

Hospice at Home Carlisle and North Lakeland

Hospice at Home Carlisle and North Lakeland

Inspection report

c/o Eden Valley Hospice
Durdar Road
Carlisle
Cumbria CA2 4SD
Tel: 01228603208
Website: www.hospiceathome.co.uk

Date of inspection visit: 19, 21 and 22 October 2015.
Date of publication: 16/12/2015

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 

Overall summary

This inspection of the Hospice at Home Carlisle and North Lakeland took place over three days 19, 21 and 22 October 2015. This was the first comprehensive inspection of the service following its registration in October 2014.

Hospice at Home Carlisle and North Lakeland (the service) is a registered charity providing 24 hour nursing

and personal care services to people in their homes who are suffering from a life limiting or terminal illness. The service operates from offices with The Eden Valley Hospice.

The service aims to provide care and support to adults who have palliative and end of life care needs and also for their families and carers.

Summary of findings

The hospice at home service provides a nursing service, occupational therapy and a Lymphoedema service. [Lymphoedema is a chronic condition where excess fluid is retained in the tissues causing a painful swelling]. There is a complimentary therapy service provided that includes massage, Reflexology, Reiki, aromatherapy and breathing and Yoga techniques. [Complimentary or 'holistic' therapies are therapies that aim to treat the whole person, not just the symptoms of a disease]. There is also a family support service and a bereavement care service available. All services are provided free of charge.

The agency had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People using the service and their relatives told us they had "confidence" in the skills of staff and that staff were "caring" and "professional". People said their privacy was respected and told us they made choices that suited their care needs and personal preferences.

Staff had been given training in recognising abuse and how to report any possible abuse or poor practices. The service provided staff with a broad range of training relevant to their roles and they were kept up to date with all training needs and supported in keeping their knowledge and skills updated. New staff had been given structured induction and mentoring in their roles. Training was given a high priority in the organisation and staff were encouraged to fully develop their skills and knowledge.

Effective staff recruitment systems were in place and these ensured that only applicants who met the service's job specifications regarding qualifications, experience, character and caring abilities were employed. There were registration and security checks done to make sure all staff were still suitable to work with people in their homes.

Regular supervision and annual appraisals were used to support staff in their work. The staff and management team used reflection and incident analysis to help them make changes to improve the care and support they gave so that they responded quickly to a person's needs. All accidents and incidents were recorded and analysed to allow for lessons to be learned and appropriate steps be taken to prevent any recurrence.

The service worked very closely with the hospice and hospital palliative care teams, GPs, the Macmillan team, community nursing services, social services and charitable organisations. This helped to make sure there was smooth cross service working to provide appropriate care to meet people's different physical, psychological and emotional.

There were systems in place to assess and to manage risk. For example, to protect people from the risks associated with medicines, falls, pressure sores and moving and handling. For staff the lone worker procedures and risk assessments for work place stress and specific training needs helped keep staff safe as well.

Systems were in place for responding to concerns and complaints. Relatives told us they could raise any concerns or make suggestions and be listened to. Staff were also clear about how to raise any safety or practice issues with the management team and said they felt they would be well supported. Regular reviews of people's care were held and people were encouraged to take full part in discussing how their needs were being met.

The service had policies in place in relation to the Mental Capacity Act 2005 (MCA). The MCA provides legal safeguards for people who may be unable to make decisions about their care. We spoke with staff that showed a clear awareness of the importance of supporting people to decide for themselves about their care and treatments.

There were clear and effective systems in place to continually monitor the quality of the service being provided and to identify and implement areas for further service development.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

Systems were in place to protect people from the risk of abuse. Staff were aware of safeguarding adults' procedures and how to use them.

Safe recruitment practice was followed, which minimised the risk of appointing anyone unsuitable for the role.

Staff handled people's medicines safely.

Good



Is the service effective?

The service was effective.

Staff of all levels had access to on going training to meet the individual and diverse needs of the people they supported.

People's healthcare needs were being monitored and discussed with people who used the service and their family members.

People had access to appropriate health, social and medical support.

Good



Is the service caring?

The service was caring.

People who used the service and their family members spoke very highly of the care and support they received.

People were encouraged to be as independent as possible, make their own decisions and maintain control of their lives.

Good



Is the service responsive?

The service was responsive.

People and their family members had been involved in planning what they wanted in their care and making decisions about what was important to them.

