance, assurance and audit to assess, monitor and improve the quality and safety of the services provided. Regulation 17(1), (2)(a), (b): Good governance

**Action the provider SHOULD take to improve**

- Check all staff who work for the organisation meet the policy and rules around criminal records checks.
- Formalise the process for ratifying policies and procedures the service uses to ensure these are accurate, complete and reflect the service provided.

# Our findings

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| End of life care | Good | Requires Improvement | Good | Good | Requires Improvement | Requires Improvement |
| Overall | Good | Requires Improvement | Good | Good | Requires Improvement | Requires Improvement |

Requires Improvement

# End of life care

| | |
|---|---|
| Safe | Good |
| Effective | Requires Improvement |
| Caring | Good |
| Responsive | Good |
| Well-led | Requires Improvement |

## Are End of life care safe?

Good

**Mandatory Training**

**The service provided mandatory training in key skills to all staff and made sure everyone completed it.**

Staff received and kept up to date with their mandatory training. Most staff were up to date with their mandatory training or had dates booked to attend training in the near future. Of the 16 topics covered, two members of staff were awaiting face to face syringe pump training and safeguarding level three training was in progress for four members of staff. This meant that 95% of staff were up to date with their skills and knowledge to enable them to care for patients appropriately.

The mandatory training was comprehensive and met the needs of patients and staff. Most staff told us mandatory training updates were delivered to meet their needs and they were able to access training as they needed it.

There were a range of topics including basic life support, syringe pump, manual handling, health and safety, information governance, infection control, symptom control and conflict resolution. Mandatory training was available using a range of methods to maximise accessibility, including face-to-face sessions and e-learning.

A full training day was scheduled for 26 November 2021 to include manual handling, CPR and mental capacity. There was also support for additional training such as symptom control and advanced communication skills.

However, during the inspection managers could not easily tell us the overall completion rate of training for staff as they did not keep an overview of totals and expiry dates. Completion of staff training was monitored by senior staff and records were kept on individual employee files. There was no central system to alert managers and staff when they needed to update or refresh their training.

The managers told us staff received training through their substantive posts within the NHS and then provided evidence of this to the registered manager. Most staff had other employment in, for example, the local hospital or community services. Staff were required to provide certificates to confirm attendance and completion. This was monitored annually by the registered manager.

Requires Improvement

# End of life care

Our initial concerns about the system for monitoring training compliance were shared with the managers at the inspection and in subsequent initial feedback. In the week following the inspection, managers provided a comprehensive spreadsheet which showed details of training attended from January 2021 to November 2021. Managers were able to see which training staff had undertaken were in date and were able to plan when staff needed to complete refresher training.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

Staff received training specific for their role on how to recognise and report abuse. We were told 80% of staff had completed safeguarding adults and children level three training in 2021. Four members of staff were in the progress of completing safeguarding training. From data shared with us after the inspection we saw documentary evidence confirming this in the provider's training performance report which showed the position as at 25 November 2021.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff we spoke with demonstrated an understanding of the different types of abuse to be alert to, and their responsibilities to report any concerns. There was a safeguarding policy which staff could easily access in their nurses' handbook and in files on the shared IT system.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They told us they would report and discuss concerns with the nurse coordinator or nurse manager. They described what actions they would take should they have safeguarding concerns about a patient. All staff were confident to challenge to ensure the safety of patients.

**Cleanliness, infection control and hygiene**

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection** when visiting patients at home.

Staff followed infection control principles including the use of personal protective equipment (PPE), such as face masks, gloves and aprons. These were readily available to staff.

We observed a home visit and saw the nurse following infection prevention control guidance and completing a COVID-19 assessment. We observed staff using hand gel when they needed to and washing their hands. Staff wore short sleeves and minimal jewellery (bare below the elbow) to ensure effective handwashing.

There was a monthly audit of PPE and hand hygiene. This showed any required updates to the infection control policy, any learning, actions completed and by whom, and how this was disseminated to the wider team. During the period from January 2021 to November 2021, there had been 100% compliance.

During a handover meeting we heard staff discussing the additional PPE arrangements for a visit that afternoon which involved an aerosol generating procedure. The team had a service level agreement with a local NHS trust who had advised the PPE requirements for the visit. This had been discussed with the family to allay their concerns. A risk assessment had been completed and noted in the patient's care plan. Action cards had been placed in the patient's home to demonstrate what was needed for staff.

**Environment and equipment**

Requires Improvement

# End of life care

**When providing care in patients' homes staff took precautions and actions to protect themselves and patients. Staff managed clinical waste well.**

Equipment for use in the patient's home was ordered by the district nursing team. Staff could expedite equipment when a patient had deteriorated and required equipment such as a hospital bed, air compressors or slide sheets. Staff said there was always a quick response.

The district nursing team managed the syringe pumps. The Kate's Home Nursing team monitored the syringe pumps when they were in the patient's home. Nurses were trained to recognise and troubleshoot problems and to provide solutions. During a home visit we saw the syringe pump box was locked to keep it safe from unauthorised access to the device. The Kate's Home Nursing team had access to the keys and the nursing coordinators carried keys as they needed access to the box from time to time.

