Lawrence Home Nursing Team limited

Lawrence Home Nursing Team Limited - Chipping Norton War Memorial Community Hospital

Inspection report

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Date of inspection visit: 04 May 2023
Date of publication: 13/06/2023

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

The location had not previously been inspected. We rated it as good because:

- 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. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key 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.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. 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
Hospice services for adults	Good	We rated this service good for safe, effective, caring, responsive and well-led.

Summary of findings

Contents

Summary of this inspection

Background to Lawrence Home Nursing Team Limited - Chipping Norton War Memorial Community Hospital

Lawrence Home Nursing Team Limited - Chipping Norton War Memorial Community Hospital provides palliative, mostly at night, nursing care to people in the last stages of their life, who wish to be cared for in their own home. It provides services for patients over 18, living around the Chipping Norton and surrounding areas, and works closely with the local GP surgeries. The service was established in May 1999, is a charitable organisation and became a limited company in July 2020.

The service had been registered with the CQC, at its current location since July 2020 to provide the regulated activities:-

- treatment of disease, disorder or injury

The service had a registered manager, who had been the registered manager since September 2022.

Lawrence Home Nursing Team, as the service was previously known, was inspected in 2016 at its previous location. It was rated as good.

How we carried out this inspection

We carried out a short notice announced inspection on 04 May 2023. We inspected Lawrence Home Nursing Team using our comprehensive inspection methodology.

We visited the service's administrative hub and spoke with staff delivering services. We spoke with eight staff including the registered manager, operations manager, three nurse coordinators, five registered nurses and a member of the board of directors.

We also spoke with two patients and six relatives of patients who had been cared for by the service. We carried out two home visits where we observed the care provided. We also sought feedback from external partners that worked with the service.

We reviewed policies, procedures and other documents relating to the running of the service. We reviewed data and reviewed five patient care and medicines records.

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

Outstanding practice

We found the following outstanding practice:

- There was a tangible sense of flexibility and adaptability amongst staff to meet people's needs and requests that exceeded what would usually be expected.

Summary of this inspection

- The hospice at home team tailored their services to individual needs and often at short notice. This included staying late with relatives or carers when a patient died at home and rearranging their out of work activities to be there for the patients.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust 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 SHOULD take to improve:

- The service should consider having a policy for the reporting and management of incidents to document the processes and procedures the service follows.
- The service should consider using a staff competency framework to demonstrate the necessary skills and knowledge required for each role, and to identify individual's strengths, areas for growth, training, and developmental needs.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Hospice services for adults

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

Is the service safe?

Good

This location had not previously been rated for safe. We rated it as good.

Mandatory training

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

Lawrence Home Nursing Team - Limited - Chipping Norton War Memorial Community Hospital (LHNT) had a training policy which defined the mandatory training requirements of staff.

We assessed the mandatory training requirements which was comprehensive and met the majority of needs of patients and staff. Training was a mixture of face to face and online training. Staff we spoke with told us there were no barriers to accessing mandatory training.

Managers could monitor completion rates and alerted staff when they needed to update their training. Senior staff, through conversation with the inspection team, could demonstrate they reviewed and had oversight of the staff's mandatory training completion rates.

Staff compliance was 100% at the time of the inspection with the exception of syringe driver management training, which was at 44%. However, the whole team was due to receive a face-to-face training session on this a few days after the inspection took place.

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.

Good

Hospice services for adults

LHNT had a safeguarding children and adult policy to guide staff when dealing with adults and/or children where abuse was either identified or suspected. The policy outlined the types of abuse staff may come across, including radicalisation and modern slavery. It contained contact details for the local authority social services duty teams, including the out of hours contact details. There was an easy-to-follow step by step guide for staff to use if they had safeguarding concerns.

There was a safeguarding lead who had completed level 3 adult safeguarding training and they could demonstrate knowledge of the correct way to report an adult or child safeguarding concern. There was also an identified member of the board who was responsible for safeguarding.

Safeguarding was part of the staff induction and mandatory training. Staff had the appropriate level of safeguarding training for their role and could demonstrate how to identify concerns, make a safeguarding referral and who to inform if they had concerns. Staff worked closely with GPs and community nurses to coordinate care for patients. Staff compliance with safeguarding training was 100% at the time of the inspection.

Staff also completed mandatory training in preventing radicalisation. Staff were up to date with this training at the time of the inspection.

Safety was promoted in recruitment procedures and employment checks. Staff had Disclosure and Barring Service (DBS) checks completed before they could for the service. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

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. They kept equipment and the premises visibly clean.

LHNT had infection control policies and procedures to help control infection risk. These and other related policies covered the actions required by staff to minimise the risk of infection and cross infection.

Staff received training in infection prevention and control (IPC), including in the appropriate use of personal protective equipment (PPE). Records showed staff were 100% compliant with training requirements.

All clinical care was performed in the patient's home and staff followed guidance on the use of PPE in this environment. Staff cleaned equipment after patient contact.

We observed good IPC practices by staff when they conducted their patient visits.

