

Tynedale Hospice at Home

Tynedale Hospice at Home

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

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

Overall summary

Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good 	Our rating of this service stayed the same. We rated it as good. See the summary above for details.



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. The care service employed 10 registered nurses, (of which four were also care coordinators), two deputy heads of care (one for nursing and one for family support), four hospice support workers, and a team of 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 13 people receiving care and support from the service.

The new head of care services was in the process of applying to be the CQC registered manager.

The service is registered with the CQC to provide:

Treatment of disease, disorder and injury

How we carried out this inspection

We visited the service's administrative hub and spoke with staff delivering services. We held interviews with service leads. We spoke with 11 staff including the chief executive, head of care services, a care coordinator, a deputy head of care, registered nurses, hospice support workers, a human resources manager and administrative staff. We also spoke with five relatives of patients who had been cared for by the service and carried out a home visit where we spoke with one patient and their relative and observed the care provided. We reviewed data about the service and reviewed five patient care and medicines records.

We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach.

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>.

Areas for improvement

Action the service SHOULD take to improve:

- The service should continue with actions already underway to develop the use of patient outcome measures and clinical audits to include qualitative, as well as quantitative measures.
- The service should ensure that key performance indicators are used to demonstrate the responsiveness of the service and how quickly patients are seen following referral.






Our findings

Overview of ratings

Our ratings for this location are:

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

Hospice services for adults

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

Are Hospice services for adults safe?

Good 

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

Mandatory training

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

Nursing staff received and kept up-to-date with their mandatory training. We reviewed training records and found that most staff had completed all their mandatory training. Two staff were 94% compliant and the rest were at 100%. Those modules overdue were by a few weeks and time had been scheduled for completion.

The mandatory training was comprehensive and met the needs of patients and staff. Modules included basic life support, fire safety, infection control and moving and handling.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff completed equality, diversity and human rights training. In addition, they received training in autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. A training log was maintained, and staff were scheduled time to complete training modules. Compliance was above 90% for all staff.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. All staff had received training to safeguarding level two for both children and adults. Care coordinators, deputy heads of care and the head of care services were trained to level three. The head of care services was the safeguarding lead and was scheduled to complete level four safeguarding training. There was also an identified member of the board of trustees responsible for safeguarding.

Hospice services for adults

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They had received training in protecting patients with protected characteristics. Staff had a good understanding of their responsibilities in relation to protected characteristics. The hospice's equality and diversity policy detailed clear responsibilities in relation to equal access to services and care for all people with protected characteristics, including disabilities, age, race, sexual orientation and gender.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff worked closely with GPs and district nurses to coordinate care for patients. They knew how to make a safeguarding referral and who to inform if they had concerns. They had access to a 'one call' number and email to contact the local authority team in the event of safeguarding concerns.

Cleanliness, infection control and hygiene

Staff used infection control measures when visiting patients in their homes.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff using PPE in line with guidance. Staff had care packs for use when visiting patients in their own home, this included personal protective equipment, such as face masks, gloves, aprons and hand gel. Staff had received 'donning and doffing' training in relation to the use of PPE and the service had policies in line with COVID-19 guidance.

Staff cleaned equipment after patient contact, and they followed local NHS infection control policies in relation to clinical waste. Compliance against infection control principles were monitored through supervision processes. Prior to the COVID-19 pandemic care co-ordinators undertook audits in patient's home, however, during the pandemic the service implemented a peer review process outside of the line management structure in order to reduce contact within patient's homes. This included monitoring of hand hygiene and use of PPE. Results showed 100% compliance with infection control principles when caring for patients in their homes.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them.

The care environment and equipment were assessed as part of initial and ongoing risk assessment processes. This included checks of accessibility and risks within patient's homes. Equipment was provided and risk assessed through the district nursing teams. Staff told us they could easily request additional equipment and moving and handling assessments and plans were carried out by district nurses or community occupational therapists working for the local NHS provider.

The service had enough suitable equipment to help them to safely care for patients. Syringe drivers (to provide continuous medicines) were provided by the district nursing team and appropriate checks were in place.