Staff disposed of clinical waste safely. Disposable items of equipment were discarded appropriately, either in clinical waste bins or sharp instrument containers.

There was a monthly audit of needles and syringes. This showed a check of expiry dates, disposal, stock replenishment and the actions taken and by whom, and how this was disseminated to the team. During the period from January to November 2021 there had been one instance where stock had expired.

**Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.**

Staff knew about and dealt with any specific risk issues. When a patient was assessed for home nursing, a full assessment of their needs was undertaken. This included standard areas such as moving and handling, and equipment needed. In those records we reviewed, there was regular update of these risk assessments and dates for how often they needed to be reviewed.

Staff shared key information to keep patients safe when handing over their care to others. Documentation and risks associated with the last days of life, such as pain assessments, were noted and acted on by staff.

Nurses we spoke with were sensitive about managing risks for patients at end of life. Staff said that where the progression of a patient's illness was clear, and this was towards the end of their life, the level of interventions were reduced to a minimum. For example, staff balanced the need to reposition a patient at risk of pressure area damage while acknowledging turning a patient could be uncomfortable for them. Care was based on ensuring patients remained as comfortable as possible.

**Staffing**

**The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave staff a full induction.**

The service had enough nursing and support staff to keep patients safe. There were 21 registered nurses, including five Queen's Nurses who had been awarded the title by the Queen's Nursing Institute because they had demonstrated a high

level of commitment to patient care and nursing practice. No staff were employed on a permanent contract they were all bank nurses. There were five nurse coordinators who provided 24-hour on-call cover. They worked over a period of three days: Monday to Wednesday, Wednesday to Friday and Friday to Monday. All nurses and nurse coordinators were required to provide clinical shifts.

Managers told us they had never advertised for staff. They had a reputation amongst professionals and had always been approached by nurses wishing to work for them.

The managers could adjust staffing levels daily according to the needs of patients. Daily nurse staffing was monitored and reviewed to ensure the right staff were in the right place at the right time. This was confirmed through senior oversight by the nurse coordinators.

Staff were required to provide availability a week in advance. There were plans to change this to a month in advance. Staffing was arranged through email or text message. All staff had to advise of their availability each week and they provided care around this. If they were gaps in cover, text messages were sent to request further availability to cover the shortfall.

There were arrangements for staff who were lone working. When staff entered a patient's home, they were required to text in and text out with the nurse coordinator.

Managers acknowledged the challenges of sustaining the workforce and sustained engagement of staff. Nursing coordinator assistant roles were being developed to support with succession planning. Managers were working with the team to redesign a new role and assess what was needed to support it.

There were handover meetings between nurse coordinators following the end of a three day on call duty. We observed the meeting and saw patients were Red/Amber/Green (RAG) rated in terms of their needs and priority of care and there was a detailed update of all patients. Areas covered included for new referrals: patient's diagnosis and current condition, COVID-19 vaccination status; medication, equipment used; family background and history; nutrition and fluid; and arrangements for support calls. Information for existing patients included suitability and adequacy of the package of care; symptom control; respiratory and mobility update; risk assessment and PPE requirements. There were also discussions about conversations with a family about care after death and provision of bereavement support.

Discussions were thorough and patients and their families were discussed with sensitivity and respect.

Nurse coordinators met monthly to discuss staff issues, clinical issues, management of the nursing bank, training and induction, and bereavement support.

There was communication with healthcare professionals. The service was led by nurses who had access to and worked closely with other clinical professionals. This included palliative consultants, district nurses and occupational therapists. There were regular monthly meetings with the district nurse clinical team manager.

**Records**

**Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.**

Requires Improvement

# End of life care

Patient notes were comprehensive and all staff could access them easily. Records were maintained on paper. We reviewed seven sets of patient records. They had a standard layout and format which assisted staff to locate the information they needed specific to the patient's condition. The records were holistic and reflected the patient's involvement in their care and their wishes.

There was a standard care communication which was used to share information between the nursing team and the district nurses. The district nurses were always involved in patients' care and used the clinical commissioning group's Gloucester Care of Dying care plan called "shared care plan for the expected last days of life."

Records were legible, complete and signed. The detail was comprehensive and contemporaneous with clear involvement of relatives and details of symptom management. There was evidence of pain assessment using a recognised tool, the Abbey Pain Scale.

Care plan completion was audited against benchmarks set using the Nursing and Midwifery Council (NMC) code. This included an observation of practice and data collection, comparing performance with criteria and standards and implementation of change. The results showed evidence of actions taken to address any shortfalls.

Records were stored securely in patients' homes and easily available to all staff providing care.

**Medicines**

**The service was not responsible for the processes to safely prescribe, administer, record and store medicines.**

The district nurses were responsible for all medicines in the home but Kate's Home Nursing staff checked all medicines during each visit to ensure all was in order and recorded this in the district nurses' notes. District nurses and GPs prescribed medicines and GPs were responsible for maintaining drug charts.

During a home visit we saw medicines were kept appropriately and safely. We observed a stock check in progress. We checked the drug chart and found it was completed safely and signed and dated.

The district nurses took responsibility for setting up the syringe pumps. These were used to give an automatic measured dose of pain relief or other medicines to a patient at a given time. Kate Home Nursing staff checked and recorded the syringe pump during every visit which included the time, volume, battery, tubing and site.

