Tynedale Hospice at Home

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The Tynedale hospice at home service provides end of life nursing care, bereavement services and a volunteer transport service. We inspected this service using our comprehensive inspection methodology. We carried out an unannounced visit to the hospice on 4 February 2019.

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 rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

We rated this service as good overall.

We found good practice in relation to end of life care:

- The service was safe and safety performance measures were in place. There had been no serious incidents since the last inspection.
- Staff used safe working practices and followed risk assessments when providing care and support for people.
- Staff could describe what it meant to safeguard people and told us how they would report any suspected abuse. Safeguarding policies were embedded and in date.
- Staff were recruited safely and there were sufficient staff on duty to meet people's needs.
- People had their medicines managed safely and training was updated annually.
- Staff training was up to date and in line with the service target.
- The hospice at home staff worked closely with hospitals, community organisations and health and social care professionals to help ensure people received the right care at the right time.
- Staff worked within the principles of the Mental Capacity Act 2005 where appropriate. People had choices about their care and their consent was sought by staff.
- Staff appraisal and supervision rates met the services annual target rate.
- The friends and family test results were very positive.
- People told us that staff were caring, supportive and respectful.
- Staff took time to engaged with patients and families. Patients said their privacy and dignity was maintained to a very high level.
- People made decisions about the care and support they received. Care was person centred.
- Staff showed an encouraging, sensitive and supportive attitude to people who use services and those close to them.
- People told us that they would be confident expressing any concerns to staff at the service and knew who to approach if they were not satisfied with the response.
- The service was delivered and co-ordinated to be accessible and responsive to people with complex needs.
- Leaders were visible and approachable.
- There was a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care.
- There was a strong emphasis on the safety and well-being of staff. Lone working policies were in date and appropriate.
- There were clear responsibilities, roles and systems of accountability to support good governance and management.
- There were clear and effective processes for managing risks, issues and performance.
- People's views and experiences were gathered and acted on to shape and improve the service.

We found areas of practice that require improvement in services for end of life care:

Summary of findings

- We did not find that relevant National Institute for Health and Care Excellence guidelines and quality standards to be embedded for example, QS13 End of life care for adults, NG31 Care of Dying Adults in the Last Days of Life. Good practice was followed, but not all staff knew which guidance they were following.

Services we do not rate:

Bereavement Service and Patient Transport

We found the following areas of good practice:

- The 27 volunteer drivers' provided a free transport service which was available for people with life limiting conditions to attend hospital appointments with ease.
- All volunteers were interviewed and screened in the same manner as employed staff. All had Disclosure and Barring Service (DBS) and reference checks.
- We found that all volunteers completed mandatory training in safeguarding, moving and handling and lone working practices.
- Patients and their relatives found the transport service invaluable.
- The bereavement support service was available for children, adults and family sessions.
- We found the childrens bereavement room to be an appropriate environment for young people. The children's bereavement room contained a TV so that the children could watch films about how children deal with grief. There were games which encouraged children to discuss their feelings.

Following this inspection, we told the provider they should make improvements, even though a regulation had not been breached, to help the service improve. These can be found at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals (North)

Overall summary

- The service was safe. There had been no serious incidents since the last inspection.
- Staff could describe what it meant to safeguard people and report any suspected abuse.
- There were sufficient staff on duty to meet people's needs.
- Staff training was up to date and in line with the service target.
- Staff worked within the principles of the Mental Capacity Act 2005 where appropriate.
- People told us that staff were caring, supportive and respectful.
- Staff took time to engaged with patients and families and patients felt listened to and felt safe.
- People were involved in developing their care plans which were person centred.
- The service was delivered and co-ordinated to be accessible and responsive to people with complex needs.
- There a strong emphasis on the safety and well-being of staff.
- There were clear responsibilities, roles and systems of accountability to support good governance and management.
- There were clear and effective processes for managing risks, issues and performance.
- People's views and experiences were gathered and acted on to shape and improve the service.