Staff received training in the use of equipment and as part of this they were assessed for their competency. This included moving and handling equipment and syringe drivers.

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.

Hospice services for adults

Staff completed risk assessments for each patient following referral. In addition, they followed risk assessments and care plans established by district nurses caring for patients in the community. Staff knew about and dealt with any specific risk issues. This included pressure area care, prevention of falls and nutritional needs and planned care relating to the assessment findings so that they kept risks to a minimum.

The service used a traffic light rating system to identify the patient's status in relation to palliative and end of life care. This helped staff to prioritise care based on patients' needs. Patients' identified within the red category were likely to be in the last days of life, amber meant they were likely in the last weeks and green they were likely in the last months to year of life.

Staff shared key information to keep patients safe when handing over their care to others. They used tablet devices to record their assessments and evaluations and these were shared with the care coordinators following a patient visit. Care coordinators ensured that information was shared with other staff caring for the patient and care records were kept in the patient's home. Information was handed over to staff internally, and to other professionals involved in the patient's care as necessary. This included sharing information with district nurses and GPs if a patient was identified as deteriorating.

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

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. We reviewed staff recruitment records and saw that all staff had appropriate checks prior to employment. This included nurses, support workers and volunteers who were subject to checks such as satisfactory references and Disclosure and Barring System (DBS) checks.

As well as the head of care there were two deputy heads of care, one for nursing and one for the family support service. There were four care coordinators who were all registered nurses. In addition, the service had a team of bank registered nurses and hospice support workers. They employed 12 registered nurses and four hospice support workers. Bank nursing and care staff were asked to commit to a minimum number of hours a month and worked varying hours depending on patient need. For example, one nurse told us they had a minimum level of 20 hours a month but usually worked 30 hours a month. Managers told us that the bank registered nurses had substantive positions in end of life care within other services in addition to working extra shifts at Tynedale Hospice at Home. The service had longer term plans to create more substantive posts, including a 28 hour a week nursing post recently recruited to as part of plans to expand the service.

The managers could adjust staffing levels daily according to the needs of patients. Because of the changing nature of the care requirements and the flexibility of the workforce, managers adjusted staffing levels based on the care needs at any one time. Because the service was a support service to other community services if they were unable to provide enough cover to care for patients on a day to day basis, they informed district nursing teams who were responsible for the care of patient's at home.

Hospice services for adults

The service monitored overall sickness rates for contracted staff within the service and these were at higher than average levels due to COVID-19. In 2021/22 there was an average of 4.9 days absent per contracted staff member which was an increase from 2020/21 when it was 1.15 days. Managers monitored absences and these were reviewed as part of governance meetings.

The service had stable rates of bank staff. All bank staff were subject to the same checks, training requirements and induction as those on contracted hours. Managers and staff told us the team of bank nursing and support workers was stable, with most staff having worked for the service for several years. Staff we spoke with were experienced and knowledgeable about providing end of life care in patient's homes.

Managers made sure all bank staff had a full induction and understood the service. This included working 'buddy' shifts as needed.

Medical Staffing

As Tynedale Hospice at Home was not a primary care provider in the community they did not employ their own medical staff. Medical support was sought through the patient's own GP or out of hours service. Additional specialist advice could be accessed through a local hospice 24 hour advice line.

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. Patient care records were held in patients' homes, with copies held at the office. We reviewed five care and medicines records during the inspection and found that these were well written with assessments and care delivery clearly recorded.

Risk assessments and care plans were routinely carried out. We saw that these included aspects of care such as communication, nutrition, breathlessness and manual handling, as well as clear records relating to end of life care.

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

Records were stored securely. Paper records were kept locked and only accessible to those staff involved in care.

Medicines

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

Staff followed systems and processes to administer medicines safely in patients' homes. Medicines were already prescribed by the GP and supplied by the community pharmacy. Tynedale hospice at home staff administered these medicines whilst they were looking after the patient if needed. Community nurses were also involved in administering the patients' medicines and there was a clear handover between staff involved in the patient's care including what medicines had been given.