The hospice had systems agreed with other community and medical professionals in place to ensure the continuity of care for people moving between care settings.

People's care needs were kept under review and staff had responded quickly when people's needs changed.

Good



Is the service well-led?

The service was well-led.

There was a clear management structure within the service. Clear governance and management strategies informed and involved people, their carers and stakeholders in service development.

Good



Summary of findings

The management team gave effective and innovative leadership and provided a clear strategy for the long term development of the service.

Staff told us the service was very well managed, that they were supported to develop and were valued by the organisation.

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.

The inspection was carried out by an adult social care lead inspector over three days 19, 21 and 22 October 2015. The inspection was announced as the registered provider was given 24 hours' notice because we needed to be sure that the appropriate people would be available when we visited.

The first day of the inspection was spent at the service's main offices in Eden Valley Hospice. We looked at the records held by the service, its policies and procedures, the assessments they carried out and the service's governance structures. We also spoke with a member of the board of Trustees, the registered manager, the lymphoedema specialist, the Senior Medical Officer based at the Eden Valley Hospice, two health care assistants, a care coordinator, two home nursing registered nurses, the Community Clinical Nurse Specialist in Palliative Care (CNS) and the social worker based at the Eden valley Hospice.

The second and third days of the inspection were used to speak with the family members of five of the people who were using the service at the time of the inspection and also with staff. We obtained the permission of people who used the service and their relatives to speak with us before we contacted them. Given the nature of the services being provided relatives provided us with information about the care, service provision and support being given. We also spoke with two people whose relative's had used the service and had been bereaved and three people who used the lymphoedema service.

Before the inspection we reviewed the information we held about the service, such as the statement of purpose for the service and notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. Before the inspection we sent questionnaires to people who received support from the service, their relatives and social, medical and health care professionals in the community who supported people who used the service. We planned the inspection using this information. We looked at all the information and survey responses we had received about the agency.

We asked the provider to complete a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They provided this information in good time.

Is the service safe?

Our findings

Relatives we spoke with of the people who used the service told us they felt this was a safe service. All the people who responded to our survey who used the service felt that the staff kept them safe. A relative told us “They do a great and very important job, it’s been a tremendous support and we have great faith in them”. We were also told “It can be such a relief to know [relative] is being cared for and is safe when I am not there”. Another relative said “It’s great that we can have the same staff coming”.

All the staff we spoke with understood their responsibilities to keep people safe at home and what they should do if they had concerns about someone’s safety. We saw procedures were in place for dealing with allegations of abuse. Training records we looked at showed that nursing and support staff had received training on safeguarding vulnerable adults. Staff we spoke with told us what they would do if they found anyone who might have been abused and knew which agencies this needed to be reported to.

We saw there were lone workers procedures in place to help keep staff safe in their work. There was an on call system so staff could get support and help in difficult situations. Staff told us that if they needed to stay with someone for longer than anticipated they contacted the service coordinator who could go out themselves to make sure the service continued to people uninterrupted. Staff told us “We don’t time our visits; we stay as long as we are needed and that might just be talking with someone who needs to do that”.

Relatives told us that they knew who would be coming from the service in advance and that “All the staff are good at what they do. We have a core team we are used to so we see the same people” Another relative told us “They are all very polite and professional and respect our home”.

We saw that the registered manager had arrangements and contingency plans in place to deal with foreseeable emergencies like bad weather and to cover any unplanned staff absences. Relatives using the agency told us that they were told if there were to be any changes to the group of staff who supported them.

The service had recruitment procedures in place. Staff and volunteers had robust recruitment procedures, which helped to make sure they were suitable to provide people’s care and support. We looked at staff recruitment files and saw that the appropriate checks of nursing and care staff suitability had been made including pre-employment health screening. Information about previous employment and employment histories were in the records. References had been sought and included the person’s previous employer. Checks had been made to ensure that nurses working in people’s home were registered with their professional body and fit to practice. All staff had records to show that Disclosure and Barring Service (DBS) checks had been conducted before commencing employment. It was the registered manager’s intention to renew staff Disclosure and Barring Service [DBS] checks at three yearly intervals. This was to make sure there had been no changes since the initial checks had been done.