Compliance against infection control principles were monitored through supervision processes. This included monitoring of hand hygiene and use of PPE. Results showed 100% compliance with infection control principles when caring for patients in their homes.

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.

Good

Hospice services for adults

All clinical care was performed in the patient's home. When a patient was referred to the service a pre-assessment of the patient was carried out. Part of this assessment included checks of accessibility and risks within the home. We reviewed five sets of records and saw the environmental risk assessments had been thoroughly completed in all.

Equipment was provided and risk assessed through the local community nursing team. LHNT staff told us they worked closely with the community nursing team and it was easy for them to request additional equipment when it was required by the patients.

Syringe drivers, which are used to continuously deliver medicines under the skin to manage patient symptoms, were provided by the community nursing team and appropriate checks were in place.

The service had enough equipment, including consumables, to provide safe and effective care to patients. Consumables were well organised and stored correctly according to policies and procedures. Staff checked expiry dates according to set timeframes and documented to show consumables were in date.

Staff followed local NHS infection control policies in relation to clinical waste.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed face to face risk assessments for each patient on admission to the service and reviewed and updated them when necessary. The service used a traffic light rating system to identify the patient's status in relation to palliative and end of life care. This helped staff prioritise care based on patient need. Patients identified within the green category were likely in the last months to year of life, amber in the last few weeks and red were likely to be in the last days of life.

When patients were referred, the service requested their patient summary from their GP, which gave them vital information including list of medications being taken and past/present medical conditions. The patient summary was usually received on the same day or within 24hrs after request. For patients requiring urgent care, the service did not insist on having the patient summary before accessing the patient.

Staff knew about, and dealt with, any specific risk issues. This included pressure area care, prevention of falls and nutritional needs. Staff planned care relating to the assessment findings so they kept risks to a minimum. LHNT, the community nursing team and GPs worked together to follow risk assessments and care plans for the patient.

Staff shared key information to keep patients safe when handing over their care to others. A LHNT patient folder was keep at the patient home, where staff recorded their assessments and evaluations at each visit. At the end of a visit staff would contact the nurse co-ordinator who had oversight of the patient's care. The nurse co-ordinator ensured information was shared with other staff caring for the patient and with other health professionals involved in the patient's care. This included sharing information and liaising with community nurses and GPs when necessary.

We reviewed five patient records and saw patient summaries, appropriate risk assessments had been completed and reviewed, and communications between teams had been thoroughly completed.

Nursing Staffing

Good

Hospice services for adults

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

The service was nurse led and had enough nursing staff to keep patients safe. They employed experienced registered nurses to operate the clinical services. The registered manager, who was a registered nurse, oversaw the clinical aspects of the service. They were supported by four registered nurse co-ordinators and a team of registered nurses.

The service operated 365 days a year for 24hrs a day and there was always a nurse co-ordinator on shift. Because of the changing nature of the care requirements, the nurse coordinators adjusted nurse staffing levels daily depending on need. Nurses were asked to commit to a minimum number of hours a month and worked varying hours depending on patient need.

We reviewed staff recruitment records and saw that all staff had appropriate checks prior to employment. This included their nursing qualifications, satisfactory references and disclosure and barring system (DBS) checks.

Staff we spoke with were experienced and knowledgeable about providing end of life care in the patient home and worked with flexibility to meet the patient need.

Medical Staffing

LHNT was not a primary care provider in the community and therefore did not employ their own medical staff. Medical support was sought through the patient's own GP or out of hours service.

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.

Patient records were comprehensive, and all staff could access them easily. Patient care records were held in patients' homes, with additional nursing coordinator notes held at the office.

We reviewed five sets of patients records and saw they contained relevant and up to date information. Care plans were individualised, and records included, patient history, medicines, relevant risk and clinical assessments. The allergy status of all patients was also recorded.

Records contained information on current advance care planning and do not attempt cardiopulmonary resuscitation (DNACPR) documentation.

Records held in the patient's home were accessible to staff involved in the patient's care. This included GPs and community nurses.

Completed records were stored securely, in a locked, fireproof cabinet. Paper records were only accessible to those staff involved in care.

Senior staff audited patient records for completeness and to highlight improvement and training needs. Formal audits were carried out annually which made it hard to improve the standard of record keeping in a timely way. However, managers told us, although it was not a formal audit, patient records were checked for completeness when patients were no longer under the care of the service and their records were being archived. In this way managers could see the standard of record keeping by staff on an on-going basis. Any improvements needed in data entry and reporting would be spotted and acted upon.

Patient records reviewed during the inspection were fully completed, accurate, comprehensive and provided a clear picture of the care and treatment each patient received.

Medicines

The service used systems and processes to safely, administer and record medicines.

LHNT did not prescribe medicines. Medicines were already prescribed by the GP and supplied by the community pharmacy.

LHNT staff administered these medicines whilst they were looking after the patient if needed. The service had an up to date safe and secure handling of medicines policy which included systems and processes for staff to follow to administer medicines safely in patient homes. Community nurses were also involved in administering patient medicines. There was a clear handover between staff involved in the patient's care including what medicines had been given, and this was recorded in the patient's records.