Some people were receiving medicines by syringe pumps (medicines delivered through the skin over 24 hours) and staff monitored these pumps when they were caring for the patient and changed them if this was required. Staff knew how to raise and escalate concerns if there were problems with medicines or symptom control.

Hospice services for adults

Staff provided advice to patients and carers about their medicines.

During the initial care assessment, a full medicine history was obtained from both the patient and the community nurse records. A detailed care plan included administering medicines for symptom control. Regionally recognised paperwork from Northern England Clinical Strategic Network was used to record all administrations of medicines so that all staff included in the patients' care could easily see what had been given. Medicines administered were also recorded in duplicate on Tynedale hospice at home records. The regional paperwork gave guidance on the equivalent doses of opioids, what medicines could be mixed together in syringe pumps, and listed pharmacies that stocked end of life medicines. Balance checks were in place for any Controlled Drugs that staff were involved in administering.

Staff managed all medicines and prescribing documents safely. There was medicine policy in place however this did not mention where medicine administration should be documented and referenced NMC standards which were withdrawn in January 2019. Following the inspection the policy was updated to reflect the areas identified. It was due to be ratified at the August 2022 care committee meeting.

Staff learned from safety alerts and incidents to improve practice. Information was disseminated to staff for awareness.

There had only been one medicine incident in 2002, none in 2021 and three in 2020 where full learning had taken place. The service conducted audits to assess compliance with their own record keeping.

Relevant medicines training was undertaken by all staff and staff told us that the provider was responsive to providing training for any needs they identified.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. This included medicines errors and issues with communication that could have had an impact on patients' care. There had been no serious incidents within the service since the last inspection.

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

Staff met to discuss the feedback and look at improvements to patient care. Care support meetings were held monthly. Discussion about incidents and significant events were discussed and learning shared to ensure improvements were made.

There was evidence that changes had been made as a result of feedback. There had been four incidents between January 2021 and May 2022. One medication administration error that resulted in no harm to the patient was reviewed and changes made to the registered nurse's induction, including working shifts with their 'buddy' and a review of their competency.

Hospice services for adults

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations as appropriate. There were no themes or trends identified as part of a review of incidents.

Are Hospice services for adults effective?

Good 

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We saw that national guidance and evidence-based practice was central to the service delivered. Relevant National Institute for Health and Care Excellence (NICE) guidelines and quality standards were incorporated into the end of life and care after death policy. This included NICE quality standards QS13 End of life care for adults and QS144 Care of Dying Adults in the Last Days of Life. Nursing staff we spoke with had a good understanding of the NICE guidance, anticipatory prescribing and medicines guidance for patients at the end of life.

The service used the Northumberland 'care for the dying patient' document alongside other professionals involved in the patient's care at home. This was based on national guidance and included initial medical and nursing assessments and ongoing reviews of patient care which all staff, including hospice at home staff contributed to.

The traffic light assessment process used by the service to assess the end of life care needs of patients was based on the national Gold Standards Framework guidelines.

At part of handover processes, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff focused on the delivery of holistic care and in taking account of national end of life care guidance, placed equal importance on the psychological and emotional needs of patients and those close to them.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. Staff provided support and advice to patients and those close to them on meeting nutritional and hydration needs. They worked closely with GPs and community nurses to ensure that needs were met and ensured specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it.

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

Hospice services for adults

Staff provided mouth care to patients at the end of life in line with national guidance. For example, we saw that discussions were held about current Royal College of Nursing (RCN) guidance on mouthcare. This included ensuring that staff were aware to use a silicone mouth cleanser rather than foam sponge swabs.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Hospice at home nurses administered pain relief as required and in line with prescriptions from the GP. Syringe drivers (an electronic pump providing medicines continuously), used to provide medicines to manage pain and other symptoms at the end of life were primarily managed by the community nursing team. Hospice at home nurses checked syringe drivers as part of their assessment and provided additional support in the event of a syringe driver needing to be changed or re-sited. All nurses had received syringe driver training and undertook annual competency assessments.

