Shipston Home Nursing CIO

Quality Report

The Ellen Badger Hospital,
Stratford Road,
Shipston on Stour,
Warks. CV36 4AX.
Tel: 01608 664850
Website:www.shipstonhomenursing.co.uk

Date of inspection visit: 28 August and 25 September 2019
Date of publication: 27/11/2019

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Shipston Home Nursing (SHN) is operated by Shipston Home Nursing CIO. SHN provides end of life nursing care and bereavement services to patients in Shipston on Stour,Wellesbourne, Kineton and surrounding villages.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced visit on 28 August and 25 September 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

The main service provided by this service was end of life care services for adults.

Services we rate

This was the first inspection of SHN. We rated this service as good overall.

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

- Staff kept patients safe from avoidable harm and abuse. Risks were assessed, monitored and managed appropriately.
- Staff used safe working practices and followed risk assessments when providing care and support for people.
- Patients care, and treatment records were clearly detailed and accurate in content. They were stored securely and managed safely.
- Staff had the appropriate skills, training, knowledge and experience to deliver effective care and treatment. Care and treatment was delivered in line with evidence-based practice.
- People told us that staff were caring, supportive and respectful.
- The services provided aimed to meet the needs of people from their whole community, and the needs of the population served, which ensured flexibility, choice and continuity of care.
- Staff worked closely with hospitals, community organisations and health and social care professionals to help ensure people received the right care at the right time.
- People made decisions about the care and support they received. Care was person centred.
- The service was delivered and co-ordinated to be accessible and responsive to people with complex needs.
- Staff showed an encouraging, sensitive and supportive attitude to people who use services and those close to them.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced.
- Leaders were visible and approachable in the service for patients and staff.
- There was a strong emphasis on the safety and well-being of staff. Lone working policies were in date and appropriate.

Summary of findings

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

- At the time of our inspection, the service did not have a robust process in place to monitor audits.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Heidi Smoult

Deputy Chief Inspector of Hospitals (Midlands)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for adults	Good 	Shipston Home Nursing provides hospice care for patients in their own homes throughout the last days of their lives. We rated the service as good because staff used safe working practices and followed risk assessments when providing care and support for people. Staff were competent in their roles. They were caring, supportive and planned and delivered care according to individual patient needs. They worked in close collaboration with other healthcare providers to ensure people received the right care at the right time.

Summary of findings

Contents

Good

Shipston Home Nursing

Services we looked at
Hospice services for adults.

Summary of this inspection

Background to Shipston Home Nursing CIO

Shipston Home Nursing is operated by Shipston Home Nursing CIO. The service opened in 1997. It is a registered local charity in Shipston on Stour, Warwickshire. The service primarily serves the communities of Shipston on Stour,Wellesbourne, Kineton and surrounding villages. It supports people aged 18 and above with incurable (terminal) illnesses who wish to be cared for in their own homes.

The service has had a registered manager in post since April 2019. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The executive director and nominated individual were supported by a team of registered general nurses specialising in palliative care and a team of health care assistants. The team of staff worked closely with local GP's, district nurse teams and staff from a variety of organisations.

The service provided free of charge care thanks to supporters, donors and fundraising. In addition, the service received a grant from the NHS, which funded approximately 8% of their annual running costs.

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

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

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors and a specialist adviser with expertise in end of life care. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection (Midlands).

Information about Shipston Home Nursing CIO

The service has had a registered manager in post since April 2017 and was registered to provide the following regulated activity:

- Treatment of disease, disorder or injury.

Activity (August 2018 to July 2019):

- In the reporting period from August 2018 to July 2019 there were 138 patients cared for by the Shipston Home Nursing.
- Patients stored controlled drugs (CDs) in their own homes. The service did not have an accountable officer for CDs.

Track record on safety:

Summary of this inspection

- Zero never events
- Zero clinical incidents
- Zero serious injuries
- Zero complaints
- More than 100 compliments

There were no special reviews or investigations of the hospice ongoing by the CQC at any time during the 12 months before this inspection. This was the first comprehensive inspection of this service.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

This was the first inspection of this service. We rated safe as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- 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.
- Staff used infection control measures when visiting patients in their home.
- The maintenance and use of facilities and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- 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.
- 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.
- 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.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.

Are services effective?

Good

This was the first inspection of this service. We rated effective as **Good** because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients' subject to the Mental Health Act 1983.

Summary of this inspection

- Staff supervised and monitored food and drink to meet patients' 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 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 tools and gave additional pain relief to ease pain.
- Staff mostly monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- 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.
- Nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

However,

- We found the service carried out audits but did not have a robust system in place to monitor audit outcomes at the time of our inspection.

