

Hospice at Home Carlisle and North Lakeland

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Inspection report

Valley Court
Barras Lane, Dalston
Carlisle
Cumbria
CA5 7NY

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17 May 2018
29 May 2018

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Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

Summary of findings

Overall summary

This inspection took place between 16 and 29 May 2018 and was announced. This was the first inspection of the service since it registered to a new address in April 2017.

Hospice at Home Carlisle and North Lakeland is a registered charity which provides 24 hour nursing services to people in their own homes who are suffering from a life limiting or terminal illness. It also provides occupational therapy, physiotherapy, lymphoedema, complementary therapies and bereavement services.

People felt safe and comfortable with the staff who provided the service. Staff were clear about their responsibilities to identify any risks or concerns so that these could be addressed to safeguard the people who used the service. Staffing was based on the current needs of people using the service. Sufficient time was allowed for visits so that people's care was not rushed.

The service was effective at providing care to people in their own homes. A range of planned and reactive services were provided by skilled, experienced nurses and healthcare assistants. A training strategy made sure all staff received mandatory and specialist training relevant to their role.

There was good communication across different teams within the service so that people received an holistic range of services and therapies to support their care. The service also worked well with a range of other health care services to make sure people received co-ordinated care and support.

People, relatives and other care professionals were unanimous in their positive praise of the caring, compassionate support provided by all the staff. This included nursing, care and office staff. People were treated with respect and dignity. People were provided with personalised care that was specific to their needs. They felt fully involved in discussions about their care and said staff listened to what they wanted. Where people were receiving end of life care the service worked within nationally recognised best practice guidelines to make sure people received compassionate, dignified support.

The culture and values of the service were paramount to individual staff members and were embedded in the organisation as a whole. Staff felt "valued" and "privileged" to work for the service that made a difference to people's lives.

The service was very well-managed and organised, with a structure that provided staff with leadership and support. Good governance arrangements were in place with clear lines of accountability and continuous drive towards new initiatives and development.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

People felt safe and staff knew how to report concerns.

Risks to the safety of people and were assessed and managed.

There were sufficient staff to provide support for the current number of people and this was kept under review.

Is the service effective?

Good ●

The service was effective.

People's care needs were assessed and monitored to make sure they received the right support across all departments in the service.

Staff were well trained and competent. They were supported in their continuous professional development.

The service worked well with other healthcare services to support the physical and emotional health care needs of people.

Is the service caring?

Good ●

The service was caring.

People and relatives felt staff were kind, caring and compassionate.

The service made sure people were given plenty of time to be supported in the right way and visits were not rushed.

People said they were treated with dignity and respect.

Is the service responsive?

Good ●

The service was responsive.

The service acted quickly and flexibly to provide care at the right time to suit people's individual needs.

The service worked to national recognised best practice standards in end of life care to make sure people were comfortable and to uphold their dignity.

The service had a complaints procedure and people said they would have confidence in this if they had an issues.

Is the service well-led?

Good ●

The service was well-led.

The registered manager was very experienced and qualified to run this service. They reported to a board of trustees.

There were robust governance systems in place to make sure the service continuously developed and there were strategies in place to ensure its sustainability.

Staff felt valued and supported in their roles.

Hospice at Home Carlisle and North Lakeland

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place between 16 and 29 May 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because the location provides a domiciliary care service. The inspection was carried out by one inspector.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC. Notifications are reports about changes, events or incidents that the provider is legally obliged to send us within the required timescales. We contacted local authority commissioning teams, as well as 12 health and social care professionals for their views about the service. These included district nurses, discharge liaison co-ordinators, clinical nurse specialists and social workers.

During the inspection we spoke with four people and four relatives about the services they received from Hospice at Home Carlisle and North Lakeland. We spoke with the registered manager, clinical lead, senior staff nurse, an occupational therapist, a lymphoedema nurse specialist, a bereavement counsellor, four health care assistants, two patient co-ordinators, the HR manager and the chair of the trustees. We also contacted 15 other nursing and care staff by email for their views.

We looked at eight people's records. We examined the recruitment, supervision and training records for four staff members and training records for the staff team. We also looked at the organisation's governance systems including audits, meetings and incident analysis.

Is the service safe?

Our findings

People told us they received safe care and treatment from the service. One person commented, "I feel safe with them – they're very good at their jobs." A relative of a person who used the service told us, "Me and my [family member] feel so at ease with them. We feel safe and very reassured by them." People and their relatives described the service as "excellent" and said they had "no concerns".