However;

- We did not find that relevant National Institute for Health and Care Excellence guidelines and quality standards were fully embedded for example QS13 End of life care for adults, NG31 Care of Dying Adults in the Last Days of Life. Good practice was followed, but not all staff could tell us the guidance they were following

Summary of findings

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Summary of this inspection

Background to Tynedale Hospice at Home

Tynedale hospice at home is a registered charity which supports people for free, who have life limiting illnesses in the Tynedale and West Northumberland areas, and who wish to be cared for in their own homes. The service also provides family services which offers pre and post bereavement support to families (including children), where an individual has been diagnosed with a life limiting illness or has passed away. Free transport is also available for people with life limiting conditions to attend hospital appointments.

The care service employed 10 registered nurses, seven hospice support workers and 41 volunteers. The chief executive officer and registered manager were based at an office hub and were supported by senior nurses, a human resources officer, finance officer, and administrative support. The team of staff worked closely with local GP's, district nurse teams and members of staff from a variety of organisations. At the time of the inspection there were two people receiving care and support from the service.

The service was financially supported by three charity shops and volunteers selling a range of clothes, bric-a-brac and books, and by local people raising funds in other ways, for example, through sponsorships and donations. Funding was also sourced from the NHS and through applications to other charitable organisations such as Children in Need.

The hospice offered a bereavement service and volunteer patient transport service. We inspected but did not rate these services.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and two specialist advisers with expertise in end of life care. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection (North).

How we carried out this inspection

We reviewed information we held about the service, including any notifications we had received from the provider. We asked that the provider complete a provider information return (PIR). A PIR is a form which asks the provider to give some key information about their service; how it is addressing the five questions and what improvements they plan to make and used their comments to support our planning of the inspection.

We spoke with three family members/carers who use the service. We also spoke with 10 members of staff. We looked at a range of records which included the care records for three people who used the service. We saw health and safety information and other documents relating to the management of the service.

Information about Tynedale Hospice at Home

The service has had a registered manager in post since July 2016. The chief executive officer was in post from October 2018.

Activity (April 2017 to October 2018):

- In the reporting period April 2017 to October 2018 There were 107 patients cared for by the Tynedale Hospice at Home; of these less than 10% were NHS-funded and 90% charity funded.

Summary of this inspection

Track record on safety:

- Zero never events
- Zero clinical incidents
- Zero serious injuries
- Zero complaints

There were no special reviews or investigations of the hospice ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected three times, and the previous inspection took place in November 2016, which found that the service was meeting all standards of quality and safety it was inspected against.

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Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Our rating of safe stayed the same. We rated it as **Good** because:

- The service was safe and safety performance measures were in place. There had been no serious incidents since the last inspection.
- Staff used safe working practices and followed risk assessments when providing care and support for people.
- Staff could describe what it meant to safeguard people and told us how they would report any suspected abuse. Safeguarding policies were embedded and in date.
- Staff were recruited safely and there were sufficient staff on duty to meet people's needs.
- People had their medicines managed safely and training was updated annually.
- Staff training was up to date and in line with the service target.
- Records audits were up to date and comprehensive.

Are services effective?

Good

Our rating of effective stayed the same.We rated it as **Good** because:

- The hospice at home staff worked closely with hospitals, community organisations and health and social care professionals to help ensure people received the right care at the right time.
- Staff at all levels received induction and on-going personal support and training suited to their roles and responsibilities to help ensure they could meet the individual needs of the people they supported.
- Staff worked within the principles of the Mental Capacity Act 2005 where appropriate. People had choices about their care and their consent was sought by staff.
- Staff appraisal and supervision rates met the service annual target rate.

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

- We did not find that relevant National Institute for Health and Care Excellence guidelines and quality standards were fully embedded for example, QS13 End of life care for adults, NG31 Care of Dying Adults in the Last Days of Life. Good practice was followed, but not all staff could tell us the guidance they were following.

Summary of this inspection

Are services caring?