Are services caring?

Good

This was the first inspection of this service. We rated caring as **Good** because:

- Staff truly cared for patients with compassion. Feedback from all patients and those close to them confirmed that staff treated them well and with kindness.
- Staff understood the importance of providing emotional support to patients and those close to them. They understood patients' personal, cultural and religious needs.
- Staff always communicated with patients about their care and treatment in a way they could understand. Staff involved patients and those close to them in decisions about their care and treatment.

Are services responsive?

Good

This was the first inspection of this service. We rated responsive as **Good** because:

Summary of this inspection

- 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.
- 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.
- The service focussed on individual needs and goals in planning care for patents in the community.
- Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.
- 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.

Are services well-led?

Good

This was the first inspection of this service. We rated well-led as **Good** because:

- Leaders had the integrity, 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.
- The service had a clear 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.
- 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.
- 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.

Summary of this inspection

- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.
- 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.
- 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. Leaders encouraged innovation and participation in research.

Detailed findings from this inspection

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

Good

Hospice services for adults

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

Are hospice services for adults safe?

Good

This was the first inspection of this service. We rated it as **good**

Mandatory training

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

Staff undertook a system of annual mandatory training to ensure they remained suitably skilled for the role they provided. Mandatory training topics included the Mental Capacity Act, safeguarding children and adults, moving and handling, conflict resolution, infection prevention and control, equality and diversity, fire safety, basic life support and health and safety. The training was a blend of e-learning and face-to-face sessions. The service used external trainers to provide mandatory training.

Nursing staff received and kept up-to-date with their mandatory training. During our inspection we noted that overall compliance was 100%.

The mandatory training was comprehensive and met the needs of patients and staff. Staff received an induction to ensure they had the skills needed for their roles. The service ensured new staff could access the computer systems, and dedicated time to complete mandatory training.

All clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. The registered manager kept an up to date staff training matrix which planned and monitored training and development.

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. Staff we spoke with said they felt confident they could recognise patients at risk of harm or abuse and were able to name several different types of abuse. All staff said they would escalate concerns to the senior member of staff on duty which was in line with the safeguarding policy.

We found the proportion of staff involved in the care of patients were trained to safeguarding level one and two in children and adults was 100%. This was in line with the provider's target.

The nominated individual was the service safeguarding lead. They had completed level three safeguarding adults training and had access to a safeguarding level four trained person.

The service had a resource file which had been put together by the safeguarding lead. It provided staff with general information about who to contact, policies and procedures, training materials, assessments, guidance on mental capacity and best interest decision making. Staff we spoke with said they found this useful.

We reviewed a safeguarding concern record book which was used when staff had any safeguarding concern. We saw one episode of safety and wellbeing concern had been recorded and referred to the local authority safeguarding team.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff had an understanding of what harassment and discrimination was and knew what to do if a patient was subjected to either form of behaviour. As stated in the mandatory training section, staff had completed and were 100% compliant with equality and diversity training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw the organisation had a clear referral pathway for safeguarding concerns which included out of hours periods. Senior nurses provided cover seven days a week over 24-hours and could contact relevant agencies out of hours to escalate safeguarding concerns.

The service had systems to ensure all clinical staff received a Disclosure Barring Service (DBS) check prior to starting their roles. We reviewed and saw DBS checks were in place for all staff.

Cleanliness, infection control and hygiene

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

Staff followed infection control principles including the use of personal protective equipment (PPE), arms bare below the elbows policy as well as using appropriate PPE such as gloves, and aprons to deliver personal care. We observed staff washing their hands before and after patient contact.

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

Staff completed IPC training as part of their mandatory training and were provided with PPE. The service had an infection prevention and control lead and had implemented an annual audit document. Hand hygiene audits had recently been implemented. The provider was developing a system of monitoring compliance with infection prevention and control. We reviewed the last completed audit and it demonstrated a staff member was compliant with hand hygiene audit. The audit carried out showed no robust evidence of the overall level of compliance or audit schedule within the service. Staff said due to the nature of service provided in patients' own homes, it was not always possible to carry out hand hygiene audits.

Where appropriate, staff provided last offices to patients who had passed away while receiving care. Last offices is a procedure performed, usually by a nurse, to the body of a dead person shortly after death has been confirmed. They were aware of precautionary infection prevention and control measures required for the safe handling of a deceased body.

Environment and equipment

The maintenance and use of facilities and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service had enough suitable equipment to help them to safely care for patients. Following the initial risk assessment, any staff members experiencing manual handling difficulties would request an additional reassessment by the community nurse. For example, we observed an assessment where a patient had been sleeping downstairs to be near the toilet as they struggled with the stairs. The nurse spoke to community services who arranged for a bed to be installed downstairs within 24 hours.