**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. When things went wrong, staff apologised and gave patients honest information and suitable support.**

Staff reported serious incidents clearly and in line with the provider's policy. There were systems to make sure incidents were reported and investigated appropriately. Staff were open, transparent and honest about reporting incidents and said they would have no hesitation in reporting incidents and were clear about how they would report them.

Staff knew what incidents to report and how to report them. All incidents were reported on a paper system. This provided a single record of each incident, subsequent investigation, agreed learning, and evidence of the learning and its effectiveness.

Requires Improvement

# End of life care

Staff raised concerns and reported incidents and near misses in line with the provider's policy. Staff said they were encouraged to report incidents promptly.

Incidents were identified by a nurse and raised with the nurse coordinator. Staff told us about an example where, during a regular check of medications, they noticed there were not enough medications in the patient's home. The incident had been investigated and they had been advised of the outcome.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Although we did not see any examples of where duty of candour had been applied, staff demonstrated an understanding of their responsibilities and could describe the process and what they would do. 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.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The incident reporting policy set out the processes for reporting and managing incidents and described the root cause analysis investigation process and the roles and responsibilities of staff involved in the process.

Managers debriefed and supported staff after any serious incident. Staff confirmed they received feedback after reporting an incident and an action plan was shared. Learning was shared using a variety of methods. Firstly, there was an immediate response and any local action taken to help prevent a reoccurrence and formal feedback methods such as team meetings or emails to help spread any learnings from incidents.

## Are End of life care effective?

Requires Improvement

**Evidence-based care and treatment**

**The monitoring of the effectiveness of the service required improvement to ensure the service provided care and treatment based on national guidance and evidence-based practice.**

Managers said they followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. However, during the inspection there was little evidence to show care and treatment was monitored to reflect current evidence-based guidance, standards, best practice and technologies.

Information about patient's care and treatment, and their outcomes was not routinely collected and monitored. During the inspection we discussed whether policies, care plans and clinical protocols had been developed in line with national best practice recommendations. These included the National Institute for Health and Care Excellence (NICE), for example QS13 End of life care for adults, NG31 Care of Dying Adults in the Last Days of Life. Managers were not able to say how they benchmarked their services and measured performance and symptom management, or how they networked with other services in the county.

Requires Improvement

# End of life care

Following the inspection, managers explained there was currently no defined good way of measuring outcomes in respect of the palliative nursing care provided to patients at the end of their lives in their own homes. They said the best in recent years was the National Association of Hospice at Home (NAHH) standards, last seen in 2013, and these principles were embedded in practice.

The service had been embedded around Nursing and Midwifery Council (NMC) guidance, Royal College of Nursing (RCN) guidance, National Institute for Health and Care Excellence (NICE) guidelines, the National Association for Hospice at Home (NAHH) Standards, the Gold Standards Framework, the Ambitions for Palliative and End of Life Care and sharing the learnings and experience of the organisations locally and nationally.

The core patient care plans were individually linked to specific national standards and guidelines and other appropriate research. The model of assessment was based on the Roper-Logan-Tierney model of Nursing: Based on Activities of Nursing.

Managers also confirmed how they networked and collaborated with other services in the county through regular meetings where learning was shared about best practice, improvements, governance advice, policies and procedures and information about new technologies.

Policies were available to all staff in a nurses' handbook and in a shared online folder and staff demonstrated they knew how to access them. Policies had been presented to the board of trustees for consideration and those requiring clinical input had been checked by the medical trustees. Following the inspection, managers had discussed the ratification of policies with their medical trustees and agreed they needed to better formalise this process.

**Nutrition and hydration**

**Staff regularly checked if patients were eating and drinking enough. They worked with other agencies to support patients. Staff encouraged patients to safely eat and drink**. We saw evidence in patient notes about patients' swallowing ability and the suitability of food and drink. Nurses described how they would have sensitive conversations with patients' families about eating and drinking at end of life.

Nursing staff were aware of the importance of providing regular mouthcare for patients nearing the end of their life, to alleviate discomfort associated with a dry mouth. This was recorded in care plans.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain, and ensured pain relief was given in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

Staff assessed patients' pain using a recognised tool. Staff used the Abbey Pain Scale, to assess the pain of patients who could not communicate verbally about their pain. Staff observed patients' facial expressions and body language to measure and assess pain where patients could not communicate verbally.

Staff had a bond and clear understanding of the patients they supported, and we could conclude from our conversations with them that they would identify if a patient needed pain relief. The patients' medicine records showed pain relief was given both as regular prescribed analgesia and when prescribed 'as required'.

Requires Improvement

# End of life care

Staff had access to syringe pumps to enable the continuous infusion of medicines when these were prescribed. However, the district nursing team were responsible for setting them up and monitoring their use.

**Patient outcomes**

**The systems for monitoring the effectiveness of care and treatment required improvement.**

There was no evidence to suggest the patients and their families did not get good outcomes from using Kate's Home Nursing and its services. However, the approach to monitoring, auditing and benchmarking the quality of the services and the outcomes for people receiving care and treatment required improvement.