Good

Our rating of caring stayed the same. We rated it as **Good** because:

- The friends and family test was very positive.
- People told us that staff were caring, supportive and respectful.
- Staff took time to engaged with patients and families. Patients felt listened to and felt safe.
- Privacy and dignity was maintained to a very high level.
- People made decisions about the care and support they received and told us that staff at the service communicated well with them.
- Care was person centred.
- Emotional support and information was provided to those close to people who used the service, including carers, family and dependants.
- Staff showed an encouraging, sensitive and supportive attitude to people who use services and those close to them.

Are services responsive?

Good

Our rating of responsive stayed the same.We rated it as **Good** because:

- People were involved in developing their care plans, which were person centred and clearly described the care and support people needed. The care plan was reviewed weekly with the person and their family.
- People told us that they would be confident expressing any concerns to staff at the service and knew who to approach if they were not satisfied with the response.
- The service was delivered and co-ordinated to be accessible and responsive to people with complex needs.
- If any treatment changed or was withdrawn, there were processes to ensure that this was managed openly and sensitively so that people had a comfortable and dignified death.

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Are services well-led?

Good

Our rating of well-led improved.We rated it as **Good** because:

- Leaders were visible and approachable.
- There was a robust, realistic strategy for achieving the priorities and delivering good quality sustainable care.
- Staff felt supported, respected and valued.
- There a strong emphasis on the safety and well-being of staff. Lone working policies were in date and appropriate.
- There were clear responsibilities, roles and systems of accountability to support good governance and management.

Summary of this inspection

- There were clear and effective processes for managing risks, issues and performance.
- People's views and experiences were gathered and acted on to shape and improve the service.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

End of life care

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

Are end of life care services safe?

Good

Our rating of safe stayed the same. We rated it as **good.**

Mandatory training

- We saw that staff induction was aligned with the Care Certificate. The Care Certificate was officially launched in April 2015. It aims to equip health and social care workers with the knowledge and skills which they need to provide safe and compassionate care. It replaces the National Minimum Training Standards and the Common Induction Standards.
- All staff underwent mandatory training in fire safety, moving and handling, information, security and governance, lone working, safeguarding adults and children level 2, equality, diversity, human rights and dignity in care and infection, prevention and control awareness.
- We saw that all staff training was up to date. The staff training matrix was planned and monitored by the senior nurse responsible for training and development.

Safeguarding

- Adult and child safeguarding policies were in place for all hospice staff. A role specific training schedule for safeguarding was produced following advice from the local safeguarding educators and was checked annually.
- Three staff members had attended 'train the trainers' study day for safeguarding awareness in preparation for rolling out training.
- The chief executive officer had attended 'designated safeguarding lead' training and the head of care had completed 'safeguarding adults for service managers' (level 3).
- We found that the proportion of staff involved in the care of patients were trained to Safeguarding Level 1 and 2 in children and adults was 100%. In addition to this, all staff required to complete safeguarding level 3 had done so.
- All care staff knew what to do if any safeguarding incidents were suspected. CQC and Local authorities were informed of any safeguarding alerts made by staff. A record of all alerts was sent to the CQC, the service chief executive office and the service safeguarding sub-committee.
- Members of staff we spoke with clearly articulated abuse and potential risks to people who used the service, as well as the correct actions they would take if they suspected any form of abuse occurring.
- We were satisfied that people would be protected from avoidable harm because staff understood their responsibilities to report issues of concern.

Cleanliness, infection control and hygiene

- All staff had been issued with a pack of equipment for infection, prevention and control when working in people's own homes. The pack contained personal protective equipment, including gloves and aprons and hand gel. This meant the provider had taken additional measures to protect staff and the people they worked with from the risks associated with infection control issues.

Environment and equipment

Good

End of life care

- All necessary equipment was risk assessed and provided by the community nursing team as the main care provider.
- Following the initial risk assessment, any staff members experiencing manual handling difficulties would request an additional reassessment by the community nurse.