The service owned one syringe driver which was serviced and maintained annually by a local NHS trust. District nurses provided all other syringe drivers upon request. Staff had been trained to use syringe drivers and had completed competencies. A syringe driver is a small infusion pump, used to gradually administer small amounts of fluid medication under the patient's skin.

Staff told us specialist equipment such as syringe drivers and hoists were readily available.

Staff disposed of clinical waste safely. The service had appropriate arrangements for the management of clinical waste and sharps. Arrangements for storing, classifying and labelling clinical waste kept patients and staff safe.

Sharp clinical waste was disposed of using waste facilities provided by the community district nurses based in the adjoining building.

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.

Patients' needs were identified using a RAG system. This was a method of rating, based on red, amber and green colours used in a traffic light rating system to denote the progression of illness and therefore prioritise accordingly. Red being higher risk and referring to people who are generally at the latter stages of palliative care. We saw evidence in the patient records we looked at. This meant people with more urgent needs were prioritised to ensure they were addressed quickly.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. At each visit a prompt sheet was completed to assess, for example, pain, breathing and mouth care.

Staff completed risk assessments for each patient on admission and updated them when necessary and used recognised tools. The service positively managed risks people might experience at the end of their life, including risk of pressure ulcer and falls.

A risk assessment was carried out at the initial assessment and staff were prompted to reassess the patient at each visit and report any changes to the nurse co-ordinator.

Care plans were individualised to cover the psychological as well as physical needs of patients. Where a patient had changing needs, for example, becoming increasingly uncomfortable staff adapted their care plan accordingly.

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe. The service was part of a governance structure via a steering group with a rapid response end of life care service which was provided by a neighbouring NHS Trust and hospices. The rapid response service provided out of hours care and support to patients and their families.

All staff had access to the details of the patients' GP. Where medical assistance was required outside of GP surgery opening times, staff used a third-party service. The service also had access to a 24-hour palliative care advice line which was facilitated by a local hospice.

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 staff of relevant grades to keep patients safe. The team was comprised of four registered nurse co-ordinators who had substantive contracts with Shipston and ten bank registered nurses. Two of the registered co-ordinators also had a bank nurse contract, meaning they were part of the ten registered nurses who worked bank. There were five healthcare assistants.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance.

The managers could adjust staffing levels daily according to the needs of patients.

The service had a recruitment policy, which provided a framework for the recruitment and selection of staff and volunteers to work with vulnerable people**.** A range of checks were carried out including proof of identity, written references, and checks with the Disclosure and Barring Service.

Further verification was undertaken for nursing staff through the Nursing and Midwifery Council to verify their continued registration as nurses. All staff had completed an application form and had been interviewed.

Nursing staff told us they felt staffing levels were appropriate, and they had time to give compassionate care.

We saw planned levels of staffing matched the actual staffing levels on the day of our inspections and there was a strong skill mix among the nursing team which included health care assistants and registered nurses.

The service did not use agency staff and employed their own bank staff. The service provided mandatory training to all bank staff.

Managers made sure all bank staff had a full induction and understood the service.

Medical staffing

Shipston Home Nursing did not employ medical staff as this was a nurse led service.

Any urgent medical assistance was accessed through the GP, out of hours service, or the community nursing and rapid response teams.

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. The patient files were kept in the Shipston Home Nursing office in locked cupboards. 'Mini packs' kept in the patient's homes had been introduced recently, following the district nurse (DN) records going paperless. The mini pack included personal details such as date of birth, address and next of kin along with their diagnosis and contact details for the GP and DN. There was a patient assessment which included prompts such as pain score and urine output, and a log for further details which were completed at every visit. Afterwards, staff were required to either fill in details of their visit in the office file or give a telephone handover to a nurse co-ordinator who would update the office record. A handover prompt sheet was used to help ensure nothing was omitted.

Records were stored securely. The complete patient file was kept in a locked cupboard in the office. The 'mini pack' was kept in the patient's own home.

During the inspection we reviewed five records for patients actively receiving end of life care. The records contained comprehensive and person-centred care plans which clearly identified patients' emotional, social and spiritual needs alongside their physical health needs. Staff completed care plans appropriately and we saw they recorded when care was carried out according to the individual's needs. Staff reviewed care plans weekly or when a patient's circumstances changed.

Patient notes were kept in the patient home as well as the office base. Updates about the patient's condition were communicated to the appropriate community nursing team on a regular basis.