During the inspection we saw audits appeared to be a data collection exercise rather than measuring current patient care and outcomes against standards. Information did not clearly show if the intended outcomes were being achieved. Information needed to be used to measure for improvement, not just for assurance. There needed to be an audit cycle where standards of best practice were agreed, data collected and analysed, and changes implemented with further audit to confirm improvement.

We saw monitoring of referrals, policies and care plans. There was an extensive list of documents which included an accountability sheet, COVID-19 risk assessment, this is me, ongoing assessment, falls risk, manual handling risk assessment, a body map and waterflow pressure area risk assessment and a summary of care. Managers told us they looked at scores and flagged any results requiring attention and did not allow trends to develop.

The provider did not have evidence of participation in monitoring activities, such as reviews of services and benchmarking information was not shared externally to show improvements in care and treatment of audit to determine if patients were getting the best inputs to their care and the best outcomes.

However, following the inspection, managers provided details of an audit they had participated in based on NHS Ambitions for Palliative and End of Life Care. Patients and their families were asked four questions about communication, coordination of care, respect and dignity, personalised care which met needs and flexibility of service with a minimum score of one and a maximum of five. For the period from January to November 2021 there were 39 returns with an overall feedback score of 98.85%. Feedback was collated and trends and learning, and actions taken were highlighted.

Managers also confirmed there was peer review of the service at regular meetings with local sister charities and with staff who had second jobs with other health providers to share learning and best practice.

Managers also advised us they had decided to adopt a benchmarking system which provided a person-centred evaluation, audit and research solutions. They had purchased a licence and were currently arranging training. The aim was to keep the process as simple and as effective as possible within the current systems. Although adaptations would be required to this tool to make it fit for purpose, the service would receive an automated annual measure of the outcomes measured.

**Competent staff**

**The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.**

Requires Improvement

# End of life care

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service. Following the inspection, information was provided to show evidence of a monthly nurse file audit. This provided an assurance all staff received the necessary training and support to undertake their roles effectively.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Clinical supervision enabled staff and managers to identify training needs, develop competence and enhance clinical practice. Most staff were positive about the frequency of clinical supervision they received.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. There was a commitment to training and education within the service. Staff told us they were encouraged and supported with training and there was good teamwork. Staff were encouraged to keep up to date with their continuing professional development and there were opportunities to attend external training and development in palliative care.

Managers gave all new staff a full induction tailored to their role before they started work. Staff received a copy of a nurses' handbook which contained a complete set of policies. Staff were required to take responsibility for ensuring they were fully familiar with the contents of the handbook and for keeping their copy up to date as revisions or additions were made. Nurses were notified by email when policies were reviewed, or new policies were created. Staff confirmed they received a comprehensive induction and received a handbook.

Competency was considered by the nurse coordinator team who were required to sign off readiness to undertake shifts. Staff felt confident, competent and prepared to work in the service.

The bereavement team received additional training to support their work. They had attended a bereavement module and a basic course in mental health, and a suicide awareness course. They also had access to support from a local chaplain.

We were told Disclosure and Barring Service (DBS) checks were completed for staff on initial recruitment. Checks were not then completed on a regular basis thereafter. We were told a DBS check was completed when there were changes to the individual's circumstances, such as a change in address, or name. We looked at staff files and saw an example where a check had not been made since 2008. This did not provide sufficient assurance of background checks on staff being made to keep patients safe. This is a service which allows organisations to check candidates for employment for their suitability to work with vulnerable children and adults.

The provider acknowledged the checks were sporadic, mainly because most of the nurses were also NHS nurses and had DBS checks through the NHS. We were informed during the inspection there were plans to undertake DBS checks on all staff in January 2022. Staff had also been asked to make their checks portable and updatable annually. There were immediate plans to do this by sending an email to each nurse with a link to the disclosure and barring service. The provider gave an assurance this would be completed by the end of January. Records would be held to show when the nurse had actioned this and when confirmation of the annual update was expected.

### Multidisciplinary working

**All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.**

Requires Improvement

# End of life care

Care was coordinated with a range of other teams and services. Staff worked collaboratively to understand and meet the range and complexity of patient's needs. This included working with palliative consultants, community palliative care nurses, district nurses and occupational therapists.

The district nursing team said the support the team had provided during the height of COVID-19 had been "priceless" and they knew the team would do their utmost to help.

**Seven-day services**

**Nursing services were available seven days a week to support timely patient care.**

Care was available 24-hours a day, seven days a week.

**Health promotion**

**Staff gave patients practical support to help them live well until they died.**

Staff understood their role in recognising patients towards the end of life and the importance of talking to patients and their families about advanced care planning and maximising their wellbeing and independence.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**

Staff made sure patients consented to treatment based on all the information available. After the nurse coordinator completed the initial assessment visit and fully explained the service, the patient and their family were asked to sign the consent section of the referral form. The consent agreed to Kate's Home Nursing care and input, and to the sharing of information with relevant healthcare professionals.

The assessment and subsequent nursing sessions included information given to the team by the community nursing service, who retained overall responsibility for the patient's care.

Whilst the overall work of the nursing team was covered by the general patient consent obtained at the assessment stage, consent was also sought about further nursing interventions. Discussions and decisions were documented in patient's records.