Assessing and responding to patient risk

- We were advised that during the first visit to any patients and family, a support practitioner or registered nurse would complete a risk assessment. Any risks such as moving and handling, were discussed with the team and if there was any risk to either staff member or patient the appropriate health and safety adjustments were implemented. If this was not possible, the service did not provide care.
- Patients' needs were identified using a RAG system. This is a method of rating, based on red, amber and green colours used in a traffic light rating system to denote the level of risk and therefore prioritise accordingly. Red being higher risk and referring to people who are generally at the latter stages of palliative care. This meant that people with more urgent needs were prioritised to ensure they were addressed quickly.
- As Tynedale hospice at home was a support service to primary care services, the initial patient assessments were undertaken by the community nursing team who drew up the initial care plan. Assessment of needs included elements that indicated nutritional and hydration status through observation and recording.
- All patients and their families were advised to contact either their designated community nurse, MacMillan nurse or out of hours service if they required urgent attention.
- Tynedale hospice at home had a specific criterion for providing their transport service and did not provide the service for any patients receiving oxygen or those who require the permanent use of a wheelchair. As part of the assessment, vulnerable clients were identified and accompanied by a responsible adult when using the volunteer transport service which took clients to hospital appointments. If unable to provide transport for anyone the service provided advice about alternative assistance.
- The head of care services received regular alerts from the national patient safety agency and shared any relevant alerts to the nursing team by way of email, and monthly team meetings.

Nurse staffing

- The service had a recruitment policy, which provided a framework for the recruitment and selection of staff and volunteers to work with vulnerable people. A range of checks were carried out including proof of identity, written references, and checks with the Disclosure and Barring Service (DBS).
- Further verification was undertaken for nursing staff through the Nursing and Midwifery Council to verify their continued registration as nurses. All staff had completed an application form and had been interviewed.
- We saw that all relevant staff were actively working towards their revalidation.
- Apart from the registered nurses who were also care co-ordinators, all care staff were on zero-hour contracts. The services ensured continuity of carer wherever possible depending on the patient's condition and staff availability. When staff were not available to provide care, the service did not accept a new patient.
- The ratio of registered nurses and hospice support worker was monitored by the head of care services to ensure the available skill mix was relevant to the categories of patients referred to the hospice.
- The service employed 10 registered nurses and seven hospice support workers. We found that actual staffing levels met with planned staffing levels. There were no staff shortages.
- Care coordinators had a handover diary which was kept in the care office. All staff working in the community handed over to either the office staff or the traceability (co-ordinator) nurse. Information from each handover was recorded in the patient's office based notes.
- The Tynedale hospice at home registered nurse and hospice support workers had 0% sickness rate.
- The hospice used several volunteers for the transport service. We found that volunteers also went through a stringent recruitment process to assess their suitability.

Medical staffing

- As Tynedale hospice at home were not the primary care provider they did not employ medical staff.

Good

End of life care

- Any urgent medical assistance was accessed through the GP, out of hours service, or the community nursing team.

Records

- During the inspection we reviewed four patient records. There were currently two patients actively receiving end of life care.
- Patient notes were kept in the patient home as well as the office base. Updates about the patient's condition were communicated to the appropriate community nursing team as required.
- Records demonstrated that people were assisted to make informed decisions about their care and supported appropriately where risk was involved.
- There was evidence of risk assessments completed for people, with family and carer involvement where appropriate.
- Risk assessments described the actions staff were to take to reduce the possibility of harm without applying any unnecessary restrictions.

Medicines

- We found that medicines for people who used the service had been prescribed by their own GP's, out of hour's doctors or by the palliative care team.
- Tynedale hospice at home staff administered medicines as per the patient care plan.
- Any changes to a patient's medicines would be discussed at handover, prior to the registered nurse attending to the patient.

Incidents

- From April 2017 to October 2018, the service reported no incidents classified as never events for hospice at home end of life care.
- 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 have happened for an incident to be a never event.
- In accordance with the Serious Incident Framework 2015, the service reported no serious incidents from April 2017 to October 2018.
- When lessons learned were identified from an incident, the senior nurse responsible for training and development would schedule the event for discussion at the next appropriate group clinical nurse's supervision meeting, which formed part of the regular monthly nurse's meetings.
- The head of care services, senior nurse or care co-ordinator applied to the duty of candour regulations to ensure openness, transparency and candour.