Staff administered and recorded pain relief accurately. They used shared medicines records from the Northern England Clinical Strategic Network that were available to all members of the multidisciplinary team in the patient's home. This ensured that when pain relief or medicines used to control other symptoms were administered all staff involved in the care could see what had been given, including community nurses not working for the hospice. Duplicate administration records were maintained by hospice staff to ensure records of administration by hospice employed staff were held by the provider.

Nursing staff we spoke to demonstrated a good understanding of anticipatory prescribing (where medicines were prescribed for use later as symptoms progressed) and the use of medicines in end of life care. They used comprehensive assessment processes to identify when pain relief was required, including non-verbal expressions of pain.

Patient outcomes

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

Patient outcomes were reviewed on an individual basis as part of their ongoing evaluation of care. This included an evaluation of both the patient receiving care and those close to them in relation to respite and bereavement support.

The service did not use a recognised patient outcome tool at the time of our inspection, however, they were reviewing the Outcome Assessment and Complexity Collaborative (OACC) suite of measures. The OACC measure supports the evaluation of the effectiveness of care through measurements of a patient's health status because of interventions of care. We saw plans in place to complete a review and potentially implement the measures in the latter part of 2022.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. There were assurance audits in place including those relating to record keeping and an evaluation of patient and family feedback. 'Live' supervision audits focused on an evaluation of staff members' approach to care and other safety measures. There were plans in place to develop a new audit programme later in 2022 with a greater focus on quality indicators.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Hospice services for adults

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. A range of training had been provided by service managers, including talks from external professionals. Examples, included symptom management, Motor Neurone Disease (MND), Parkinson's disease, spirituality and a talk by the coroner.

Managers gave all new staff a full induction tailored to their role before they started work. Induction processes were well organised and structured to the needs of the individual staff member or volunteer. They were adapted to role being undertaken and included relevant training and a buddy system to ensure new staff and volunteers were appropriately supported.

Managers supported staff to develop through yearly, constructive appraisals of their work. We saw records that showed all care staff had received an appraisal in the last year.

Managers supported nursing and support staff to develop through regular, constructive clinical supervision of their work. Care staff had access to group supervision facilitated by a qualified supervisor. An audit of supervision attendance showed 50% of staff had attended a minimum of four sessions in the last year. The audit aimed to identify any barriers to supervision. It identified that many registered nurses also received supervision in their primary roles and maintained reflective accounts of their work as part of their Nursing and Midwifery Council revalidation. Feedback from the audit was shared with staff with an aim to develop different approaches and reduce any barriers to access. Managers supported staff to access supervision and gave staff time to reflect and debrief on any difficult care situations.

Care coordinators carried out 'live' supervision sessions, working alongside staff delivering care. They focused on professional development and acted as a practical process to support staff, monitor effectiveness of care provision and identify potential risks for staff and patients. Aspects of care such as effective communication, record keeping, compliance with policies and demonstrating a compassionate approach were included in the process.

Managers supported the learning and development needs of staff. We saw that additional training staff completed included advance care planning, end of life care, the assessment of spiritual wellbeing, dementia and autism awareness.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff were required to attend 50% of the monthly care meetings held within the service. Minutes of meetings were shared, and staff received additional information from a monthly bulletin sent by the chief executive officer.

Managers identified poor staff performance promptly and supported staff to improve.

Managers recruited, trained and supported volunteers to support patients in the service. Recruitment processes included checks to ensure that volunteers were appropriate for the role. Roles included family support, driver and retail positions. Volunteers were supported by the volunteer leads within the service.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Hospice at home staff attended multidisciplinary meetings linked to GP practice and community nursing teams when patients at the end of life were reviewed. There were strong links with other service providers and staff communicated daily with other professionals involved in patients' care.

Hospice services for adults

Seven-day services

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

Tynedale Hospice at Home provided services in patient's homes 24 hours a day, seven days a week. Activity was planned based on individual patients needs.