We found that medication for people who used the service had been prescribed by their own GP’s, out of hours doctors or by the palliative care team. Registered nurses were responsible for advising on administration and for the safe disposal and the safe storage of prescribed medication. Medication was kept in the person’s own home and remained their property and there were risk assessments in place to help identify any potential risks involved with particular medications. There were agreed procedures in place for the use of as ‘required medicines’ and controlled drugs [medicines liable to misuse]. The medicines policy and current practice reflected current national guidance for the safe management of medicines.

Is the service effective?

Our findings

All of the family members of people being cared for by the service had only positive things to say about the service they had received. This included, “There is a wide range of staff skills” and “Very pleased with the quality of care” and “We have been delighted with the help we have received”. Another relative commented “Everything they have done for us has been well done”.

Staff told us they were well supported within the service by an informed and accessible manager who was available for them to speak to during the working day and there was an ‘on call’ system at night. Staff had received regular clinical and management supervision that had been documented and reviewed. Staff confirmed the records we saw and told us they had an annual appraisal that helped generate their personal development plans. These individual plans were to help identify individual learning needs for all staff and also made clear what the organisational needs were for staff as the service developed. New staff members had received a comprehensive induction to the service and to their role before they provided care to people in their homes.

The service had staff who could work at short notice or ‘bank staff’ to cover for unexpected absences. Staff told us “We have a bank and we will cover for each other, if need be then we would rally round”. There was a stable staff team within the service with very little staff turnover and low sickness levels. An audit had been recently carried out to try to assess areas of care where there might be unmet needs. This had identified that staffing levels needed adjustment and as a result two new health care assistants and two registered nurses had been recruited.

Records showed that training was kept up to date so all staff had access to training that promoted current best practices. Staff received mandatory training in Equality and Diversity, Safeguarding, Consent to Care and Treatment,

the Mental Capacity Act (including DOLs), information governance, infection control, moving and handling and dementia. Sage and Thyme Communication Skills Training (level 1) had also been added to mandatory training for all staff members to help promote effective and appropriate communication skills. A relative told us “Everyone is very professional”. We found that the service attended and participated in best interest meetings relating to people they supported who might not have mental capacity to make decisions.

Staff told us that their understanding of procedures and practice was considered during their informal as well as formal management supervision and at clinical team meetings. We found that staff had been supported to attend non mandatory training events and the service linked with

external training providers for aspects of training and other agencies such as Cumbria Voluntary Service and local NHS. Registered nurses told us they were well supported to maintain their clinical skills and to prepare for revalidation with the professional regulator.

The service had policies in place in relation to the Mental Capacity Act 2005 (MCA). The MCA provides legal safeguards for people who may be unable to make decisions about their care. We spoke with staff that showed a clear awareness of the importance of supporting people to decide for themselves about their care and treatments.

Nutritional assessments were carried out by the district nurse as part of their care planning for people and the two services worked together to monitor and evaluate nutritional needs. We saw that nursing and care staff had received training on maintaining nutrition and hydration and issues around nutrition and hydration for people with palliative and end of life needs. This enabled them to provide support and information to people and their families on understanding the place of nutrition at the very end of life.

Is the service caring?

Our findings

All the people we spoke with who had used the service praised the caring approach of the staff and managers at the service. We were told by family members that the service had been “Absolutely invaluable in helping us have a more normal life” and also “We have got to really know them well and them us, so we feel that they really do care and are interested”. Other comments included “They (staff) are very efficient and caring” and “Really excellent care and kindness”. They told us they were introduced to staff who would be coming to their homes and that their views on the support given by these staff had been sought.

All the families we spoke with who used the service told us their loved ones privacy and dignity was respected and it was their choices that staff worked with. We were told that staff respected family and carer knowledge and “Take notice of my suggestions”. All the staff we spoke with told us about the importance of having a good relationship and “mutual respect” between them and the people they cared for and that this was at the basis of their supportive relationship. Relatives told us they had confidence in the staff that came to help them and one said “They [staff] respect [relative’s] privacy and are cheerful and friendly with them, puts you at ease”.

We talked with the senior medical officer from the Eden Valley Hospice who had worked closely with the service as people were discharged back home after a stay in the Eden Valley Hospice. They told us that The Hospice at Home Carlisle and North Lakeland was a “very caring organisation” and that they had “very high standards of care”. They spoke of how they had found the service to “sensitively” handle difficult situations. Specialist palliative care community nursing staff we spoke with told us “They do go the extra mile and do work well with other community services and across boundaries to get the care people want”.