Staff were provided with regular training in safeguarding procedures. Safeguarding was discussed as a standard agenda item at monthly clinical meetings. Staff also had written direction about safeguarding guidance in the staff handbook. In discussions staff were fully aware of their responsibilities to report any concerns and to safeguard people who used the service. There had been no safeguarding concerns about the service in the past year.

When people were referred to the service initial information was gathered about the person including an overview of any risk factors associated with their care and aids or equipment used. Any identified risks were addressed to keep people safe during their care delivery. Lone working and consideration of other possible hazards which could affect staff were also assessed to make sure their safety was maintained. Health care assistants were instructed to text the office before they set off to make a visit and when they reached home.

The people who used service told us they felt there were enough staff to provide the support they required. One person commented, "They always come when they say they will and before they go we always make another appointment together for the next time." Another person said, "We arranged it so they come sometime in the morning. It doesn't matter exactly what time because they stay as long as we need them. If I need to make any changes to the visit I just ring and they arrange another visit to suit us."

Staffing levels were monitored on a daily basis and were flexed accordingly. People described how they were offered extra visits or respite breaks for their main carers whenever there was additional staffing available. The organisation had recently used an audit of 'unmet need' to determine whether there were sufficient staff employed and had increased staffing as a result. The audit was to be repeated on a six monthly basis. There was an on-call system overnight so staff had access to management support throughout the day and night.

Some external health care professionals felt the service did not always have enough staff to provide 'double-up' calls, that is where a person might need two members of staff to support them with their mobility needs. However, the service was specifically designed to provide palliative care and was willing for its health care staff to work alongside care staff from social care agencies to provide double-up support if necessary.

The provider had safe recruitment procedures in place when employing new staff. Applicants had to submit an application before being shortlisted for a formal interview with senior staff. Background checks included references from previous employers and a Disclosure and Barring Service (DBS) check. DBS checks help employers make safer recruitment decisions by reducing the risk of unsuitable people from working with

vulnerable people or children.

In a small number of cases references had not been taken up from the current employer. In one instance references were character-based and supplied by a former colleague rather than a supervisor or employer. The HR manager was able to describe the rationale for this but this was not recorded on the personnel file for future reference.

The service did not routinely support people with medicines except where people may need overnight support with 'just in case' medicines. (These are medications for end of life symptoms that are prescribed by a doctor in advance so that they are already available in case they are required.) The nurses who provided overnight palliative care would administer these. We saw written confirmation to show that the nurses had up to date training in using syringe drivers. Any other medicines would be managed by the person, their relatives or district nursing services.

The organisation had robust infection control policies and sought advice from infection control nursing services to ensure these met required guidance and best practice. There were two infection control leads on the staff team who took responsibility for ensuring good hygiene practices were met. There was a cleaning protocol in place for all equipment stored at the service offices. For example, mobility equipment was deep cleaned every three months. Staff were provided with personal protective equipment, such as gloves, and completed hand hygiene training and checks at monthly staff meetings.

Debriefing sessions were held over any specific events, were recorded and any lessons learnt were shared with the staff team. For example, a recent debrief related to the emotional effect on staff members of the death of a person they had cared for. The service provided end of life care to many people and it was natural that staff could become affected and bereaved by this. The service offered counselling and complementary therapy sessions to staff that helped them to cope, and consideration was given to each staff's rota so they did not only attend to one person.

Is the service effective?

Our findings

Referrals to the service could be made by health care professionals such as GPs and district nurses, or by people or their relatives. People's needs were assessed and their care service was based on their individual preferences as well as current best practice guidance. A senior staff nurse carried out an assessment of each person's care needs before the support arrangements were put into place. This meant the service was able to check whether that the service was appropriate for the health care needs of each person.

Hospice at Home Carlisle and North Lakeland worked to national recognised best practice standards. These included Gold Standards Framework (optimising care for all patients approaching the end of life) NICE guidance (quality clinical care of dying adults in the last days of life), and NHS England Northern England 'Deciding Right' principles (helping people make emergency or end of life care healthcare decisions in advance).

Staff had training, supervision and support to be competent in their roles. People said staff were skilled and well equipped. They felt their care and treatment was delivered in an effective way by well-trained staff. One person commented, "They know what they're talking about. Everything they've done for me has helped me feel better." Another person told us, "I feel very confident in their skills and abilities. They are very professional." A relative said, "They are competent, medical professionals and the service is excellent."

Staff told us, and records confirmed, they received training in mandatory health and safety subjects including moving and assisting and infection control. New health care assistants had to be experienced and have already achieved a national recognised care qualification. All staff completed induction training and worked alongside established staff before they could start lone-working. One staff member commented, "I had three weeks shadowing which was great. That included the chance to go out with an occupational therapist and physiotherapist as well. I didn't have to work solo until I felt ready."