Some patients were receiving medicines by syringe drivers, medicines delivered through the skin continuously to manage patient symptoms. LHNT staff monitored these drivers and completed a checklist, which was kept in the patient's records, when they were caring for the patient. Staff completed balance checks for any controlled drugs that staff were involved in administering.

Staff knew how to raise and escalate concerns if there were problems with medicines or symptom control.

Relevant medicines training was undertaken by all staff, including training on the new syringe driver which was starting to be used in the region. Staff told us that the provider was responsive to providing training for any needs they identified.

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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. This included medicine errors and issues with communication that could have had an impact on patient care. The service used a paper incident reporting form. This form went to the registered manager who was responsible for adding the incident onto the incident register, ensuring they were investigated, and actions put in place to mitigate the incident reoccurring.

Good

Hospice services for adults

From May 2022 to April 2023 there had been 15 incidents reported. In the same time frame, the service had reported no serious incident or never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need to have happened for an incident to be a never event.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations as appropriate. Incidents were a standing agenda item on the quarterly clinical committee meeting. We reviewed minutes from these meetings and saw this was the case. Information and feedback was disseminated down to LHNT staff and learning shared to ensure improvements were made. Staff could give us examples of when procedures had changed or additional training had occurred due to an incident. All staff we spoke with during our inspection were committed to providing an excellent service to their patients. Staff told us they saw learning from incidents as a vital tool to help them achieve this.

Staff at all levels knew how to report and manage incidents. However, LHNT had no policy on incident reporting and management. This meant, there was no documented framework for staff to follow or to refer back to if needed.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. Staff we spoke with understood the need for openness and honesty with patients and those close to them. Managers and staff apologised when things went wrong. Duty of candour and its process was detailed in the LHNT Complaints policy.

The registered manager monitored patient safety alerts and would cascade to the teams if actions needed to be taken.

Is the service effective?

Good

This location had not previously been rated for effective. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Clinical guidelines and policies were developed and reviewed in line with National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies. This included NICE guidelines NG31: Care of dying adults in the last days of life and the NICE quality standards QS13: End of life care for adults. A process was in place for policies to be reviewed and updated with any new or amended guidance.

Staff followed up-to-date policies to plan and deliver care according to best practice and national guidance. Policies and protocols were available to staff in electronic and paper format.

If the patient was at end of life this was supported by the individualised care and communication record for a person in the last days or hours of life. This was in line with national standards and guidelines.

The service undertook audits to ensure healthcare was being provided in line with standards. They used audits as a quality improvement process to improve patient care and outcomes through systematic review of care against explicit criteria.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff completed patient nutrition and hydration assessments at initial assessment and reviewed them when needed. Staff provided support and advice to patients and those close to them including those with specialist nutrition and hydration needs. They worked closely with GPs and community nurses to ensure needs were met, and ensured specialist support from staff such as dietitians and speech and language therapists, was available for patients who needed it.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Malnutrition screening tools were used by the community nursing teams and LHNT staff had access to these records when delivering care and followed relevant care plans.

Staff provided support and advice to families of patients nearing the end of life with limited or no oral intake, this included giving mouth care to patients in line with national guidance to maintain their comfort.

Pain relief

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

Staff assessed patient pain using a recognised tool and gave pain relief in line with individual needs and best practice. LHNT nurses administered pain relief as required and in line with prescriptions from the GP. Staff discussed and recorded pain and pain relief with patients during their initial assessment and regularly reviewed patient pain levels on subsequent visits in case of changing needs.

They used comprehensive assessment processes to identify when pain relief was required, including non-verbal expressions of pain.

Syringe drivers used to provide medicines to manage pain and other symptoms at the end of life were primarily managed by the community nursing team. However, LHNT nurses checked syringe drivers as part of their visit assessment, and provided additional support in the event of a syringe driver needing to be changed or re-sited. All nurses had received syringe driver training and undertook annual competency assessments.

Staff administered and recorded pain relief accurately. They used shared medicine records from the local NHS trust. This ensured when pain relief or medicines used to control other symptoms, were administered all staff involved in the care would use the same documentation and could see what had been given.

Nursing staff we spoke with demonstrated a good understanding of anticipatory prescribing (where medicines were prescribed for use later as symptoms progressed) and the use of medicines in end of life care. They would also liaise with the patient's GP or the community nursing team if pain medicine needed to be reviewed or was not effective.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

LHNT had systems and processes in place to monitor and audit the quality of services, and the outcomes for patients receiving care and treatment.

The service used the Outcome Assessment and Complexity Collaborative (OACC) tool. The OACC is a suite of measures used to assess the care that matters most to people and their families at the end of life, such as control of their pain, breathlessness and fatigue, the opportunity to discuss worries, or to achieve one more personal goal before they die. By collecting this information the team caring for patients were able to plan care, treatment and support, to best meet the needs of each individual patient.

