Care Quality Commission

Kate's Home Nursing

Kate's Home Nursing

Inspection report

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

Ratings

Overall rating for this location	Inspected but not rated	
Are services safe?	**Inspected but not rated**	
Are services well-led?	**Inspected but not rated**	

Summary of findings

Overall summary

We carried out a focused inspection following information of concerns we had received. The concerns related to the use of some medicines used at the end of a patient's life, encouraging unnecessary hospital or hospice admissions against the dying persons wish, assessment of some patients to ensure funding is given to Kate’s Home Nursing and encouraging patients and their families to leave money to the service. The concerns were investigated thoroughly during the inspection, and we found them to be incorrect and therefore not proven.

We followed up on the requirement notice issued at the last inspection around governance arrangements and found this had been addressed.

As this was a focused inspection of Kate’s Home Nursing, we only inspected parts of 2 key questions: safe and well led. We did not inspect effective, caring and responsive.

Our inspection had a short announcement of the evening before to enable key staff to meet with us.

We have not rated this inspection due to this being a focused inspection.

- Patients had a comprehensive assessment on referral to the service and all assessments were reviewed and updated on each visit.
- Staff had access to a shared record keeping system with other health care professionals to enable them to be kept up to date with the patient’s condition. This system was secure and only authorised staff had access.
- Staff monitored medicines used and were able to administer certain medicines for symptom control.
- Governance systems had been implemented since our last inspection to monitor service provision. Feedback from patients’ families was all very positive about the provision of the service and staff.

Summary of findings

Our judgements about each of the main services

Service	Rating		Summary of each main service
End of life care	**Inspected but not rated**		We did not rate this inspection. • Patients had a comprehensive assessment on referral to the service and all assessments were reviewed and updated on each visit. • Staff had access to a shared record keeping system with other health care professionals to enable them to be kept up to date with the patient's condition. This system was secure and only authorised staff had access. • The service monitored the use of medicines well. Records were detailed up to date and staff had easy access to them. • Leaders ran services well using reliable information systems and monitored these systems to make sure patients received safe care to meet their needs.

Summary of findings

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Summary of this inspection

Background to Kate's Home Nursing

Kate's Home Nursing is a registered charity set up to provide hospice at home care for patients in the last stages of illness. They provide end of life care and hospice nursing at home for patients who have expressed a wish to be at home. All palliative nursing care was provided free of charge and paid for from charitable funds. The service received support from some funding from a statutory source but had to raise most of the funds.

The service's team of registered nurses provides specialist palliative care for patients and support for their families.

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

- Treatment of disease, disorder or injury.

The service has a manager registered with CQC.

The last inspection was on 17 November 2021. It was rated as requires improvement overall.

How we carried out this inspection

Three inspectors visited this location to follow up on the concerns we had received. This involved looking at 4 patient records and records pertinent to the service. We spoke with the registered manager, nominated individual and 1 coordinator.

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.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
End of life care	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

End of life care

Safe	Inspected but not rated
Well-led	Inspected but not rated

Is the service safe?

Parts of safe were inspected but not rated.

Assessing and responding to patient risk

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

Staff completed a full assessment of each patient's needs following their referral to the service. This assessment was reviewed regularly, including after any incident. We were shown records of initial assessments for 2 patients. These covered several areas and included mobility and their environment, nutrition, and elimination. To ensure assessments were regularly reviewed, the shift checklist had questions formulated to ensure staff had reviewed and updated all risk assessments at their visit.

Staff shared key information to keep patients safe when handing over their care to others. Staff made sure they handed over to the coordinators all key information about each patient following each visit. A record was made of this information in the shared computerised system used for patient records. This was then shared with other health care professionals involved in their care.

Shift changes and handovers included all necessary key information to keep patients safe.

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 notes were comprehensive, and all staff could access them easily. For most of the patients', staff from this service and other health care professionals had access to a computerised system for the management of records. This meant all staff who were involved in the patient's care could access all records relating to the patient and there were no delays in the exchange of information. The service covered several areas which had different NHS trust providers, this meant not all patients had computerised records. For those who did not have computerised records paper records were used.