Health promotion

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

The service had relevant information promoting health and wellbeing. This included advice and support on nutrition, pain control, social, emotional and spiritual needs. Staff cared for patients using a holistic approach and regularly monitored patients' wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients were unable to be involved in decision about their care staff discussed care and treatment with those close to them. This included in relation to 'do not attempt cardiopulmonary resuscitation decisions' (DNACPR). DNACPR records were held in patients' homes where all staff involved in their care had access to them, including records of wishes and preferences about treatment.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. They recorded discussions about care and treatment, and we observed staff speaking to patients in a way that they could understand their options. Staff made sure patients consented to treatment based on all the information available.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. They worked with members of the multidisciplinary team to do this, including community nurses and the patient's GP. Staff clearly recorded consent in the patients' records.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This was monitored by managers and we saw that compliance with training completion was 100%.

Staff had received training in advance care planning, where patients near to the end of life discussed their wishes with staff so these were recorded. This meant that patients wishes were evident to all staff if the patient was no longer able to be involved in care discussions.

Are Hospice services for adults caring?

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

Hospice services for adults

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff caring for patients and those close to them with compassion and taking time to listen and understand what was important to them. Staff developed a good rapport with the patients they were caring for. They were discrete and respectful in their interactions.

Patients said staff treated them well and with kindness. Relatives of patients cared for by the service consistently told us that staff were caring and supportive. They spoke of the time staff took to provide the care that was needed, and the respectful and compassionate approach demonstrated throughout the Tynedale Hospice at Home care team.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. One relative spoke of the calm manner staff exhibited when caring for a patient with dementia, which they said helped to minimise the disorientation the patient felt when receiving care.

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

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff we spoke with had a good understanding of the holistic needs of patients and those close to them. The hospice provided a bereavement support service to both adults and children. This included support prior to and following bereavement. Adults could access one to one support from family support practitioners, in addition to service provided small group support for specific types of loss. This included groups for people who had experienced the loss of a spouse and for those who had experienced the loss of a parent.

Family support practitioners offered an active listening service and provided books and workbooks for children, used to explore grief and provide support through the process. The family support practitioners also worked with specially trained volunteers to host after school clubs and activity days to provide support. Children's group activities were also facilitated so that children grieving the death of someone close to them could receive support in a group setting.

The bereavement service provided two bereavement cafes in the local community where people seeking support for a bereavement could 'drop in' and meet other people in similar circumstances and seek support from staff. Volunteers supported new participants who did not want to attend the bereavement café on their own.

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Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. They talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients and those close to them were encouraged to provide feedback about the service. This included the use of a Friends and Family Test survey. Care coordinators contacted all patients or those close to them on a weekly basis to ensure they had the support they needed. Staff adjusted the service provided based on these discussions. For example, if carers required additional respite or overnight stays, or if a patient required additional nursing visits.

Staff supported patients to make advance decisions about their care. As part of the initial assessment process nursing staff established if patients had existing advance decisions about their future care. In addition, staff supported patients to record information about their advance decisions this was used to plan and deliver care.

Patients gave positive feedback about the service. We reviewed results from the Friends and Family Test (FFT) patient survey and saw that 100% of patients surveyed stated they would be extremely likely to recommend the service to their friends and family.

We viewed feedback comments as part of the FFT. For example; 'Everyone involved was so professional and kind showing great compassion for the whole family', 'their skill and confidence and guidance saw us through our tragic loss. We will never forget them', and 'a comfort blanket of professionalism wrapped around you and your family when most needed'.

Are Hospice services for adults responsive?

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

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. They worked closely with other providers to ensure the service was designed to meet people's needs. Service leads had recently increased their contact with GPs and community nursing teams to establish closer working in planning and organising services. They also engaged with regional end of life care networks and local authorities to ensure they were identifying patients in need of support. A key aim of the service was to provide additional support for patients wishing to die at home. This included patients on 'rapid discharge' from hospital into the community in the last days of life.