The service also used the Phase of Illness measure and the Australian Karnofsky Performance Status (AKPS). Phase of Illness categorises the patient into one of five phases, stable, unstable, deteriorating, dying and deceased. The tool was used as a measure to determine key changes in the trajectory of patients' illness and to identify and respond to a patient's changing needs.

The service used patient and relative feedback tools to measure patient outcomes. Information was sought on a range of quality indicators and the findings were used to make improvements to the service where needed. We were given examples where changes had been made.

The service used internal audit to assess the effectiveness of the measures they used to measure patient outcome.

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.

All staff with a professional qualification were subject to pre-employment checks to ensure their professional qualification was active and with no restrictions in place. We reviewed staff files and found they contained relevant information to demonstrate staff suitability and competence for their role.

LHNT had a well-planned induction programme for newly appointed staff. This was a set programme for staff to orientate themselves with the service, the expected behaviours, any development needs highlighted and a plan to address them put in place, and training in procedures and policies. This was tailored to the individual's role within the team.

The service did not use a competency framework to ensure staff had the appropriate skills and knowledge to manage patients safely and effectively. Instead, they used a staff self-assessment during their yearly appraisal to ascertain if staff thought they were still competent or required development in set criteria. This put the emphasis on the individual to identify if they had the necessary skills or gaps in their knowledge to be effective in their role, rather than being assessed as competent in a specific task by the service.

Clinical supervision was provided to staff every six to eight weeks. In addition, at the end of every shift the team member called the nurse coordinator on duty to handover. Staff found this was another way to get support or debrief and reflect on their practice when needed.

Nurse coordinators carried out shadowing visits with the team where they would work alongside staff delivering care. They focused on professional development and acted as a practical process to support staff, monitor effectiveness of care provision and identify potential risks for staff and patients. Aspects of care, such as effective communication, record keeping, compliance with policies and demonstrating a compassionate approach were included in the process. This helped to keep standards consistent across the team.

Managers supported staff to develop through yearly constructive appraisals of their work. We saw records that showed all care staff had received an appraisal in the last year. Staff had the opportunity to discuss training needs and were supported to develop their skills and knowledge. Staff told us they found the appraisal process useful and they were encouraged to identify any learning needs they had, and any training they wanted to undertake. Poor or variable performance was identified through the appraisal process, complaints, incidents and feedback. Staff were supported by their managers to improve their practice where indicated.

Managers supported the learning and development needs of staff and provided internal and external training if required. We were told of recent dementia and learning disability training that had taken place.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. This made sure staff were fully informed and up to date with any changes made to the service.

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.

Multidisciplinary working was a fully embedded practice within the service and ensured a joined-up approach to delivering care and treatment to the patient.

LHNT had good working relationships with the GPs, surgeries and community nursing teams they worked with. The nursing team attended Gold Standard Framework (GSF) meetings with local GPs where they discussed each patient on the end of life register and how they could best support them.

LHNT had good links with other healthcare providers in the local area, including the local NHS trusts, the integrated care boards, and local authorities. Information and support was shared to offer joined up services, care and treatment for patients. LHNT also worked closely with other hospices to share information, learning & training and best practice.

Seven-day services

Good

Hospice services for adults

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

LHNT provided services in patient homes 24 hours a day, seven days a week. Activity was planned based on individual patient need.

Patients admitted to the service could contact a member of the nursing team 8am – 10pm if they required support. Outside of these hours they were asked to either leave a message or if urgent help required to call 111.

A nurse coordinator was available to the nursing team 24 hours a day, seven days a week.

Health promotion

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

Staff assessed each patient's health and well-being when they were admitted into the service. The team worked together to give personal co-ordinated care to patients. This included advice and support on nutrition, pain control, social, emotional and spiritual needs. Staff cared for patients using a holistic approach and regularly monitored patients' wellbeing.

Consent, Mental Capacity 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.

LHNT had up-to-date policies and procedures regarding consent and the Mental Capacity Act 2005.

The Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) was included in the adult safeguarding mandatory training. Staff demonstrated an understanding of MCA and DoLS, and the procedures and documentation used by the service to assess a patient's capacity.

Staff were aware when patients lacked the mental capacity to make a decision, best interest decisions were made in accordance with legislation and took into account patients' wishes, culture and traditions. They worked with other healthcare professionals to do this, including community nurses and the patient's GP. Information was documented in the patient's records. If the service was making difficult or complex decisions to deprive a person of their liberty, then the service would follow the legal framework to do so and work in close partnership with the local authorities.

Staff we spoke with understood the importance of consent when delivering care and treatment to patients. When admitted to the service patients were assessed to see if they had capacity to give consent and were asked to sign a consent form to allow LHNT to provide care. Patients that did not have the capacity needed to have a best interest decision made.

We observed staff seeking consent from patients prior to examination, observations and delivery of care. In most cases this was implied consent and not documented.

Good

Hospice services for adults

Staff were aware patients may make decisions that they did not agree with. We were told if patients do not consent then they do not proceed. When this happened, staff said it was their role to mitigate any risks as far as practicably possible. Staff would document when consent had not been given.