Are end of life care services effective?

Good

Our rating of effective stayed the same. We rated it as **good.**

Evidence-based care and treatment

- The hospice at home service had a two-year review schedule for monitoring quality of care. This included audits of record keeping, one to one supervision and review/audit of any service improvements undertaken during the previous year.
- Policies were reviewed annually and staff notified of any changes in care provision because of changes in guidelines for example, National Institute for Health and Care Excellence.
- We did not find that relevant National Institute for Health and Care Excellence guidelines and quality standards were fully embedded for example, QS13 End of life care for adults, NG31 Care of Dying Adults in the Last Days of Life. Good practice was followed, but not all staff could tell us the guidance they were following.
- An "all about me" profile for further patient centred care assessment was in the patient's home records. When patients or their carers requested alternative therapies, the service would refer them to another provider who offered these services.
- We saw that policies for safeguarding and equality and diversity were reviewed in accordance with current guidelines.
- The service regularly audited their training matrix, peer supervision, record keeping, notifications of death, their service criterion (RAG system) and volunteer service.

Nutrition and hydration

- All malnutrition universal screening tools (MUST) scores were assessed by the community nurse as the primary care provider. Any actions required because of the MUST score were documented and followed by the Tynedale hospice at home staff.
- Assessment of needs included elements of nutritional status which was monitored through observation and recording.
- We saw that fluid input and output was monitored and recorded in accordance with the patients assessment and care plan.

Pain relief

- Registered nursing staff were aware of policies on the administration of controlled drugs as per the Nursing and Midwifery Council Standards for Medicine Management. We saw that all policies were in date and reviewed on a two-yearly basis.
- All medicines were prescribed by the general practitioner (GP) and managed by the community nursing team.
- The hospice at home registered nurses administered medicine PRN (pro re nata / as required), and in accordance with the prescribed medicines on the patient care plan.
- Any changes in people's prescribed medicines were logged via a call into the office and recorded in the person's daily notes.
- Registered nurses attended annual syringe drive update training in line with the competency framework.

Competent Staff

- Following successful interview and the completion of employment reference checks, all care staff underwent occupational health pre-employment checks on vaccination status, and training records were established.
- Annual objectives in line with the departmental objectives were agreed at appraisal and monitored throughout the year at regular intervals, which enabled effective performance management.
- Continuous professional development (CPD) needs were identified during this process and linked to the training matrix which tracked when CPD activities were due and completed.
- All appointed staff were clear about their roles and had demonstrated criteria specified in job descriptions specifications detailing the requirements for each role.
- All staff involved with providing the service had been Disclosure and Barring Service checked.
- All staff followed an induction programme to enhance their knowledge, skills and abilities.
- The senior nurse for training and development discussed training needs and arranged a training plan with each staff member.
- We found that new staff were buddied until they felt safe and competent and their mentor was satisfied for them to work alone and were unable to enter a patient's home until they had completed moving and handling training.
- We were advised all new staff underwent an initial six-month probationary period with a three-month interim review.
- All staff underwent annual peer supervision. Support worker supervision was undertaken by a registered nurse.
- Training needs were identified through the appraisal process and regularly reviewed and recorded on a training matrix.

Multi-disciplinary working

- We spoke with partners services and were advised that Tynedale Hospice at Home maintained effective and frequent communication with community nurses and Macmillan nurses. Verbal and writted communication was shared on a daily basis.

Seven-day services

- Tynedale hospice at home services were available seven days per week, 24 hours per day.
- New referrals were not accepted at the weekend due to potential lone working risks.

Access to information

- All staff and volunteers used a secure hospice email addresses to communicate with each other and the office base. The service also utilised an encrypted messaging system to relay information between staff and the office base.
- All care staff had access to advice whilst working in the community. This was provided by the care office who consulted with the community nursing team, the traceability nurse (co-ordinator) and the out of hours service.