Staff explained care and treatment to patients to gain their consent and told us they would do this even if they were not sure the patient could hear them speaking to them. When patients could not give valid consent, staff made decisions in their best interest, considering patients' wishes, advice of their families, culture and traditions.

Assessment of capacity was made by the doctor or GP in charge of the patient's medical treatment. If there were circumstances where there was a significant change in the patient's condition this might become a matter of judgement for the nursing team in conjunction with the doctor and district nursing team.

Requires Improvement

# End of life care

There was a resuscitation policy which outlined the guidance for managing the decisions and processes of resuscitation and a recognition of life extinct in adult policy.

The verification of expected death checklist and policy did not reference the most recent and relevant guidance. This is the 'Care After Death: Registered Nurse Verification of Expected Adult Death (RNVoEAD) Guidance' which was issued by Hospice UK in conjunction with the Royal College of Nursing and updated on 9 November 2020, in light of the COVID-19 pandemic. We discussed this with the registered manager who was not aware there had been a change to the guidance.

Following the inspection, the registered manager acknowledged this omission and explained information had not been received through any of the usual channels. Information had been found and noted, and discussed with a medical trustee. The policy had been updated with a link to the latest guidance. The registered manager provided us with the updated policy.

The registered manager told us it was the responsibility of the district nursing team to ensure a patient's resuscitation status was accurately recorded in the nursing notes and a Recommended Summary Plan for Emergency Care (ReSPECT) form was completed. The nurse coordinator made every effort to ensure there was a (ReSPECT) form with a recent DNACPR. The team would liaise directly with the district nursing team and the patient's GP to ensure this was the case.

The nurse coordinator ensured information about any existing ReSPECT form was passed on to the nurse visiting the patient who in turn checked the form and DNACPR status at the start of each shift. Any updated information was passed on to the nurse coordinator.

During a home visit we observed the ReSPECT form in the patient's home was not completed. This raised a concern which was shared with the nurse. The nurse coordinator was made aware and they told us they were absolutely sure she had seen a completed form in the home when she did the assessment and the patient's wife confirmed this to be the case.

The registered manager told us patients had access to their own documents and these were sometimes mislaid, but the team said they always either managed to locate them or replace them in a timely manner. The registered manager told us, as was usually the case, the following morning the original document was found in the patient's home.

## Are End of life care caring?

Good

**Compassionate care**

**Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.**

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted dignity. Relationships between patients and their families and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by managers.

Requires Improvement

# End of life care

We heard numerous examples where staff had 'gone the extra mile' to care for patients and their families. Staff showed a compassionate, respectful and considerate approach to caring for patients and their families. Their interaction with patients and their families was warm, caring and friendly and it was clear they had developed a special bond and a relationship of trust with both the patient and their family.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients and their families felt really cared for and that they mattered. During our inspection we observed a home visit where the patient was treated with kindness, dignity and respect. Staff were open, friendly and approachable and interactions were very caring, respectful and compassionate. There was a good rapport and trust between the patient and their family. The whole family was considered, including family pets.

Relatives said staff treated them and their loved ones well and with patience and kindness. Relatives spoke highly of the support offered to them and the care provided to them and their loved ones. Feedback from patients and relatives was overwhelmingly and continually positive. Relatives said staff went the extra mile and their care and support exceeded their expectations.

Staff we met showed a kindness and compassion to both the patients, but also to their families. When staff spoke about the patients they were caring for they showed understanding of each patient's individual needs, abilities, and their likes and dislikes. We had numerous examples of the deep understanding and empathy staff had for the families and recognised and shared their compassion and kindness with them.

We spoke to five relatives and were shown examples of feedback received from other relatives. The comments are shown below:

- "The care and love that was displayed was extraordinary by people who had been complete my strangers. Extraordinary to watch and see relationship with wife."
- "Brought a sense of calmness each time they visited, allowed everyone to have precious time with [relative]. They gave us something that we will never be able to forget as they gave us more time with [relative]. They removed fear and protected us from being frightened."
- "Looked after both of us. Afterwards the care was amazing too. Some attended funeral. Invited to coffee mornings with other bereaved people. So nice to see nurses again after all the input."
- "You cared for [relative] with such dignity and compassion and your kindness, support and calm towards all of us will never be forgotten.".
- "You are all angels without wings. The phone call after individual had passed was really appreciated. Stayed until 10.30pm when should have finished at 6pm."
- "The nurses brought light, love and laughter and a link to the outside world."

We also saw positive feedback from other clinical professionals, for example palliative consultants and district nurses who described the team's input as "invaluable", "highly professional in their approach" and "hugely compassionate".

Another commented "from working with them I have come to learn that they operate in an extremely professional manner. All members of staff conduct their duties in a very safe, kind, caring and timely manner in order to benefit our mutual patients."

The bereavement team provided supportive and compassionate care. The bereavement staff contacted families the day following death and again until the necessary arrangements had been made. They provided leaflets with information to support families to complete required actions and to plan funerals.