Nurse coordinators had a handover diary which was kept in the main office. All staff handed over to either the office staff or the nurse on the next shift. Information from each handover was recorded in the patient's office-based notes.

Information needed for each patient's ongoing care was shared appropriately in a timely way. The service sought and obtained patient consent to share information with other services such as GP's.

Medicines

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

Staff followed systems and processes when safely administering and recording medicines. We found that medicines for people who used the service had been prescribed by their own GP's or by an out of hour's doctor.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We saw staff administered medicines as per the patient care plan.

Good

Hospice services for adults

Staff managed medicines in line with the provider's policy. Medicines kept in the patients' own homes was their responsibility to store safely.

Registered nursing staff were aware of policies on the administration of controlled drugs as per the Nursing and Midwifery Council Standards for Medicine Management. Patients stored controlled drugs in their own homes.

Staff followed current national practice to check patients had the correct medicines. Any changes to a patient's medicines would be discussed at handover, prior to the registered nurse attending to the patient.

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.

In accordance with the Serious Incident Framework 2015, the service reported no serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from June 2019 to May 2019.

Staff knew what incidents to report and how to report them and were aware of their incident reporting roles and responsibilities. There was an incident reporting policy which explained the process.

Staff reported all incidents that they should report. Staff completed an incident form which was kept on file in the office and reviewed by the registered manager.

From June 2019 to May 2019, the service reported no incidents classified as never events for hospice at home end of life care.Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Staff had a clear understanding of the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The service had a guide for all staff to follow in respect of their obligation regarding duty of candour, which had been distributed to all staff. The guide was displayed on the notice board in the nurses office.

Are hospice services for adults effective?
(for example, treatment is effective)

Good

This was the first inspection of this service. We rated effective 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 protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. All policies had been reviewed within the last 12 months. All staff had a copy of the policies which they were required to carry with them at all times. They were encouraged to refer to the policy if they needed guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

Patients had a clear personalised care plan which reflected their needs and was up to date. Staff delivered care to patients in the last days of life that met the 'five priorities of care of the dying person'. Individual care plans took account of symptom control, psychological, social and spiritual support and we saw evidence of discussion with patients and relatives recorded in care plans. This gave us assurance care plans were agreed and developed with the consent of the patient.

Staff used a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) as a personal emergency care plan summary. ReSPECT forms provide health and care professionals responding to an emergency with a summary of recommendations to help

them to make immediate decisions about the person's care and treatment. We saw staff used ReSPECT forms in the initial assessment and in subsequent assessments. Staffed stored ReSPECT forms in patients' own homes to ensure it could be located promptly when needed.

An initial assessment was completed which included details of the patient's diagnosis and their physical needs such as support required with mobility and any sensory problems. The assessment was reviewed frequently.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Policies were reviewed in a timely manner and were version controlled. Team notice boards we saw displayed changes in policies, legislation and National Institute for Clinical Excellence (NICE) guidelines.

Nutrition and hydration

Staff supervised and monitored food and drink intake to meet patients' needs. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We saw fluid input and output was monitored and recorded in accordance with the patient's assessment and care plan.

Staff used a nationally recognised screening tool including malnutrition universal screening tool to monitor patients at risk of malnutrition. We saw the initial assessment stated whether there were any dietary restrictions and any issues with swallowing.

The service actively promoted healthy lifestyles acknowledging the physical and psychological fragility of the patients and carers.

Specialist support from third party staff was available for patients who needed it. Patients' nutritional status was recorded in the initial assessment documentation. Any concerns identified were escalated through the district nursing team and referred on to the dietetic service where appropriate.

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 tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients' pain scores were assessed as either severe, moderate or mild and recorded at each visit. The Abbey pain scale was used. This is a tool used to assist in the assessment of patients who are unable to clearly articulate their needs.

Staff administered and recorded pain relief accurately. Upon review of patient records, we saw all medicines were prescribed by the GP and managed by the community nursing team.

Anticipatory medicines for distress, agitation, seizures and pain were prescribed and given in line with NICE guidelines for care of the dying adult in the last days of life and palliative care for adults.

The registered nurses administered medicine as required and in accordance with the prescribed medicines on the patient care plan.

Registered nurses attended annual syringe drive update training in line with the competency framework.

Patient outcomes

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

Managers carried out an audit programme. For example, managers carried out a monthly audit on a selection of patients notes to ensure they were meeting requirements, the results of these audits were left at the front of the notes stored in the office for nursing staff to see and update if necessary.