Good

End of life care

- Drivers and family support volunteers could contact the care office for advice during office hours and they were all aware that they could contact the care office for debriefing at any time.
- All registered nurses and health support workers had access to patient records in the home which included care plans, and risk assessments.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
- We saw that where Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were in place this had been discussed with patients, their families and relevant healthcare professionals. A DNACPR is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. This meant the service involved and enabled people and their families to fully contribute to advance decisions about their end of life care through sensitive, respectful discussions.
- We saw that emergency care plans and DNACPR paperwork were held in a yellow envelope in the patient's home so they could be easily seen.
- Four patient files we reviewed a current and complete care plan that set out their advanced care preference and had a current advanced decision in place.

Are end of life care services caring?

Good

Our rating of caring stayed the same. We rated it as **good.**

Compassionate care

- We saw the friends and family test (FFT) survey results showed a 40% return rate (12 out of 30 completed forms). The friends and family test is an important feedback tool which supports the fundamental principle that people using the service should have an opportunity to provide feedback on their experience.
- The FFT highlighted that 11 out of 12 respondents were 'extremely likely' to recommend the service with one patient 'likely' to recommend the service.
- The feedback received from people using the service, relatives and healthcare professionals was positive.
- One feedback card said, "we went through our loss together with the help of Tynedale hospice at home. The comfort they gave us was very helpful".
- Another patient said, "we are extremely fortunate to have had access to such a life changing resource in Tynedale and will never forget the difference the hospice has made to our lives".
- We spoke with a family member who told us that all staff were "extremely respectful" and "supportive". Another said they "treated my husband with such respect".
- A community nurse we spoke with told us the service was "absolutely invaluable".

Emotional support

- Relatives told us that Tynedale hospice staff provided bereavement support on an individual basis or as a family, including children. The service had two rooms available for adult and child pre and post bereavement support.
- At the time of our inspection, there were 44 adults and 24 children receiving bereavement support.
- We found the childrens bereavement room to be an appropriate environment for young people. The children's bereavement room contained a TV so that the children could watch films about how children deal with grief. The videos were used to initiate conversations about their feelings. There was a pack of 'feelings cards' where the children could select a card appropriate to how they were feeling, a Jenga game with statements relating to grief for the children to respond to, cuddly toys and stress sticks which the children could hold whilst they were talking should they wish to. In addition to this, the room had grief bowls which were used to explain to the older children how grief initially seems all consuming but as time goes by it takes up a lesser part of their lives.
- We heard feedback that staff made patients 'feel safe and secure' and how 'patients trusted the team'.

Understanding and involvement of patients and those close to them

Good

End of life care

- All patients had an assessment by a registered nurse at the first visit. The patient or their representative gave written consent to the care plan being shared with key professionals involved as necessary.
- We spoke to patients and relatives who advised us that senior nurses contacted them on a weekly basis to identify if needs had changed to ensure the appropriate member of staff was allocated, for example whether to send a registered nurse rather than a support worker.
- Any specific patient requests about how they wished their needs to be met were documented in the nursing and office notes.
- Staff invited carers to assist and/or participate with care if they wished.
- We were informed by family members that the Tynedale hospice at home team always took time to understand patients and spent longer with those patients struggling to speak.
- We also heard examples of family member being listened to and their concerns or needs being heard.

Are end of life care services responsive?

Good

Our rating of responsive stayed the same. We rated it as **good.**

Service planning and delivery to meet the needs of local people

- Staff provide the senior nursing staff with their availability for work at the beginning of every week. This was entered onto a spreadsheet. The registered nurse care coordinator matched patient care with available resources. We found that staff resourcing was linked to financial planning and risk management.
- A standardised referral system was in place which followed traffic light guidelines (green, amber and red, red being priority) with a fast-track referral offered if the patient is near the end of their life.
- Tynedale hospice at home sought the views of stakeholders regarding their needs and used their feedback to plan the service. In addition to this, focus groups were held to gain client and patient feedback.
- We saw that the service engaged with community health services; linking with other partners such as the palliative care partnership group.
- Tynedale hospice at home monitored service demand trends from previous years to plan resourcing for the following year. In addition to this, an ongoing recruitment program was in place to ensure the service could meet demand.
- We saw that the service had identified future improvements such as to provide support to patients in the community earlier in the palliative care journey. This was being incorporated into the plans for the new care strategy
- The service has been requested by stakeholders to increase work with people with a broader range of needs, for example Chronic Obstructive Pulmonary Disease(COPD), Motor neurone disease (MND), and dementia.