Requires Improvement

# End of life care

**Emotional support**

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.**

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff providing emotional support to patients during their visit. Patients' individual concerns were promptly identified and responded to in a positive and reassuring way. Relatives felt confident leaving their loved one in the care of staff. Several relatives told us staff understood their initial anxiety about leaving their loved one.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. There was a genuine understanding of the impact that caring for a loved one at the end of their life had on the family, and staff spoke of their responsibility to support families, not just patients who used the service.

Families told us they viewed the staff as members of their extended family, such was the strength of the bond they had developed. One relative told us, "I think the staff genuinely cared for my husband". Likewise, staff told us they felt privileged to work so closely with patients and their family members. Relatives told us the staff always asked them how they were and picked up when they were low in mood or struggling to cope. One relative, who was struggling to cope emotionally and psychologically, told us they felt the support they had received from staff was "life-saving." Another relative told us "staff always seemed to know how I was feeling and the right thing to say."

Staff supported patients and relatives who became distressed and helped them maintain their privacy and dignity. Relatives told us they felt their loved one's privacy and dignity "really mattered and staff always respected their personal space and never intruded."

Staff worked flexibly to support patients and their families. The service considered the needs of families. Staff spoke passionately about what they saw as their duty of care to families. One relative said, "they bend over backwards to support us."

**Understanding and involvement of patients and those close to them**

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. Relatives and carers were involved in discussions about the plan of care with the aim that they fully understood the reasons why decisions were being made. We spoke with seven relatives who told us they felt well informed about the care and treatment for their loved one.

Staff talked to patients and their families in a way they could understand, using communication aids where necessary. Patients and families were active partners in their care. Staff were fully committed to working in partnership with patients and their families and making this a reality. Staff always empowered patients and their families to have a voice. Individual preferences and needs were always reflected in how care was delivered. Relatives told us they could approach staff with their questions and did not feel hurried.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service as described in the section above.

Requires Improvement

# End of life care

## Are End of life care responsive?

Good

**Planning and delivering services which meet people's needs**

**The service planned and provided care in a way that met the needs of local people and the communities served.**

Managers planned and organised services so they met the needs of the local population. The service had been established to provide home nursing care for patients at end of life. Patients and relatives who used the service said this met their needs and was an invaluable service in their lives. One relative told us "we want every family in Gloucestershire to have the support, care and empathy we had."

Patients were referred to the service by their GP or the district nursing team. The Kate's Home Nursing team provided specialist nursing care with particular emphasis on effective pain relief and symptom control. There was no set pattern of care. Nursing ranged according to need from a few hours of respite care for a patient's family to all night nursing. The service could also offer some holistic therapies including gentle touch massage and acupuncture.

The service was available to all adults whose disease was not responsive to curative treatment regardless of factors including age, sex, marital status, income, racial or ethnic origin.

Once a patient had been referred to the service a nursing coordinator liaised closely with the district nursing team and made a full assessment, including a home visit. The nurse coordinator assessed what nursing was required and would discuss with the patient, their family or carer details of the cover provided. Information was handed over to the nurse to ensure they were fully prepared for the first visit.

Night and daytime nursing was provided on any day of the week, dependent on the needs of the patient and availability of nurses.

There were systems to ensure effective communication both within and outside of the organisation. This ensured the right care was provided to patients nearing the end of their life. For example, there was a close working relationship with the local district nursing team and local GPs.

**Meeting people's individual needs**

**The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.**

Care was planned and coordinated with the district nursing team and other nursing agencies. Nursing activity was monitored and a weekly spreadsheet was available showing the number of hours worked during the day and night.

Requires Improvement

# End of life care

Leaflets about the service were available to patients and their families. They provided information about the service, who they were and what they did. There was also a leaflet giving a practical guide about what to do immediately after death, such as registering the death and funeral arrangements to ensure families understood the practical arrangements needed after the death of their family member.

Information was also available about the support provided by Kate's Home Nursing bereavement team. They supported patients and their families before and after death. They helped families to navigate through practical, religious and cultural issues. Staff said they did their very best to achieve patients' and families' wishes and requirements and helped them to do "what [families] did not want to think about." One of the nurses, who was often already known to the family, would contact the family at an appropriate time to discuss and explain how support was offered.

We saw the minutes of bereavement meetings from June to September where patients were reviewed and support work was discussed including the carer's café, coffee mornings and walking groups. The team were developing support and engagement with men who were often isolated in grief. They were developing groups for fishing, gardening and cooking. We also saw and heard about the plans for a Christmas lunch and an evening of Christmas reflections where relatives could place a star of remembrance for their loved one on the Christmas tree.

Staff attended patients' funerals if invited by the families. They would also telephone and visit one or two weeks after death. Relatives told us the team still kept in touch after two years and they were invited to attend local events and groups.

A local chaplain was also available to provide pastoral support and spiritual care to patients and their families. They provided support for all faiths (and none) and maintained close contact with faith leaders in the community.

**Access to the right care at the right time**

**Patients could access the specialist palliative home nursing service when they needed it.** There was very little waiting time from referral and all relatives we spoke to told us a nurse coordinator had contacted them immediately after a referral was made.

During the last year, 160 patients had been supported by the service.

There was a monthly audit of referrals which included the patient's details and their current symptoms and medication, their mobility, nutrition, a risk assessment and consent to care. Monthly data was amalgamated and reported annually to the clinical commissioning group (CCG).