The service used the advance care planning framework to help make decisions about the care patients would like at the end of life and do not attempt cardiopulmonary resuscitation (DNACPR) forms to document each patient's wishes in emergency situations. We reviewed five sets of patient records and this information was completed comprehensively and correctly for all.

Is the service caring?

Good

This location had not previously been rated for caring. We rated it as good.

Compassionate care

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

Staff were aware of the importance of providing compassionate care and the impact their actions had on the patient and their families during this time of their lives. Support was always given by caring and empathetic staff who put patients and their loved ones at the heart of everything they did. During our inspection we saw pleasant interactions between staff and patients and their loved ones. We saw staff treat patients and their relatives with warmth and care, they were courteous, professional and demonstrated compassion to all.

Staff introduced themselves to patients and all staff wore name badges on their uniform which enabled patients to easily identify which staff member was providing their care/support.

Patients were treated with dignity and respect at all times. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients. Peoples' privacy and dignity was always considered.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. They had received training in equality and diversity and staff we spoke with understood the importance of individualised patient care. Their approach was person centred and adapted to meet individual needs as required.

Patients and relatives we spoke with commented positively about the care and treatment their loved one had received. We were told:- 'staff were amazing, so kind and caring to us all, not just me and my husband but the wider family'; The staff were great, they enabled me to get respite from constant care'; they always did everything and more to help'; 'staff had really good knowledge and always communicated with us in a clear way'; 'staff took time to get to know the things he liked and spent time interacting with him in a beautiful way'.

The service monitored feedback from patients, those close to them and stakeholders. It was overwhelmingly positive about the way staff treated people. We looked at thank you cards, and feedback received through the relative survey which was sent to relatives six weeks post bereavement. The service had a return rate of 64% with 100% of relatives

being positive with the care their care their loved ones had received. Comments included, 'I can never, ever thank you enough for your empathy, kindness and dedication'; 'you made the end of life journey dignified and peaceful';' extremely kind, caring and professional'; 'wonderful care'; 'I will never forget the compassion of your team'; you went above and beyond to make sure my mum was comfortable, peaceful and pain-free'.

Emotional support

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

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, and consistently took account of this when providing care and treatment. Staff we spoke with had a good understanding of the holistic needs of patients and those close to them.

During our inspection we were told by staff emotional support came in different forms depending what was required by the patient and those close to them. Staff listened to patient's worries and addressed their concerns.

LHNT did not provide formal bereavement support to bereaved relatives and friends before or after the death of their loved ones. However, the team had received bereavement training, could offer support and would complete a post bereavement visit to the family which included signposting the family to other services if required.

LHNT always sent a card of condolence to a patient's family after their loved one had passed to provide kind words and comfort.

LHNT held an annual candles of remembrance service. The service was a time for people to remember loved ones that had passed.

Feedback from patient's relatives showed the emotional support given to them by the team, comments included; 'so grateful for the help & support'; 'love and support given'; you gave me 100% support in my hour of need, thank you from the bottom of my heart'; 'deeply appreciate the holistic approach as I often felt cared for myself as well as you looking after my mother'.

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 were committed to working in partnership with patients and their relatives, involving them in decision making processes about care and treatment.

Staff made sure patients and those close to them understood their care and treatment and supported patients to make advance decisions about their care. The service used advance care plans so patients could plan for future health and treatment options if they should lose their decision-making capacity. These plans captured their values and wishes and enabled them to continue to influence treatment decisions even when they could no longer actively participate. We saw advanced care plans in records we reviewed.

Good

Hospice services for adults

The service had developed a patient and carer communication sheet that was kept in the patient records in their home. The patient and their relatives could write their question or observations on the sheet at anytime and this would be picked up by the nursing team during their visit.

Feedback we reviewed and relatives we spoke with told us information was explained gently and with sensitivity, questions were never ignored or remained unanswered. We were told staff had time to answer questions and would answer in a way they could understand, including what the end process would look like so relatives knew what to expect and when to say their final words. With one relative saying 'I will be externally grateful for this as it gave me an opportunity to say the really important things to my husband, I don't think I would have done this had I not been guided by our nurse'.

Is the service responsive?

Good

This location had not previously been rated for responsive. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

LHNT cared for patients in their own homes. The team worked collaboratively with others in the wider system to design and plan palliative and end of care services for patients in the local community. This included local GP surgeries, care homes, and community nurses from the local trusts.

They also engaged with regional end of life care networks and local authorities to ensure they were identifying patients in need of support. A key aim of the service was to provide additional support for patients wishing to die at home. This included patients on 'rapid discharge' from hospital into the community in the last days of life.

The service also provided respite support for families and carers, meaning they could leave their loved ones to attend an appointment or to have a break from their caring duties.

Nursing hours were planned on a weekly basis and adjusted to meet the needs of patients and those close to them. Due to the changing needs of the patient the team were flexible and could cover shifts at short notice when needed.