The head of nursing services carried out a monthly audit, during which they spot checked many nursing elements of the organisation to ensure all staff were meeting the expectations of the organisation and were aligned with national standards. Another manager carried out a further monthly audit. In addition, a nurse coordinator completed and reported on a monthly patient/relative

visit to assess the quality of care provided. Evidence reviewed showed staff carried out audits but did not collate them to ascertain compliance rates. There was no evidence of actions being taken following audits to improve performance. We raised this with senior staff during our inspection. Following our inspection, the provider produced an internal audit checklist for September 2019 which included for example, consent form audits, referral date to assessment audits and an audit of allergy status. This revealed an overall compliance of 87%. The checklist contained no compliance target.

Policies, procedure and guidelines were reviewed every two years or sooner if local or national practice changed.

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.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

The service ensured staff competencies were assessed regularly. Competency assessments for registered nurses included various skills around for example; symptom control and syringe drivers. The service was in the process of introducing an annual medicines management training day, specifically relating to palliative care.

Managers gave all new nursing staff a full induction tailored to their role before they started work. There was an induction program to ensure new staff were competent to perform their required role. For example, clinical staff records reviewed revealed they were supported by a comprehensive competency assessment booklet which covered key areas applicable across all roles including equipment, and clinical competency skills relevant to their job role and experience.

A new induction programme had been developed for the healthcare assistants. All new staff worked alongside a senior member of staff until they were competent. Areas for development were considered on an individual basis.

A mentor was allocated to all new employees and they supported and guided them through their induction period. Any areas of concern were addressed and mentors reinforced a patient centred ethos.

Annual objectives, in line with the departmental aims, were agreed during appraisal meetings and monitored throughout the year at regular intervals during one-to-one meetings

Managers supported staff to develop through yearly, constructive appraisals of their work. The services appraisal rate for all staff was 100%. Permanent staff received an appraisal every six months and bank staff received one annually.

Nurse co-ordinators had one to one meetings with the registered manager monthly or bi-monthly. Clinical supervision was held every six weeks with an independent person.

Staff were required to revalidate in accordance with their registration body. Senior staff supported nurses to complete professional revalidation with the Nursing and Midwifery Council. Revalidation is a process by which nurses can demonstrate they practice safely before they can be reregistered with their professional body.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. A bi-monthly meeting was held for everyone to attend including one of the trustees. The nurse co-ordinators had two-weekly or monthly meetings to discuss patients.

The service had sourced training from experienced Macmillan nurses to deliver training around loss and bereavement, difficult conversations, and effective communication to staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff were not required to have a palliative care qualification, but healthcare assistants completed the care certificate and various end of life care courses were provided by the Macmillan nurses. Some courses had been attended by a member of staff which was then shared with the rest of the team. Examples included 'managing breathlessness' and 'symptom control'. A member of the management team had attended a falls clinic and put together training for the staff.

Managers made sure staff received any specialist training for their role. Staff shared learning following attendance at any study days/conferences all of which was funded by the charity.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. All requests for additional training were considered, dependent on cost and benefit to service.

Managers identified poor staff performance promptly and supported staff to improve. Joint visits were done by the nurse manager. This involved attending a patient's home with the member of staff to make various checks including: identification badge worn, appropriate personal protective equipment used. Any issues identified were recorded and followed up.

Multidisciplinary working

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. Each patient was assigned to one nurse co-ordinator who was responsible for ensuring their file was kept up to date. Meetings were held two weekly or monthly where staff discussed all the patients who were rated 'Red'. Patients rated as red were in the last 72 hours of life and 'Amber' patients were deteriorating.

Staff worked across health care disciplines and with other agencies when required to care for patients. A weekly meeting was arranged with the district nurses, but we were told this was sometimes cancelled due to workload. However, the offices were next door to each other so a nurse from Shipston visited the district nurses daily to receive an update and share information. We observed a conference call which was held daily with Shipston Home Nursing, other hospices, Macmillan nurses and the acute palliative care team.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Multidisciplinary team working helped the effective planning and delivery of care and enabled the service to provide holistic support to patients.

Staff within the service told us they worked effectively with professionals from other services and could refer to mental health services if required.

We spoke with partner services and were advised that Shipston Home Nursing maintained effective and frequent communication with community nurses and the rapid response team.

The head of nursing services attended quarterly meetings with neighbouring organisations to ensure all palliative care initiatives were cascaded from NHS England down to a local level providing county wide best practice and alignment. In these meetings training resources were shared to ensure all palliative care staff had up to date information.

Attendance at multidisciplinary meetings ensured information sharing and information gathered was disseminated through team meetings. Minutes of relevant meetings were made available to ensure knowledge was shared.