**Learning from complaints and concerns**

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**

Patients, relatives and carers knew how to complain or raise concerns.Patients said they felt they could raise concerns with the clinical staff they met. Most patients told us if any issues arose, they would talk to the nurse coordinator. They felt confident they would be taken seriously and treated compassionately. They felt their complaint or concern would be explored thoroughly.

Requires Improvement

# End of life care

Information about the comments and complaints policy could be accessed on the website with advice about how to resolve concerns quickly and how to make a complaint.

Although there had been no complaints in the last ten years, managers described how they would investigate complaints and identify themes and share feedback and learning with staff.

Staff understood the complaints system and knew how to handle them. They were able to explain what they would do if concerns were raised by patients and families.

## Are End of life care well-led?

Requires Improvement

**Leadership**

**Although leaders had the experience, capability and integrity to run the service and were knowledgeable about the issues and priorities, they were not always able to easily provide evidence of their oversight of quality and performance.**

Some processes did not always meet the governance responsibilities around the safety and quality of the service. The trustees had an informal oversight of audits, risk assessments and mitigating actions, mandatory training and quality assurance. This accountability needed to be on a more formal basis.

The leadership team consisted of the chief executive officer and the clinical nurse lead. There was also a board of eight trustees who had a variety of core skills including clinical and business. The trustees included two GPs, a palliative care consultant, an accountant, a solicitor, a chartered surveyor, an ex-nurse who was also the fundraising lead, and a bereavement support volunteer.

The trustees had regular communication with the chief executive and the clinical nurse lead by phone, email and in person when appropriate. Video meetings had proved successful during COVID-19 and more accessible for those who would normally have to travel.

We saw the minutes of the meetings held in March, July and October 2021. The meetings included a financial overview, report from the chief executive, the head of nursing, the number of patients seen and the number of nursing shifts, the treasurer's report and a fundraising report.

The team were knowledgeable and passionate about the service and had a commitment to the patients who used the service, and to their staff and each other. They were visible and approachable in the service for patients, families and staff.

All staff we met said they felt valued and part of the team and were proud to work in the team. They felt supported by the management team and their colleagues. We received consistently positive feedback from staff who had a high regard and respect for their managers.

Managers encouraged learning and a culture of openness and transparency. Staff were supported to develop their skills and competencies within their roles.

Requires Improvement

# End of life care

The leadership team understood the challenges in sustaining the service and the succession planning of the workforce.

There were no issues we could identify in relation to the future sustainability of the service. From the evidence provided after the inspection we could see the organisation was financially stable. There were sufficient funds to safely run the service and ensure continuity of care and support.

**Vision and strategy**

**Leaders told us about their vision for the future.**

The original vision of the service was to remain as a small and local one. Managers had started to consider options regarding office premises as the service was outgrowing the current space. A relocation would be fully scoped and planned in line with the vision and in liaison with the board of trustees.

**Culture**

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care and their families. The service had an open culture where patients, their families and staff could raise concerns without fear.**

All staff told us they loved working for the service and felt proud to be a part of it. There was a great sense of teamwork, camaraderie, and shared values. Staff felt respected and valued.

The culture was centred on the patient and their families and this was paramount throughout our inspection. They were proud of being able to make a difference and felt supported by the leadership team and their colleagues. It was clear their work was important to them and they felt passionate about their contribution to care and were committed to providing the best care possible.

Leaders encouraged compassionate, inclusive and supportive relationships among staff to ensure they felt respected, valued and supported.

The service had an open culture where families, carers and staff could raise concerns without fear. Staff told us they would not hesitate to report concerns to managers and believed these concerns would be taken seriously and acted upon with integrity and sensitivity. The organisation encouraged openness and honesty throughout all levels of staff. Everyone we spoke with recognised the importance of staff being able to raise concerns without fear of retribution.

The process for protecting staff in situations of lone working was effective. The homes and environments in which staff visited were assessed by a nurse coordinator before staff visited, and any risks identified were recorded. The team would then decide what safety systems needed to be used to protect staff. This included, for example, two members of staff working together, or staff only attending at certain times. Staff were also made aware of situations within the family which might put them at risk, and strategies were found to avoid these where possible.

The provider used a lone worker alarm service provider, with whom the nurses checked in and check out whilst working. This alarm service provider used an agreed system to contact the charity and the police should a nurse not be in contact when expected. The use of the system was audited and a report was provided to Kate's Home Nursing.

Requires Improvement

# End of life care

Leaders spoke positively about their staff and told us they recognised the incredible efforts they had made across the service during the COVID-19 pandemic.

We recognise the dedication and professionalism of everyone working in the service in adapting to the COVID-19 pandemic. We acknowledge the continued acceptance of every patient referral despite a reduced workforce and the close working with commissioners, and other local charities.

**Governance**

**Governance processes required strengthening to demonstrate how the quality and safety of the service was overseen, measured or benchmarked and did not show where improvements needed to be made to ensure delivery of evidence-based care.**

The board of trustees and the management team interacted with each other appropriately. However, the arrangements for governance and performance management were not fully clear or did not operate effectively. There was no clear performance management reporting structure with regular governance meetings looking at operational performance. This needed to include a review of incidents reported, complaints, staffing, audit status, infection control, risks identified on the risk register and risk management, and education and training.