Staff working across the organisation we spoke with were proud to work for the organisation and showed a great commitment to supporting people and making a difference to their care and quality of life. Staff we spoke with knew the people they were supporting well and their different

individual and family situations, needs and preferences. Staff demonstrated knowledge of people’s different specific needs and ‘champion roles’ had been introduced to support and inform both staff and people using the service and their relatives.

Information on advocacy services, support services and advance care planning was also included in the information given to people. An advocate is a person who is independent of the service and who can support a person to share their views and wishes if they want that help.

The service was in the process of starting a ‘befriending’ service. Following a ‘gap analysis’ of the services it had been found that sometimes people just needed a helping hand and friendship not purely nursing or personal care. For example a day out or attending a special occasion that people just needed a companion to be with them and help them access their community. This helped make sure resources were well used to make sure people got what they actually wanted and needed to make their lives better.

A ‘patient support group’ had also been started to continue care and support for people beyond the community care service provided and promote more social involvement with others. People using the service had asked for a more social and educational aspect to care. A member of the hospice home nursing team attended so people could ask questions and get any information they might want. We were told by staff that 40 people had attended the first session and at the next session they were doing some practical sessions to help empower people in their own care and promote control and independence coping with their illnesses.

We looked at the minutes of a debrief meeting with staff and saw how the service had helped and facilitated practical arrangements for people to be able to do something that was important to them. This could be a journey or trip to a significant place. We saw these had been successful but staff had also used the events for learning for the future to avoid possible problems and make it as smooth as possible for people. For example one area the service now investigated more thoroughly was how local medical support systems operated when someone travelled to another area.

Is the service responsive?

Our findings

Relatives told us that the hospice home nursing team responded quickly when people needed them. One relative told us “The service has been a tremendous help to us, we have certainly appreciated the way they have risen to every challenge in doing this very important job”. We were also told “We have been delighted with the way it has worked for us and that we have been given all this help”.

Relatives told us they knew how a complaint could be raised and had been given information on this in the information given to them by the hospice when they started using the service. We were told “We have not needed to make a complaint thus far but I do make comments from time to time and these have always been well accepted, which is useful”. Another told us “I know how I could make a complaint but have not needed to. Without exception everything has been as we wanted it”. We were told people using the service and their families could express their views and were involved in making decisions about all aspects of their care.

The service had a complaints procedure that was made available to people they supported and their family members. All the relatives we spoke with said they had been given a copy of the complaints procedure when they had started using the service. Compliance with the complaints process was monitored through reviews and the audit process. Concerns, complaints and compliments were recorded and any complaints were addressed in line with the service’s complaints policy and the necessary actions taken. All incidents were reported back to the Assurance Group and the Board of Trustees for monitoring.

The Hospice at Home Carlisle and North Lakeland had a website which provided information about the service and the different types of support offered. When people accessed the service they said they had been provided with a welcome pack which provided further details of the type of care and support they could expect to receive and how they could make a complaint.

An assessment had been undertaken with each person referred to the service. Their care needs were identified and recorded in a shared record with the District Nursing service. Hospice at home staff followed the district nursing care plan and that included all other nursing risk assessments.

Patients and carers confirmed they had been asked about their care preferences and how they wanted the home nursing service to support them. Individual wishes in relation to expressed preferences and choices about treatment and support in relation to end of life care were recorded in a person’s care plan, and via EMIS, the electronic patient record system. This is a system that allows healthcare professionals to record, share and use vital information, so they can provide better, more responsive care

Any health professional could make a referral and people who had been referred had on going involvement in their care from a range of community services which included Macmillan nurses and community district nursing teams. Relatives we talked with told us that that once referred they could contact the service when they felt they needed to.

Risk assessments had been undertaken in relation to potential and actual risks and palliative care needs. The assessment for home nursing and support was made by the clinical services manager, the senior staff nurse or registered nurse. Part of that assessment was to establish whether the person needed the skills of a health care assistant or for more complex care, a registered nurse.

People who used the service, their families and other professionals had been involved in the risk assessment process. They told us that they had a copy of the service’s risk assessments and a summary of care. These were kept in people’s own homes and a copy at the service’s office. Staff told us they communicated with other professionals, such as GP’s and hospital staff to ensure people’s current risks were shared.