The service had systems to help care for patients in need of additional support or specialist intervention. The service worked with commissioners to ensure provisions for patients with additional support needs. For example, they worked with a local authority as part of a mapping exercise of service for patients with dementia. This included contributing to

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service mapping within an older person's pathway group for Northumberland. Service leads demonstrated an understanding of the local community, including pockets of increased deprivation. They worked to match ethnic diversity within the staff and trustee teams to that of the local community to ensure representation in order to increase access to services for underrepresented groups within the community.

Managers monitored and took action to minimise missed appointments. Nursing and hospice support worker hours were planned on a weekly basis and adjusted to meet the needs of patients and those close to them. There were ongoing recruitment processes in place to ensure enough staff were employed, with flexibility to cover shifts at short notice when needed.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff had received training in supporting patients with poor mental health, those with learning disabilities and those with dementia. Service leads liaised closely with specialist services such as dementia care services to identify the needs of patients to ensure they could help patients access the service.

Staff supported patients living with dementia and learning disabilities by using personalised care plans and involving patients and those close to them in planning their care. This included advance care planning and working with those close to the patient to identify their preferences in relation to care, including when the patient was unable to be involved in discussions themselves. We viewed feedback from a relative of a patient with dementia who had been cared for by the service and saw that staff adapted their approach to take account of the patient's needs.

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

Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

Patients could access the hospice at home service when they needed it.

Managers made sure patients could access services when needed and received treatment and care as soon as possible. Staff and the provider gave examples of how they had worked to respond to the needs of patients including those in urgent need. Care coordinators had weekly meetings with community nursing leads within the area to discuss patients at the end of life who would benefit from the service. Service leads monitored referrals to the service. We saw that in 2021/22 there had been 215 referrals which was an increase when compared to the 117 referrals in the previous year. We saw that most referrals (90%) to the service came from community nurses or specialist palliative care nurses.

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The service did not have specific key performance indicators around the time taken to make contact with the patient following referral. However, they did monitor the referral to visit time for patients who had been 'fast tracked' from hospital. The aim was to see these patients within 24 hours of the referral, and we saw that service leads monitored and met this target. Staff told us they usually saw patients within a few hours of referral when their needs were more urgent and that patients were prioritised based on their care needs.

Managers worked to ensure that patients referred received the care needed. However, there were occasions when this was not possible due to insufficient staffing or the complexity of patient needs. We saw that in 2021/22 there had been 25 occasions where the service was unable to provide care. When this happened, the patient was referred back to the community nursing teams as the primary care provider in the community. In addition, staff worked to provide alternative care where possible. This included one occasion where care could not be delivered overnight, however alternative provision was put in place with a twilight shift of 7pm until midnight.

Service leads monitored the place of death of patients who died while being supported by the service. We saw that approximately 75% of patients died at home.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Information provided to patients and those close to them at the beginning of their care package about how to complain.

Staff understood the policy on complaints and knew how to handle them. The service complaints policy clearly set out the process to respond to complaints. Staff and volunteers knew to escalate concerns to their line manager.

Managers investigated complaints and identified themes. There were clear processes in place for monitoring trends and themes, however, there had been no formal complaints in the year prior to our inspection. Staff knew how to acknowledge complaints and there were processes for patients to receive feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints, concerns and compliments with staff and learning was used to improve the service.

Are Hospice services for adults well-led?

Our rating of well-led stayed the same. We rated it as good.

Leadership

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

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The chief executive officer and head of care services were the leads for the service. In addition, there were two deputy heads of care, one for the nursing service and one for the family support service. There were four registered nurses who shared care coordination responsibilities, ensuring there was a care coordinator on shift each day.

Service leads understood the priorities and issues facing the service and had developed plans to address these. Staff told us the leads were visible and approachable and that they provided support as needed.

Vision and Strategy

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

There was a clear vision and strategy for the service. The service mission was to ease the end of life care journey for people in the community and the vision was to ensure everyone in the community had access to the resources and care they needed to reduce the distress caused by life limiting illness or sudden death.