Processes and systems must assess, monitor and drive improvement in the quality and safety of the services provided. They must also include scrutiny and overall responsibility at trustee level.

Providers must continually evaluate and seek to improve their governance and auditing practice to ensure they remain effective.

Our concerns were raised with the managers who responded by explaining they were confident there were processes to ensure the quality and safety of the service but accepted this it was not easy for them to evidence. Managers also explained governance was deliberately person driven rather than a process driven system. The methods employed worked well for the service and those in its care.

Following the inspection, the managers sent a detailed overview of their processes and advised us about their decision regarding how they would move forward in recording and presenting evidence. Since our inspection the provider had researched benchmarking and outcome measures and purchased a licence of a benchmarking tool to achieve this.

However, managers also advised us of their commitment to make governance a formal agenda item. Trustees would be assigned to each area of governance and a governance committee would be established to oversee the quality and safety of the service.

A comprehensive set of policies were readily available in nurses' handbooks and in files in the shared IT system. Policies were categorised in three groups: firstly, underpinning policies: which included health and safety, risk analysis, moving and handling, consent, and fire safety. Secondly, core clinical policies: which included: treatment and care, handling of prescribed medication; infection control and needle stick injuries; record keeping; incident reporting; moving and handling; comments and complaints; safeguarding. Thirdly: as an employer, which included: recruitment, training, sickness and absence.

A couple of policies were reviewed each month. Following the inspection managers had discussed the ratification of policies with their medical trustees and agreed they needed to better formalise this process.

Requires Improvement

# End of life care

**Management of risk, issues and performance**

**There were systems for identifying risks and plans to eliminate or reduce them.**

There was a risk management policy. The service maintained a risk register which identified individual risks. These related to service and business interruptions; patient and staff feedback; litigation; adverse publicity and reputation; quality of the patient and staff experience and outcome; performance targets; injury and harm and financial cost and loss. The register was linked to incidents and how they were managed.

However, risks were not scored, or rated, and actions were not documented to demonstrate mitigation of risk and those responsible for taking action. There was no overarching document which captured those risks which the service ran, and how it was managing them. Risk was not overseen by the trustees.

Following the inspection, the risk register was adapted to include Red, Amber, Green (RAG) ratings. This framework allowed for assessing risks and evaluated both the likelihood of the risk being realised and the consequence and the actions taken. However, risks were not presented to the trustees for oversight.

There was a business continuity plan which focused on potential risks to service provision and the actions to minimise their potential impact and the responsibility of individuals.

**Information Management**

**The service collected data but analysis, management and use of data was limited.**

Staff had access to information about patients to ensure they had sufficient and up-to-date knowledge to provide safe care and treatment.

Staff we spoke with were familiar with the shared IT system and knew where to find the information they needed.

**Engagement**

**Leaders and staff actively and openly engaged with patients and their families, staff, the public and local organisations to plan and manage services.**

Patient and families were encouraged to provide feedback whilst the team were delivering the service at home. Relatives' feedback was also sought following the death of their loved one. Staff were mindful of the timing of such requests and relatives appreciated the sensitivity of the request. Further detail of feedback is described in the caring section of the report.

There were effective systems to engage with staff. There were bi-monthly newsletters and quarterly individual emails to all staff.

Staff we spoke with felt supported in their roles and were proud to work for the organisation. They felt well supported and never afraid to ask for advice. They said they were privileged to work for the service. They were allowed into the lives of patients and their families at a precious time and they had one chance to get it right. Staff felt "dying was as good as it could be for our patients."

Requires Improvement

# End of life care

Staff were paid one hour each week to manage their emails and staff were encouraged to be involved in the development of the service. Staff said they were encouraged to speak up and voice their suggestions and solutions.

Staff were encouraged to pop into the office wherever possible. During COVID-19 this became difficult and some staff experienced isolation. Every nurse was offered an appointment with an external occupational health company and a risk assessment was completed with a personal individual report about infection prevention and control. Staff said this really supported the team to feel valued and gave them a confidence to return to work.

There was normally a summer party and a Christmas get together with the trustees and fundraisers and during the height of the pandemic quizzes with had been organised and held remotely by video conferencing. Staff were sent vouchers for "bubbles and chocolates" to enjoy during the quizzes.

Staff who had personal use of the service told us "it made me really appreciate what it is we do for our patients."

**Learning, continuous improvement and innovation**

**All staff were committed to continually learning and improving services.**

Staff and managers were proud of the way in which the service had expanded and improved its service to patients and their families.

From evidence provided after the inspection we noted the provider's approach to seeking out new models of care to improve service delivery and ensure high-quality care for patients. The provider was planning to attend a national conference about the next steps for palliative and end of life care which included the latest thinking and strategies for developing patient-centred care and evidence-based improvement for improved health and better care.

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 17 HSCA (RA) Regulations 2014 Good governance<br>• Governance processes required strengthening to demonstrate how the quality and safety of the service was overseen, measured or benchmarked and did not show where improvements needed to be made to ensure delivery of evidence-based care. |