The service had a clear training strategy that ensured staff were trained to the latest best practice principles. A new training development meant that all staff now had intranet access to a wide range of training topics offered through an e-learning programme. Training was also accessed from external sources, including courses on dementia awareness, and 'Sage and Thyme' (supporting staff to advance their communication skills with people who were distressed). Nurses had access to NHS training so kept up to date with clinical competencies, palliative care training and specialist health care conditions. All staff received regular supervision and an annual appraisal to support their continued professional development.

The service provided palliative healthcare which did not routinely include support with eating and drinking as this could be provided by relatives or social care agencies. However, where any issues were identified, people were signposted to other services such as dietitians and speech and language therapists.

It was evident there was very good collaboration between different staff teams and different elements of the service. For example, people who received palliative care might also be referred internally by staff to the lymphoedema or occupational therapy services wherever they required this additional support. Staff told us

the communication was "very good" across all departments in the organisation. The nurses and healthcare assistants provided handovers following their visits and reported any important changes in people's needs to the office so this could be updated on the EMIS system. This meant other health professionals had access to information about the progress of a person's well-being.

The service had very good links with the NHS and other healthcare providers, and promoted coordinated care for people. The service was part of a multidisciplinary group which held meetings to share information and collaborate with other health professionals. Daily referral meetings were held with the local hospice service. The service carried out clinic services at local community hospitals across the county. The lymphoedema specialist nurse carried out supervisions of nurses at two other independent hospice services in the county. The service also provided placements to student nurses and provided end of life training to the university. This collaborative work helped to support best practice and sharing of new developments.

People's consent was explored at the initial assessment stage, although this related more to sharing of information. People's consent to their treatment was reported within other healthcare professional records, for example district nursing notes and on the EMIS system (electronic patient records) which was accessed by all healthcare professionals.

All the staff we spoke with said verbal consent to receive the care and treatment was sought before every care intervention, and this was confirmed in discussions with people who used the service. Staff had training in the Mental Capacity Act 2005 (about people's capacity to consent) and were mindful of people's rights to decline any support. We discussed how consent could be made more explicit on the service's own records where this had been discussed with them at the time their plan of care was being recorded.

Is the service caring?

Our findings

All the people and relatives we spoke with were extremely positive in the comments about the caring nature of all the staff who worked for the service. For example, one person told us, "They have been fantastic. They are such lovely people. They go the extra mile for you. They are always so helpful, nothing is too much trouble and they've done so much to help me." Another person told us, "I have nothing but praise and compliments for them. They are all excellent and we are so lucky to have such great care." Another person told us, "They are a genuinely nice bunch of people."

A relative told us, "I feel so at ease with them and they are uplifting. We have lots of lovely chats and laughter. My [family member] is the patient but staff feel more like good friends to me."

People felt staff were very kind and compassionate and supported their emotional as well as physical needs. A relative commented, "They are very good with both of us – they are comforting and reassuring." Another person told us, "They are very considerate towards me and my [family member]."

People told us they felt fully involved in making decisions about their care. People receiving support from health care assistants told us they were encouraged to decide what they need from the staff at the time of each visit so they are the decision-makers about the service they receive. For people receiving the occupational therapy or lymphoedema services their treatment plans were agreed with them after their assessment and were discussed with them at every visit. For example, one person said, "They include me in all discussions about my treatment and they tell me how I'm progressing, so I'm fully involved."

People made many positive comments about how staff treated them with dignity. For example, one person commented, "They treat me with the greatest respect." A relative told us, "They are wonderful in every way with my [family member], and they are so nice with them. They've always got time to talk and they always ask how I am as well as my [family member]."

People described the positive impact of the service on their well-being and independence. For example, one person commented, "They've done so much to help me be more independent. They used to make me a cup of tea when they came, but now I can make them one and it's because of their help."

Staff also felt the service was 'caring' towards them and all the staff we spoke with told us they received emotional support from colleagues. For example, one staff member told us, "They're all very supportive and lovely to work for. If I'm worried about anything they are all very helpful." Another staff member commented, "Everyone is lovely. The [supervisors] always make sure you're alright and would come out and help if necessary."

External health care professionals also expressed many positive comments about the caring nature of the service. These included, "the care is compassionate" and "caring – yes, the care given by hospice at home is of a very high standard".

Is the service responsive?

Our findings

People felt they received a service that was tailored to their specific needs. Some people used several aspects of the service, for example, palliative, lymphoedema and occupational therapy support. They told us the service responded quickly to any changes. For example, one person told us, "It's an excellent service. They provide the care I need and change it as and when my needs change." Another person said, "They've done so much just for me. They tried various pieces of equipment to help me until they found the right thing just for me."