The service had developed a prioritisation tool which they used if demand for the service outweighed nurse availability. Patients were scored according to four categories, patient's home support, their physical/psychological dependency score, phase of illness and their Australian Karnofsky performance status. Senior staff told us this tool was very rarely needed as they had capacity to cover the nursing shifts required.

Meeting people's individual needs

Good

Hospice services for adults

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 plans and risk assessments for patients were person-centred and consistently tailored to each individual patient's needs. Each person's care plan was devised in discussions with the patient about what was important to them. The care plans were regularly reviewed and updated.

Staff had training to be able to support patients with complex needs. Clinical staff told us, if needed, they would liaise and involve relatives, specialist practitioners in the local community and from the local trust who were already involved in the patient's care, to make sure they supported patients appropriately and to make sure there was continuity of care.

The service had an accessible information standard policy which contained guidelines of how to effectively support patients to live a fulfilling and as independent life irrespective of their limitations as far as possible.

Staff understood and applied the policy to meet the information and communication needs of patients with a disability or sensory loss. They had access to communication aids, including interpreters and signers. Any communication needs were identified at the initial assessment and on an ongoing basis and staff worked with other services, the patient and family members to meet those communication needs on an individual basis.

Access and flow

People could access the service when they needed it and received the right care promptly. The service ensured patients did not have to wait for care.

LHNT had effective processes to manage admission to the service. Managers made sure patients could access services when needed and received treatment and care as soon as possible. Staff and senior staff gave examples of how they had worked to respond to the needs of patients including those in urgent need.

Referrals came mostly from GPs, community nurses, and hospitals in the local area. If patients were eligible, fitted the admission criteria and the service was able to meet the patient's need, they would be offered comfort care from the team.

Nurse coordinators, or nurses who had the appropriate training, would visit the patient and their carers in their home to complete the initial assessment. Using this information and working closely with the patient's GP and community nurses a care plan was put in place.

LHNT had developed good links with the local hospital palliative care team, GPs and community nurses. This meant everyone involved in the patient's care were informed of the person's changing health and social care needs. This benefited patients by providing coordinated care and well-being at a distressing time.

The service did not have specific key performance indicators around the time taken to make contact with the patient following referral. However, the aim was to see patients within 24 hours of the referral. Staff told us they usually saw patients within a few hours of referral when their needs were more urgent and that patients were prioritised based on their care needs.

LHNT worked to ensure patients referred received the care needed. However, there were occasions when this was not possible due to insufficient staffing or the complexity of patient needs. We saw from May 2022 - April 2023 there had been 12 occasions where the service was unable to meet the needs of the patient, which was 1.75% of the total care given. However, we were told when this happened the team could usually offer a flexible solution to ensure the patient and their family gets support from the team. For example, by providing a twilight shift rather than a night visit. Where complex care was needed which LHNT could not provide the patient was referred back to the community nursing teams as the primary care provider in the community.

Nurses recorded where their patients wanted to be cared for on the assessment visit and managers collected information on patient place of death. The service did not compare these two measures for an individual or used it as a key performance indicator of the success of the service. This was because the service felt there could be a change in the patient's circumstance which meant the patient preferred place of death also changed. However, LHNT were proud to have cared and supported 82.5% of their patients to die at home in the previous 12 months of the inspection.

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.

LHNT followed the up-to-date complaints policy. The policy stated the staff roles and responsibilities, and the timescales for dealing with complaints.

Staff were aware of the complaint's procedure. Staff told us they always tried to resolve any issues or complaints at the time they were raised. If this was not possible, patients could be referred to nurse coordinator or the registered manager. If complaints or concerns could not be resolved informally, patients and/or those close to them were supported to make a formal complaint.

Information how to raise a complaint was given to patients and their carers on admission to the service. Information on how to raise a complaint could also be found on the LHNT website. Complaints could be made in person, by telephone, and in writing by letter or email. In addition, carers could raise concerns using the LHNT feedback opportunities such as the service surveys. Relatives we spoke with told us they knew how to make a complaint or talk through a concern, although no one had needed to.

Staff said learning from complaints and concerns would be communicated to them mainly at handovers and team meetings. Staff we spoke with were committed to providing an excellent service to their patients. Staff told us they saw learning from complaints and concerns as a vital tool to help them achieve this.

LHNT had received only one complaint since the last inspection. We reviewed documentation relating to the complaint and saw it was investigated thoroughly and according to the LHNT complaints policy. Organisational learning had been identified and actions agreed. We saw evidence this information had been disseminated and discussed with staff. Support and a time to reflect had been given to staff involved in the complaint.

LHNT received many compliments from people that used their services. Managers monitored this feedback and celebrated positive comments. Managers fedback peoples' thanks and kind words to staff.

Good

Hospice services for adults

Is the service well-led?

Good

This location had not previously been rated for well-led. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

LHNT had a clear management structure in place with defined lines of responsibility and accountability.

The clinical service was led by the registered manager, who was a registered nurse with a wealth of experience and expertise developed from working in the palliative and end of life care sector. The registered manager was supported by the operations manager, finance manager and the head of fundraising to deliver the service.