Seven-day services

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

The service provided a 24-hour service. A co-ordinator covered a 24-hour shift where they were in the office during the day and on-call at home overnight. They were available for the nurse sitters (specialized caregivers who provided companionship) to contact for assistance and advice and for patients who did cover.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. There was a rapid response night service which could be contacted at short notice to provide advice and support.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support. Staff identified patients who needed extra support and discussed changes to patients' care and treatment with patients and their carers'. The service provided support to families and carers to maintain their own health and wellbeing.

Good

Hospice services for adults

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

The service actively promoted healthy lifestyles acknowledging the physical and psychological fragility of the patients and carers.

People who used services were empowered and supported to manage their own health, care and wellbeing and to maximise their independence.

Consent and Mental Capacity Act

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. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. Mental Capacity Act and Deprivation of Liberty training completion was at 100%.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

The service looked at each patient's mental capacity as part of the personalised care for the last days of life plan. We saw evidence capacity was assessed prior to decisions about end of life care being made.

Do not attempt cardiopulmonary resuscitation (DNACPR) decisions were recorded on appropriate respect forms and completed accurately in all the patient records we reviewed.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. The service had introduced a best interest form which allowed nurses to consent for the patient if no one was available to sign a consent form.

Are hospice services for adults caring?

Good

This was the first inspection of this service. We rated caring as **good.**

Compassionate care

Staff truly cared for patients with compassion. Feedback from all patients and those close to them confirmed that staff treated them well and with kindness.

Patients said staff treated them well and with kindness. The relationships between patient, relatives and staff were highly valued which was encouraged and supported by the senior team.

Staff treated patients with compassion, 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.

Staff followed policy to keep patient care and treatment confidential. Care observed met National Institute for Health and Care Excellence (NICE) QS15 Statement 1: 'Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty', NICE QS15 Statement 2: 'Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills', NICE QS15 Statement 3: 'Patients are introduced to all healthcare professionals involved in their care and are made aware of the roles and responsibilities of the members of the healthcare team' and NICE QS15 Statement 13: 'Patients' preferences for sharing information with their partner, family members and/or carers are established, respected and reviewed throughout their care'.

Patient's individual preferences and needs were always reflected in how care was delivered. For example, staff arranged to move a patient receiving end of life care to a more suitable living space to enable them to spend their last days in the same room with their spouse within their home as per their wish.

Good

Hospice services for adults

We spoke to a relative who praised Shipston Home Nursing (SHN) for the care, support and professionalism. They described it as 'a service that ensured the two most important people in my life were able to spend their last days at home together surrounded by their family and cared for and supported by SHN'.

We spoke with a relative who said SHN staff sat with their spouse which allowed them peace of mind and they were confident and happy to leave their loved one in their care because they had observed the professional, caring and compassionate care their spouse received.

Staff said they always strived for improvement and did all to ensure they delivered a truly caring service. They gave an example of when they had gone an extra mile to support a patient living with learning difficulties by enabling them to have a choice in who provided their care. The patient was moved into a care home, however, staff continued to care for them until the patient had settled into their new home.

The service had a 'heart inside the home' logo and staff said it reflected the care they provided was given with compassion and care, and the patient was at the heart of everything they did.

Senior staff said they recruited staff they believed had the personal qualities to deliver care with empathy and communicate with dignity, respect and compassion.

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.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff understood the importance of providing emotional support to patients and those close to them. 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. We saw staff were positive and attentive to the needs of patients within their own homes.

We listened to a telephone conversation between a member of staff and a relative who required advice. Staff provided emotional support including health promotion advice while caring for their loved one.

SHN staff priority was to support patients and their relatives in the choices they made, and nurses were always happy to listen to their concerns and where appropriate, source specialist help through their network of healthcare professionals.

We observed staff providing kind, thoughtful, supportive and empathetic care. Relatives also commented on how supportive the staff were. They provided them with assurance and reassurance which enabled patients to relax and settle well into the hospice and accept the care and support provided.

SHN staff cared passionately about what they did and felt privileged to be able to look after patients and their families who were facing a difficult period in their lives.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff provided bereavement support on an individual basis or as a family, including children. For example, we observed a planned bereavement follow-up call to a relative whose spouse had recently passed away and this was done in a very sensitive compassionate manner. Staff recognised and respected the totality of people's needs. They always took people's personal, cultural, social and religious needs into account, and found innovative ways to meet them. The aim of the service was to relieve as many worries for a patient as possible, so they could concentrate on caring for the whole person and their relatives.

A patient told us they and their relatives were respected and empowered as partners in their care both practically and emotionally by an exceptional service.

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. Patient's emotional and social needs were seen as being as important as their physical needs.