This service strategy been developed in collaboration with relevant stakeholders. We saw that 'away days' had been facilitated between senior staff and members of the board of trustees to review the direction of service provision. Priorities of the strategy included positioning the service to be more of a primary rather than secondary care provider and to focus on increasing referrals, including for patients identified as being disadvantaged and who may not typically access services. Work was underway to increase awareness of the service provided, both to professionals involved in end of life care and to the wider community.

Service leads engaged within the wider health economy, including end of life care networks and they contributed to discussions about local end of life care strategies.

We viewed a 2022-2023 business plan that included objectives for care services, funding and governance. These included priorities for expanding the service to provide care for more people in the community and increasing staffing to meet this need. Staffing priorities included increasing contracted care staff to ensure available capacity to meet any increase in referrals. We saw that action included the recent advertisement for a contracted nursing role to work alongside the current bank nursing provision.

Additional progress had been made to develop community partnerships and co-production of services with external providers. Examples included providing joint visits to patients in the community with local community nursing teams and working with local dementia services to better meet the needs of patients with dementia at the end of life.

We saw that business cases had been developed when new services were introduced. These were ratified by the board of trustees and included the implementation of a formal counselling service to work alongside the current 'listening' approach to support by practitioners. A further business case had been developed to provide a complementary therapy service.

Culture

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

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Staff told us they felt valued by service leads. They were focused on the needs of patients and those close to them. There was a positive team atmosphere and staff were flexible in their approach to meeting patient's needs. Nurses and hospice support workers were positive about their experience working within the service, telling us they enjoyed going to work.

The service had an equality and diversity policy and staff had received training. Service leads understood the need for a workforce that was representative of the community served. They had aims to increase the diversity of the workforce in line with the local community.

The service had a positive approach to enabling patients and those close to them to raise concerns. Staff and service leads were open to feedback and there were processes in place to provide support to those raising concerns and enable them to be involved in resolving them. Service leads were aware of the need for honesty and openness with patients and those close to them in line with duty of candour requirements. They encouraged feedback in a number of ways including by phone, email or in person. Staff told us they felt able to raise concerns should the need arise.

There were succession plans in place for care staff. This included ongoing recruitment to ensure that there were enough staff to deliver the service. Service leads were exploring the possibility of increasing staff working contracted hours in order to develop the service to work alongside other services within a primary capacity. There were limited development opportunities for care staff due to the nature of the provision, however, staff had access to training to enhance their skills.

The service had a staff wellbeing group and we saw that methods of supporting staff wellbeing were being developed. This included the provision of mindfulness meditation sessions.

Governance

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

There were effective governance structures, processes and systems of accountability and a clear governance framework to support the delivery of the hospice at home strategy. The hospice at home leadership team were accountable to the board of trustees. Service leads reported to the board of trustees through board papers submitted, including a regular care services report. Quarterly board agenda items included progress reports against the strategy, minutes of committee meetings, risk management, policy ratification and the quality of services.

Members of the board of trustees chaired the governance committee and the care committee and quarterly meetings were held. Governance committee meetings included a review of governance processes such as those in relation to recruitment and the management of information. We saw that issues around quality, risk and compliance were discussed at these meetings. Meeting minutes reviewed showed that issues such as clinical audit, training compliance and safeguarding were discussed at the care committee meetings. Hospice policies were reviewed by the governance committee.

Monthly senior management team meetings were held where strategic, operational and development issues were discussed, and full hospice staff meetings were held periodically. Care support meetings were held monthly and chaired by the deputy head of care for nursing. This meeting gave the opportunity for staff to feedback and make suggestions

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and these would be incorporated into the care services reports that went to the relevant committee and board of trustees. All hospice meetings were held quarterly to ensure that all staff and volunteers were aware of the performance of the Hospice and future plans. The chief executive officer produced a fortnightly bulletin for staff and volunteers, sharing information about committee meetings, priorities and service developments.