Meeting people's individual needs

- All patients had an individual assessment and an "about me" section which identified and documented any significant people involved in the patients care. Any specific patient requests about how they wished their needs to be met were also documented in the nursing and office notes.
- Complex care needs or vulnerabilities were identified at the first care assessment and on the risk assessments.
- Any reasonable adjustments were made in conjunction with community staff as they were the primary care provider. Any issues regarding mental capacity were highlighted at time of referral and documented.
- Training opportunities were offered to the team regarding dementia awareness. It was those staff who were prioritised to provide care for patients with dementia.
- Training opportunities were provided for palliative care for people with learning disabilities.
- Tynedale hospice at home had access to the Big Word translation services. This included sign language translation. There was no evidence of leaflets being available in a range of languages. Any difficulties with communication were identified at the initial risk assessment and the appropriate person contacted to assist.

Access and Flow

- A community nurse advised us that the service was "responsive to new referrals within a matter of hours". Recruitment was driven by trend analysis of demand for services.

Good

End of life care

- The ratio of registered nurses and health support workers was monitored by the head of care services to ensure the available skill mix was relevant to the categories of patients referred to the hospice. We were advised that the service only provided care if appropriate staff were available.
- Care staff provided their availability for work two weeks in advance to enable the nurse co-ordinator to schedule patient visists accordingly.

Learning from complaints

- The Tynedale hospice at home service had received 19 compliments and no complaints between April 2017 and October 2018.
- We saw that there was a complaints policy in place and the target for resolving complaints was 20 days.
- Any concerns raised would be sent to the line manager or head of care. Contact with the complainant would then be made within 48 hours (unless extenuating circumstances prevented this) to acknowledge their concern and attempt resolution. The person raising the concern would be contacted a second time and informed of any follow-up action.
- Patients were informed of ways to complain and all information was provided in a pack prior to care being delivered.

Are end of life care services well-led?

Good

Our rating of well-led improved.We rated it as **good.**

Leadership

- The head of care services (registered manager) had been in post since July 2016. The chief executive officer commenced post in October 2018.
- We were advised that senior managers practiced an open-door policy and encouraged staff to raise any concerns promptly.
- Senior managers advised that democratic discussions took place between senior manager and employees. Examples were provided of changes made because of employees raising concerns, such as meeting times being inconvenient resulting in poor attendance.
- The service trustees chaired sub-committees for care, finance, governance, human resources and community engagement, as well as income generation and marketing. Feedback from the sub-committes was distributed by the chief executive officer.

Vision and strategy

- The provider had a mission statement which was "easing the end of life journey for people in our community". Through discussion with patients and relatives, and staff, it appeared that the mission statement was imbedded across the organisation.
- Tynedale hospice at home's vision and values were co-produced with the assistance of staff (including zero hours workers) and stakeholders, alongside the quality framework. These values were for staff to be caring and compassionate, professional, trustworthy, accountable, positive and to have a can-do approach to delivering care.
- Patient and client feedback was sought and the service held focus groups with ex-service users to enable development of the service. Immediate action was taken when shortfalls in care provision were identified.

Culture

- The service equality and diversity policy covered all protected characteristics such as age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, pregnancy and maternity. Reasonable adjustments were made when required.
- A whistleblowing policy was in place and senior staff actively encouraged staff to raise concerns or issues.
- We found there was an emphasis on support, fairness, transparency and an open culture.
- There were no allegations of bullying or harassment within the organisation.
- We were advised by external partners that communication and information sharing was very good within the service.
- We spoke with staff member who informed us that the senior team were a "fantastic, supportive team", and that "nothing was too much trouble".