The registered manager was accountable to the board of directors. The board of directors, currently nine, were actively involved and had a range of relevant expertise to contribute to the effective running of the service.

There were four registered nurses who shared nurse coordination responsibilities and reported to the registered manager. A nurse coordinator was available 24 hours a day seven days a week to the bank of nurses employed by the service.

The senior leaders and directors understood the issues, challenges and priorities facing the service and beyond and developed plans to address these.

Staff at all levels told us the leads and board were visible and approachable, and they provided support as needed.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a clear vision and strategy for the service. The service strategy had been developed in collaboration with relevant stakeholders. The service aims were to:-

- Provide nursing care to people with a terminal illness who wished to remain at home.
- Provide additional support to the community-based services already available.
- Work in close contact with the primary health care team.
- Work alongside other agencies that may be involved.

Progress against the strategy, which included a review of the service finances, was reviewed at the quarterly board meeting to ensure the service was meeting the aims and objectives set.

The operation plan to achieve the strategic aims was reviewed yearly to make sure it reflected the changing national and local healthcare environment, and to make sure it was meeting the palliative and end of life care needs in the local community. The service was in the early stages of planning a review of current service provision and if changes needed to be made, which would include input from staff, service users and external partners.

The registered and operations managers engaged within the wider health economy, including end of life care networks and local sister charities and contributed to discussions about local end of life care strategies.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt positive about working at LHNT. They were passionate about the care they provided and were proud to work for the service. Staff told us they were committed to providing the best possible care for patients and those close to them. There was a positive team atmosphere and staff were flexible in their approach to meeting patient's needs. We observed positive and respectful interactions between staff at all levels. Staff told us they all worked well together, they supported and cared for each other and treated each other with respect.

Staff we spoke with were positive about managers and the board, and said they were visible and approachable. Staff told us they could openly discuss issues or concerns which would lead to resolution. They felt valued and their opinions were sought before changes which affected them were taken.

Staff cared for each other. There was a lone working policy in place and nurse coordinators monitored where staff were when on shift and ensured staff were safe. The service had invested in a lone working device which staff carried with them when working alone for the service. Staff could use this device if they felt unsafe and needed assistance.

None of the staff raised any concerns about bullying or inappropriate behaviours from colleagues. Arrangements were in place to ensure staff could raise concerns safely and without fear of reprisal. The service had appointed a freedom to speak up guardian (FTSUG) which reflected national guidance and whom staff could talk to in confidence if they had concerns. Staff were aware of the freedom to speak up guardian role.

The service had an equality and diversity policy which was aligned to the requirements of the Equality Act. Staff received mandatory training on equality and diversity.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Good

Hospice services for adults

LHNT had a governance framework in place through which the service was accountable for continuously improving their clinical, corporate, staff, and financial performance. Governance accountability was from the board of directors, delegated through to the registered and operations managers for operational and clinical management.

The service had four main sub-committees which met quarterly, governance, clinical, finance and fundraising, where specific operational issues were discussed. Information from the service fed into these meetings.

Information from the sub-committees fed into the quarterly board of director meetings. This meeting had a set agenda which included a review of committee reports and the risk register. We could see from the minutes and through discussions that the directors had good oversight of the service. This enabled them to make confident decisions and make sure the service was developing the strategic aims.

Each meeting had a term of reference and a purpose, they were planned and structured. We reviewed agendas and meeting minutes from the clinical, governance and board meetings and saw they were thorough in their content, ensured the service delivered safe and effective patient care, and any actions were recorded and reviewed at the next meeting. Members of the board of directors chaired the governance and clinical committee meetings. The clinical committee meeting covered clinical processes and systems and used data to monitor quality and effectiveness of care.

Nurse coordinator meetings were held every six weeks where operational and development issues were discussed. Nurse meetings were held every six weeks and chaired by the registered manager. This meeting disseminated information to the team and was also an opportunity for staff to feedback and make suggestions. We talked to staff and reviewed minutes from these meetings and found they covered areas needed to deliver safe, effective, compassionate and high-quality care and had staff participation.

Arrangements were in place to manage and monitor contracts and service level agreements with partners and third-party providers. Contracts were reviewed when required, which included a review of quality indicators and feedback, where appropriate.

Management of risk, issues and performance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were clear and effective processes for identifying, recording, managing and mitigating risks. The service had an up-to-date risk policy and related policies and procedures available to staff which were developed to minimise risk to staff and families who use the service.

The service had a risk register, which included risks from across the organisation. The register included a description of each risk, the potential impact of the risk, alongside mitigating actions and controls in place to minimise the risk and what further action was required. Each risk was scored according to the likelihood of the risk occurring and its potential impact. New risks were added as they occurred, which made the risk register a live document and process.

Risks were discussed at the clinical governance meeting. Existing risks were reviewed and discussed, and decisions made to change the rating of the risk or close if appropriate. Risks rated as amber or red were also reviewed at the board of directors meeting to ensure the board had oversight of risk and had assurance that appropriate measures were in place to mitigate the risk.