We spoke with one of the two care coordinators who told us about how they worked to make sure that people using the service and their families got the care they wanted. That care might be personal care or a block visit so that a carer could have some free time away from the home. We were told “We explain that as things change what is provided can change, we want them to know it’s led by them”.

We spoke with senior medical officer from the Eden Valley Hospice that worked closely with the hospice at home service. They told us about their daily joint meetings with the service where they could discuss and plan for discharges into the community. The meetings were also attended by the hospice staff, occupational therapists, the

Is the service responsive?

MacMillan nurse, social worker and also the chaplain. The hospice at home service also provided care and support for people and families through its lymphedema nursing service, occupational therapy and the complimentary therapies for patients and families and also family support and bereavement support. This was a holistic approach to providing care and support as all teams were involved and everyone could be clear about what was needed from them.

The hospice social worker told us that they worked alongside the hospice at home staff and found they were accessible and open and always had the time to discuss people's care needs and that communication between the services was good. We were told that it was "valuable" having such a specialism available in the community. We were told that as the hospice at home service worked alongside care agencies that could be providing general support and they "spread their skills to them" so generalist staff gained a better understanding of certain conditions.

Is the service well-led?

Our findings

Everyone we spoke with had positive things to say about the way the service was organised and run. People whose relatives received support from the service told us “The management has always been very helpful and sensitive to our requirements” and “Management is very good, very responsive and helpful whenever we have spoken”.

There was a clear management structure within the service. The service had a registered manager in place as required by their registration with the Care Quality Commission (CQC). The staff we spoke with were aware of the roles of the management team and told us the registered manager, senior staff and trustees were approachable and available to speak with should they want to. Staff commented that the management had an “open door” at any time and the organisation was “open and transparent”.

We were told also that staff would recommend them as an employer and that they were provided with all the resources they needed to carry out their work. More than one staff member told us that they felt the organisation cared about them and their welfare and how much they enjoyed their work and morale was high. All staff we spoke with told us they had a commitment to providing a good quality service for people who they supported. We spoke with the senior medical officer from the Eden Valley Hospice who told us that the expansion of the community service had been well planned and that the increased workload had been “Very well and successfully managed”.

The provider had systems and procedures in place to monitor and assess the quality of their service. These included seeking views of people they supported through satisfaction surveys and care reviews with people and their family members. Questionnaires had been sent to a sample of people regarding their experience of the first visit they received from the service.

We saw that across the service there was a programme of auditing and information gathering. This included records, care documents and auditing clinical processes and looking for unmet needs that needed to be addressed. The hospice governance structure included a board of trustees and a trustee attended the team meetings to represent the

board and have a clinical governance perspective on the items being considered. We spoke with a member of the trustees who was very involved in the general running of the service and in supporting staff

The provider had systems in place to identify, assess and manage risks to the health, safety and welfare of people who used the services offered. Risks were reported back to the Assurance Group and Board of Trustees for monitoring. Records reviewed showed the service had a range of quality assurance and clinical governance systems in place. For example audit analysis was being used to assess any unmet needs for people the service cared for in the community with occupational and physiotherapy services. Also a hosiery measuring clinic had been started for people who used the lymphoedema service after an audit of outcome measures for lymphoedema identified the need.

The service received clinical and equipment safety alerts and the information from these were passed onto staff via team meetings. We saw that team meetings took place on a monthly basis and the minutes were recorded. These included debriefing for staff on incidents and a consideration of any incidents under clinical governance and a policy of the month. We saw that staff had attended the organisation’s annual general meeting and were represented at committee level in the organisation. We were told by staff “There is excellent leadership, at our meetings we discuss strategic as well as care issues and the chair of trustees comes so we are all involved and all work together”.

Following a staff audit with the National Association for Hospice at Home (NAHH) staff had been surveyed to find out what their needs in relation to bereavement training. As a result a tailored training programme was delivered by Cruse (a charity that focuses upon people who have suffered a loss) and an action plan developed to address the needs identified within the NAHH national audit. The NAHH is the representative body for Hospice at Home services in the United Kingdom and works closely with Help the Hospices and other national organisations to raise the profile of hospice at home and identify and spread best practice in end of life care. The service’s quality monitoring systems and proactive and forward thinking approaches meant that risks were identified and managed and systems were in place to help the service to continually improve and develop.