The hospice at home had a range of policies in place to help govern the service. We reviewed policies including safeguarding, complaints, equality and diversity, whistleblowing and the end of life care policy. We saw that these were up to date, had been reviewed in line with guidance and approved by the board of trustees.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The service had a risk register where risks were identified, including in relation to areas such as service provision, health and safety, standards of care, information governance and finance. Control measures and relevant gaps were identified as part of the risk management process. We saw that risks were reviewed as part of committee and board meetings and the register updated with progress measures. In addition, risks and performance were discussed in one to one sessions with departmental leads.

Risk assessments were carried out in relation to areas such as premises, patient visits and lone working. We saw that comprehensive lone working processes were in place. The service had a traceability policy in place and the care coordinators monitored where staff were and ensured that staff were safe.

There were arrangements in place to ensure the safety of volunteer drivers who took patients to hospital appointments and to undertake domestic activities. There were appropriate checks in place, and we saw there had been no incidents in relation to this.

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

Information Management

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

The service collected activity data and reviewed it as part of their governance and development processes.

Staff had up to date and comprehensive information about patient's treatment and care. They used an a regional 'care of the dying patient' record that was kept in the patient's home and used by all staff involved in the patient's care, including GPs and community nurses. The service maintained their own records, and these were shared with care coordinators following a visit using a tablet device so that records were also maintained at the office.

There were clear and standardised information governance processes that ensured the security of patient information. Computers and electronic devices were encrypted, and password protected. Paper records were stored securely, and we observed staff maintaining the confidentiality of patient records.

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Engagement

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

The service leads recognised that they needed to engage with stakeholders in order to develop their services. We saw examples of engagement with other providers including GPs, community nurses, specialist nurses and other organisations involved in end of life care. In addition, service leads had expanded their engagement to include more specialist services where there may be an element of end of life care support needed. This included dementia specialists and older people's services.

Senior staff attended local and regional meetings about end of life care and were members of relevant groups. This included the regional palliative care partnership, older people's pathway meetings and executive clinical leads in hospice and palliative care (ECLiPH). The hospice at home service was represented at the regional palliative and end of life network in relation the workforce strategy group, taking a lead role in developing the workforce of the future. A member of the board of trustees was a representative on the Hospice UK Advisory Council. The Chief Executive Officer represented hospices across the North East and Cumbria on the National Hospice UK Advisory Board.

Senior staff collaborated with partner organisations to improve services for patients. This included supporting another local hospice at home service to improve their governance processes and support for GP and community services to develop learning from incidences.

The service sought feedback from patients and those close to them about the service. Feedback from family members included that they wished they had known about the service sooner. As a result, service leads took action to engage more effectively with referrers and local networks to raise the profile of the service. This was done through structured meetings with community nurses and GPs. In addition, service leads actively participated in local network meetings to raise awareness and encourage earlier referral where possible.

We saw examples of the service engaging with staff and volunteers internally about the service. This included surveying care staff about the supervision process with a view to making this more effective. A 2021 staff survey showed that 90% of respondents considered that their line manager was approachable. Staff said they could see a clear link between their role and the vision and values of the Hospice, they felt proud to work for the Hospice and felt supported

We viewed minutes of a volunteer meeting that included engagement with volunteers about their role and potential development. We saw that volunteers were able to contribute their views and that these were incorporated into the future development plans.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

There were processes for continuous improvement and shared learning. There were a range of audits in place to provide assurance and action was taken to improve as a result. For example, a traceability audit monitoring lone working within the care team identified that calls relating to staff arriving at and leaving a patient's home were at 89% and fell below the required standard of 100%. We saw that findings had been shared with staff and discussed at relevant meetings. Enhanced reviews of the process were implemented to measure improvements.

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Incidents were reviewed and learning shared to make improvements. For example, actions following medicines incidents included additional training, supervision and competency assessment where required.

There were clear plans in place to develop the service to ensure it met the needs of patients and the local community. There were examples of the service looking at ways to improve the service and engage with other services and professionals to support this process. The service had recently successfully completed an assessment process to provide year two and year three student nurse placements from two local universities. In addition, there were plans to provide placements for medical students in year two and three of their training.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.