There was alignment between the recorded risks and what staff identified as risks within the service.

From speaking with staff and reviewing documentation we were assured the service was able to recognise, rate and monitor risk. This meant the service could identify issues that could cause harm to patients or staff and threaten the achievement of their services.

Performance was monitored through a dashboard of collated information relating to incidents, activity levels, patient feedback, staffing and performance indicators.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service had clear service performance measures, which were recorded, reported and monitored. Data collection was detailed and included data on a range of performance measures and quality indicators, which included audit results and patient feedback. We saw evidence from speaking with staff and reviewing documentation that areas of good and poor performance were highlighted and used to challenge and drive forward improvements.

Where relevant, performance was tracked over time to highlight unexpected variations in performance which warranted investigation. This meant staff could identify at a glance, areas of increased performance or performance trends and areas that required investigation and improvement.

Staff had access to a range of policies, procedures and guidance which was available on the LHNT's electronic system. Staff also told us IT systems were used to access the e-learning modules required for mandatory training.

Computers and laptops were encrypted, and password protected to prevent unauthorised persons from accessing confidential patient information.

Information governance was included as part of mandatory training for staff. Staff understood the need to maintain patient confidentiality and understood their responsibilities under the General Data Protection Regulations.

There were effective arrangements to ensure data and statutory notifications were submitted to external bodies as required, such as the Care Quality Commission. There was transparency and openness with all stakeholders about performance. The service made its annual reports available to the public and were published on it's website. Although the last available report was from October 2020.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

LHNT actively encouraged patients and their relatives to give feedback to help improve services. For example, through patient satisfaction questionnaires and feedback. Information gathered was used to inform improvement and learning, and to celebrate success.

LHNT had a presence on social media which included an informative website for people wanting to find out about the organisation and the services that it offered. The website was easy to navigate, used consistent layouts and visual cues for functionality across the site. However, not all areas were up-to-date.

LHNT was a registered charity and fundraising was crucial to enable the service to continue to provide care to patients. A wide range of events and initiatives were put in place to raise money and to remember those who had been supported by the team. This included sponsored events, days out and giving in memory. We saw tributes from patient's families who wanted to give back to the service for the care and support their loved ones had received.

Staff views were sought and acted on. There were regular all staff meetings which gave employees an arena to discuss ideas and seek practical solutions to improving their working experience. The service had undertaken a staff survey in 2021 that allowed staff to provide anonymous feedback on nine areas including the management & leadership, health & well-being and delivery of services. There was an 86% return rate. Overall, the responses were positive across all relevant sections with 100% of those respondents stating they were not considering leaving the organisation. The service had an action plan for the three areas that had been identified as areas of improvement.

Each board meeting included a staff member presentation. This gave the board an insight into the day-to-day workings of the team, the challenges they might face and how the service operated. The staff valued this opportunity and made them feel supported and listened to.

The service managers recognised the need to engage with stakeholders in order to develop their services. LHNT worked in partnership with other services providing end of life care to ensure patients' individual needs were effectively met. For example, liaising with NHS trusts, attending gold standard framework meetings with local GPs and working closely with the community nursing team. Managers met regularly with local sister charities, attended local and regional meetings about end-of-life care and were members of relevant groups. This included the regional palliative care network. Feedback we received post inspection from external organisations the service worked with were complimentary. We were told the contribution the service gave to the local end-of-life healthcare community was collaborative, of a high standard and invaluable.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Staff were actively encouraged to think of ways to improve services.

LHNT was committed to improve the quality of services offered to patients and their relatives and used a number of ways to do this.

There were a range of audits in place to provide assurance and action was taken to improve as a result. For example, the documentation audit which had highlighted areas for improvement, such as how identification of care was recorded.

Incidents were reviewed and learning shared to make improvements. For example, the use of head torches for power cuts and the creation of the pressure area policy after advice about re-positioning a patient at end of life was misinterpreted.

Feedback from families was used to make improvements. For example, a pre-visit risk assessment had been developed to capture any pre-visit risks, such as parking & access issues or pets at the property, and the development of a '*what to do after death*' leaflet.

Good

Hospice services for adults

All staff were actively encouraged to think of ways to improve their service. During our inspection we were told of many ways improvement had been made and of further developments to the service. This included:

- the improvement in record keeping and the patient folder kept in the patient's home. Staff had decided to use green paper in the folder for pages that held important information the patient and their family might need in a hurry, such as contact numbers and what to say if the 111-service needed to be called.
- Nurses in the team had developed an identification of care need coding system that could be used in patients records. The code started with a number depending on the type of need, for example 1 meant physical need, 2 psychosocial need, 3 spiritual need and 4 social need. This was followed up by a letter relating to the need, for example R – respiratory problem. This had become an embedded way of classifying the patient's care needs and made it easy for the nursing team to see what was required for the patient.
- Adapting the service to care for patients during the COVID pandemic, when patient's visits needed to be limited.
- Training in bereavement support, so the team could give more support to families after their loved ones had passed. The management had arranged an acute bereavement training with a local hospice.