Records were stored securely. All staff had a specific log on for the use of the computerised system and could access the system from their devices.

Medicines

The service had systems and processes to administer medicines safely.

Inspected but not rated

End of life care

Staff followed systems and processes to administer medicines safely. Staff explained medicines were administered to end of life patients living in the community against prescriptions recorded on the area wide end of life prescription chart. We were told nurses from this service would only administer one off immediate single doses of prescribed medicines. Their nurses would monitor syringe drivers set up by nurses from other services.

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

Staff completed medicines records accurately and kept them up to date. Staff explained when administering medicines this was recorded on the paper end of life prescription chart in the patient's home. Staff showed us the duplicate administration records they also recorded in the patients' electronic records. Staff from other providers were authorised to access the patient's electronic records. Staff from other providers had access to the different sections depending on the access agreements.

Staff stored and managed all medicines and prescribing documents safely. Staff explained how their staff and the staff from other providers undertook balance checks of medicines in the patient's home.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts and incidents to improve practice.

The service ensured patient's behaviour was not controlled by excessive and inappropriate use of medicines. Staff described occasionally the administration of medicines or the setting up of syringe drivers were delayed if patients wanted to discuss their wills or estate with solicitors or other legal professionals. Staff ensured they were not present if this took place.

Is the service well-led?

Inspected but not rated

Parts of well led was inspected but not rated.

Governance

Leaders operated effective governance processes, throughout the service. Staff at all levels had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective structures, processes, and systems of accountability to support the delivery of the strategy and good quality, sustainable services. These were regularly reviewed and improved. At the last inspection we issued a requirement notice for the service to maintain and strengthen an effective system of governance, assurance, and audit to assess, monitor and improve the quality and safety of the services provided. We found at this inspection this had been addressed. The service shared with us their audit programme for each year. They also had several meetings where service performance was discussed, for example, the trustee meetings and the quality risk and governance meetings. We were sent minutes of some of these meetings.

This was a focused inspection, and we reviewed the audits that were pertinent to the concerns raised. One concern related to patients having unnecessary admissions to hospital or hospices, but who wanted to die at home. The service

sent to us following the inspection their preferred place of death audit for April 2022 to March 2023. There were 103 deaths and of these 93 were in their preferred place of death. For the 10 deaths that were not in their preferred place the service had monitored where the patient had died and the circumstances for change of location. For example, 1 patient had been admitted to a hospice for symptom control but had deteriorated and died in the hospice.

Audits were completed on the care records completed on the computerised system. We were sent 5 audits of records. Areas for good practice had been identified as well as areas for learning. Where staff had not completed all, for example, risk assessments, feedback was shared with all staff.

Learning from incidents was shared with staff. We were shown 2 significant events staff had been involved in. One was where staff from Kate’s Home Nursing had identified an error with the recording of medicines. This involved other providers, and the service worked with these providers to identify the error. As a result, changes were made the template for recording of quantities of medicines for Kate’s Home Nursing staff. The learning from this was shared with staff, and the shift checklist was introduced to help staff complete all the required tasks relating to record keeping.

Feedback from patients, families/carers was used to monitor service provision. Senior staff shared with us some of the ‘thank you’ cards they had received. We also saw 3 feedback questionnaires from families. These were all very positive about the care and support they received. One had raised some issues with the delivery of equipment. We understand this was fed back to the provider who delivered the equipment.

Staff did not encourage patients or their families to leave donations to the service. Senior staff told us they did not ask patients or their families for donations. If they wanted to give a donation to the service, by leaving money in their wills or following their funeral, information was available on their website. We were shown records of donations which included the source and the amount. We were told about an incident where a patient wanted to make changes to their will, whilst the nurse was present. We were informed the nurse left the patient before this took place and reported it to senior staff.