Palliative healthcare staff predominantly worked to care plans for people which had been devised by the district nursing service. If the district nursing service was not involved with a person, the service devised a plan of care. The occupational and lymphoedema staff developed an individual treatment plan with each person and these records clearly demonstrated people's involvement in their own care planning.

Healthcare staff described how they were provided with detailed verbal information about the individual support needs of each person they were to visit. The written assessment forms in the office included information about people's current physical, emotional, cognitive and spiritual situation. Staff told us they felt they had enough information to carry out what each person expected of them. Staff also commented they were hoping to start developing a 'This is Me' type record. This would provide a concise profile of people's specific communication skills and preferences.

Healthcare staff described how they always asked people, and their carers where appropriate, what they would like support with as soon as they arrived. They put people at the centre of the care they provided and listened to what people wanted. One person told us, "They see what we need. They noticed I needed more time and support and they provided it. They make sure I am as well as I can be and they make my life as easy as they can."

Staff told us the flexibility and responsiveness of the service meant they could spend more time with a person if they needed it during a visit. A relative commented, "They arranged the visits to suit us. Whatever my [family member] needs that day they do it. They never rush in or rush out. They always take their time and I'm so grateful to them."

One of the service's main aims was to enable people to be cared for at the end of their lives in their own homes, where this was their preference. All staff were trained in palliative care and in dignity and privacy. All the staff we spoke with were clear about their role in helping to make sure people died in comfort and in dignity. The service provided bereavement counselling and contacted people after a short period to offer this support.

The relative of a person receiving palliative care told us, "They are very good with us both. They comfort me and talk to me. They are all very special." Another relative told us, "They were fantastically supportive when my family member died. They are excellent listeners and make all the time for you."

There was an information booklet for people who use the service about how to contact the service if they wished to discuss anything. At the time of this inspection the information booklet was being revised and the registered manager agreed this was an opportunity to include a summary of the complaints procedure and response times so that people would know what to expect if they had any concerns.

All the people we spoke with said they would have no hesitation about contacting the "office" about any issues. They told us care and office staff were "very helpful" and receptive. People and relatives felt confident that any issues would be listened to and acted upon. One person commented, "I can ring them or visit them in the office at any time. I would feel very comfortable if I wanted to raise something. They are very friendly and approachable."

We saw the service kept a complaints log that included any issues raised. The one complaint recorded had been responded to quickly and in a sensitive, empathetic way. We saw the complaint had been thoroughly investigated, a detailed written response had been sent to the complainant, and any lessons learnt were shared with the staff team.

Is the service well-led?

Our findings

The provider was a registered charity that was governed by a board of trustees. The chief executive and founder of the service was registered as the manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff in all departments commented extensively on the credible and supportive management of the service. Staff felt there was clear vision of the service and felt "privileged" to be part of an organisation that provided high-quality care and support that was valued by the people who received. One newer staff member commented, "This was always my dream job and now that I'm working here it has really lived up to my expectations." Another staff member commented, "It's the best job ever. There is something amazing about the care."

Staff were clear about the shared ethos and positive culture within all areas of the service. An experienced member of staff commented, "It's a very good organisation with a very good culture. They really look after the staff, so they can feel able to look after people." Another staff member told us, "I get excellent support from colleagues and from management."

People had been invited to give their views in a number of surveys, including the information booklet and this was currently being revised. A sample of people had been visited by trustees to seek their views about the service they received. The service was planning to explore the potential for the university to be involved in surveying and collating people's views.

Staff shared monthly clinical meetings together as well as quarterly joint organisational meetings. Trustees held four committees relating to workforce, health, safety and well-being, finance and income-generation and clinical assurance. Some staff commented that they did not know the trustees, which was at odds with the collective cross-working between the rest of the staff teams.

The service used a number of audits to test its quality and effectiveness. These included, for example audits of the response time in relation to the time taken from referral to the care provision and allocation of night time service. The organisation kept a log of any risk-related incidents that affected the service of staff, such as accidents. Action plans with timescales were in place where any remedial action was required to reduce the risk of reoccurrence. Incident reports were checked and reported to the relevant committee and collated into an annual report for board of trustees.

The service had a strategic five year plan 'More Care, More People' setting out its plans for development and sustainability from 2015 to 2020. The service continued to contribute to accredited initiatives in palliative care and delivered end of life training to other providers. An external community health service commented, "The service provided by Hospice at Home remains a valued part of palliative care in the community alongside many other services".