Governance, risk management and quality measurement

Good

End of life care

- Care service provision was on a one to one basis and patient centred. This was formalised in the use of the well-established Roper, Logan & Tierney model of nursing care. Staff regularly attended updates on current practice issues and other areas of interest.
- A quality framework was in place which set out how Tynedale hospice at home ensured safe, effective, caring, responsive and well led services were provided.
- Staff attended external meetings locally to share learning and improve their knowledge, for example, the palliative care partnership forums and hospices North East study days.
- We found that the community matron attended the nurse meetings by agreement or when there was a significant event to discuss. The community matron also updated the team of any changes to community documentation or strategies.
- Trustees had oversight of all Tynedale hospice at home activity and met as a board to review activities and the corporate risk register bi-monthly. The risk register was also regularly reviewed by the senior management team.
- Responsibility for care service oversight was delegated to the sub-committee that met regularly to review service data and included a former general practitioner, a former senior nurse and a practising NHS senior nurse manager, along with the Tynedale hospice at home CEO and head of care.
- Day to day operations were led by the CEO who supervised the head of care. The CEO and other senior managers met and communicated regularly with colleagues from other North-East hospices via the collaborative network to discuss cross hospice working and potential development and to share experience and learning.
- Care team meetings took place regularly so that staff could share learning from training and to identify and resolve problems collaboratively. Any learning or improvements were shared with the hospice North East collaborative. This provided assurance that the hospice at home did not work in isolation.
- Internal communications included a bi-monthly newsletter distributed to staff, volunteers and trustees. In addition to this the CEO provided fortnightly updates for staff regarding changes to practice, feedback from trustee meetings and any relevant news.
- We found that quality assurance checks ensured that the training matrix was kept up to date. This meant that the provider had a robust system in place to monitor staff training.
- We saw minutes of team meetings which covered a multitude of areas including training and development, duty of candour, feedback, community matron updates, General Data Protection Regulation(GDPR), friends and family test results and patient reviews. The minutes were not comprehensive but had recorded the key points in a bullet format with outcomes / action points.
- We found that all policies were in place, appropriate and in date. Most policies had been reviewed in 2017 and were due for review again in 2019.

Engagement

- The service stated it was committed to supporting and valuing staff by giving staff a voice at meetings and one to one discussions with the chief executive officer.
- Staff were proactively supported and encouraged to provide feedback to enable service improvement via group and individual supervision, which led to frequent improvement of services.
- Service evaluation questionnaires were included in all patient and client introductory packs.
- A post box to collect feedback from the local community had been placed in a local health centre as a trial and will be rolled out if successful.
- The hospice website provided the opportunity for any members of the public to provide feedback about all services.
- Family bereavement support services collected qualitative and quantitative data.
- A focus group was held at the beginning of 2019 involving former clients who had experienced bereavement.

Learning, continuous improvement and innovation

- Tynedale hospice at home provided examples of ongoing change made by means of feedback from staff meetings and individual meetings with the chief executive officer. One example related to changing meetings from day time to evening to maximise attendance.
- Clinical audit programmes were monitored during one to one meetings between the head of care and chief executive officer.

Good

End of life care

- There were plans in place to upskill the recently appointed senior nurse / quality lead, in registered manager skills, abilities, and experience.
- A dedicated learning and development budget allocation was linked to appraisal personal development plans to enable proactive continuous professional development.
- The service was in the process of obtaining assistance from an external source in creating a more robust data analysis system for monitoring the qualitative data they collect.
- The service continues to involve staff, volunteers, and stakeholders in strategy planning and development of the new strategy which aims to be implemented in 2019.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that relevant National Institute for Health and Care Excellence guidelines and quality standards are embedded for example, QS13 End of life care for adults, NG31 Care of Dying Adults in the Last Days of Life. Good practice was followed but not all staff new which guidance they were following. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9.