Understanding and involvement of patients and those close to them

Good

Hospice services for adults

Staff always communicated with patients about their care and treatment in a way they could understand. Staff involved patients and those close to them in decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. The service had a visible patient-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity and independence where possible. Patients were actively involved in their care.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

We observed patient care during a home visit. The initial assessment was comprehensive and carried out at the patient's pace. The patient's daughter was also present and able to contribute as appropriate. The nurse explained what the assessment would be about and the services they could provide. She had a friendly manner and communicated well with both the patient and the family, allowing them ample time to ask questions.

Staff made sure that people who used services and those close to them were able to find further information, including community and advocacy services. They could ask questions about their care and treatment. Staff are fully committed to working in partnership with people and making this a reality for each patient.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Bereavement and feedback forms were sent out to all families who had used the service, the response rate being approximately 50% in the last 12 months.

Any specific patient requests about how they wished their needs to be met were documented in the nursing and office notes.

Staff invited relatives to assist and/or participate with care if they wished.

Staff supported patients to make informed decisions about their care. All patients had an assessment by a registered nurse at the first visit. We observed an initial assessment at our inspection.

Staff offered families the option to engage and receive support after the death of their loved one. Often, this was very private, and a deeply personal time and staff said they always respected the families' wishes about their level involvement.

The service had a close affiliation with a local charity who had the necessary expertise to guide and help families through a bereavement period. Staff gave examples of when they have had to use this service for both bereavement and counselling.

The service encouraged self, family and third-party referrals through their website and word of mouth from as early as possible post-diagnosis to enable them gradually manage and plan the overall patient experience as opposed to just in the last weeks of life. This allowed for quality relationships to be developed between staff and families. This ultimately led to more targeted and tailored patient care and an improved overall experience.

Are hospice services for adults responsive to people's needs? (for example, to feedback?)

Good

This was our first inspection of this service. We rated responsive 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. Nurse coordinators made phone calls to patients' or relatives under their care to find out how the patient and family was coping and to confirm visits.

The service engaged with community health services; linking with other partners such as the palliative care partnership group. This helped them plan services to meet patient needs.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. This service was provided by a neighbouring organisation.

Managers ensured that patients who were not at home for their appointments were contacted. Staff gave examples of how they would contact a patient through a telephone call if they missed their appointment.

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. Complex care needs or vulnerabilities were identified at the first care assessment and on the risk assessments. Staff planned care around patient needs to ensure individual needs were met.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Any reasonable adjustments were made in conjunction with community staff as they were the primary care provider. Any issues regarding mental capacity were highlighted at time of referral and documented.

The service had redesigned the Advance Care Planning (ACP) document to make it user friendly for the patient. They had created an explanatory guide to accompany the ACP which enabled them leave the document with the patient. This allowed the patient to consider and record their wishes in their own time. If the patient did not have an advance care plan they were provided with information to develop one. This involved making plans about future healthcare for when the person was not able to make and/or communicate their own choices

Managers made sure staff, and patients, loved ones and carers could get help from interpreters when needed. The service had arrangements in place to access translation services for patients. Staff we spoke with could tell us how they would access these services and provided examples of occasions that they had done so.

The service focussed on individual needs and goals in planning care for patents in the community. Staff identified patient goals and put a plan in place to achieve the goals. Staff monitored and reviewed the changing needs of patients through frequent care plan reviews.

Patients had individual assessments on referral which were carried out with respect to the wishes of the patient, within 48 working hours. Following our inspection, the provider carried out an audit in September 2019 which showed 100% of individual assessments had been carried out within 48 hours of referral. Assessments were carried out by the head of nursing services or a nurse coordinator who had both training and experience in undertaking such assessments. The initial assessment included understanding the needs of the patient and family/carer and establishing the preferences of the patient and family/carer.

Staff reviewed the needs and wishes of the patient and the family/carers at each patient visit. Patient visits were often conducted with other healthcare providers such as GP's or district nurses to enable all parties work collaboratively in the planning of the care being provided.

We reviewed five care plans and saw that services were coordinated with other agencies to provide care to patients with more complex needs. Staff could give examples of when they had referred patients to community services.

Care plans were person centred and we could see that people and their carers had had the chance to discuss them and contribute towards their care.

Staff had access to communication aids to help patients become partners in their care and treatment. This could be arranged through the district nursing team.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes. The service ensured that a member of staff was available to respond to any urgent referrals on the same day.

Good

Hospice services for adults

The ratio of registered nurses and health support workers was monitored by the head of nursing services to ensure the available skill mix was relevant to the categories of patients referred to SHN.

The service had processes in place to manage admission to the service. Referrals came from the local hospitals, hospices, care/nursing homes, patients/relatives and GPs.

The service had a criteria for referrals so that all those receiving support from the service had been assessed by their GP service as likely to die within 12 months.

The service worked as part of a holistic healthcare team including GP surgeries, rapid response and district nurses.

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. People we spoke with told us they knew how to make a complaint or raise concerns and felt comfortable doing so. Staff understood the system and had access to policy and procedures to guide them in managing complaints.

Staff understood the policy on complaints and knew how to handle them. We reviewed the complaints policy and saw it was relevant, up-to-date and clearly outlined the complaints process and steps people could take if unhappy with the outcome of a complaint.

Managers investigated complaints and identified themes. The service had received more than 100 compliments and no complaints from June 2018 and May 2019.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us that lessons learned from complaints would be shared in team meetings and managers would discuss lessons learned from complaints with the individual staff involved and identified individual actions or learning needs.

Are hospice services for adults well-led?

Good

This was the first inspection of this service. We rated well-led as **good.**

Leadership

Leaders had the integrity, 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.

The service was led by a chairman of board trustees who was responsible for the board of trustees. The executive trustees was made up of a board of trustees who passed down responsibilities to executive director (ED). The ED was employed on a consultancy basis since November 2017 and was responsible for the day to day operational running of the service.

The ED oversaw the implementation of strategic review actions and managed the daily operational activity of the charity. The ED reported to the chairman of the board of trustees and was responsible to the board of trustees. The head of nursing, head of operations and clinical advisor reported to the ED. Staff told us that the executive director was respected, visible and supportive.

Leaders were visible and approachable. Senior managers practiced an open-door policy and encouraged staff to raise any concerns promptly. We saw and staff commented on positive relationships between staff and leaders. Staff we spoke with felt connected to the service as a whole and described themselves as one team.

All leaders we spoke with had a clear understanding of the challenges to quality and sustainability of the service. They could identify actions to address these such as investing in staff terms.

Staff said the clinical lead was visible and they felt well supported. Nursing coordinators met fortnightly with the clinical lead to discuss any issues surrounding the service and reviewed patient care.

All the employment files had been maintained to provide assurance of checks to ensure directors and trustees met the fit and proper persons requirement. Services are required to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 19 of the Health and Social Care act (Regulated Activities) Regulations 2014). This regulation ensures that directors/ trustees are of good character and have the right qualifications and experience to carry out this important role. This regulation includes those in interim positions. We found all the employment files had been maintained to provide assurance of checks to ensure that the necessary requirements were met.

Vision and strategy

The service had a clear 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.

The vision was 'to ensure that every adult in our community has access to free high-quality end-of- life care at home'. All the staff we spoke with were fully aware of and proud of the vision of the service.

The mission of the service was 'to develop trusting relationships with, and provide high quality, specialist care to people who are approaching their end of life. We aim to provide patients and their families with clinical, practical and emotional support which meets their individual care needs and preferences'.

The services' induction programme included a presentation from the head of nursing services and the executive director who further reinforced the vision and values of the charity.

The service had a strategic plan, with identified specific imperatives, which were monitored, risk assessed and discussed as relevant. All staff were encouraged to understand and fully embrace the vision, mission and values.

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.

Managers within the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The service had a caring culture. Staff told us they enjoyed working in the service. Staff liked their jobs and described good working relationships with their colleagues. Managers treated staff with respect and understanding.

The clinical lead held regular meetings with the nursing teams. They felt this kept them well informed and involved in decisions. Staff felt they were kept up-to-date and were made aware of changes and developments within the service.

Staff told us that there was a culture of openness and honesty and they felt they could raise concerns without fear of blame.

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.

The service had a clear governance process to continually improve the quality of service provided. Staff understood their roles and responsibilities in relation to governance. Governance arrangements were clear and appropriate to the size of the service.

The organisational structure of the charity was changed in the first quarter of 2018 with a focus on:

- Reducing administration time of clinical staff and diverting resources to patient care.
- Further upskilling some nursing staff to support NHS community nurses.

- Improving record keeping.
- Optimising fundraising to balance effort expended, cost and revenue and diversify income channels.

The service had a clear management structure with defining lines of responsibility and accountability. There was a clinical lead who provided support to the clinical staff.

Care service provision was on a one to one basis and patient centred. This was formalised in the use of the well-established model of nursing care. Staff regularly attended updates on current practice issues and other areas of interest.

We found quality assurance checks ensured the training matrix was kept up to date. This meant the provider had a robust system to monitor staff training.

We found all policies were appropriate and in date. Policies had been reviewed in 2019.

We reviewed two sets of minutes of the clinical governance sub-committee and saw the committee was attended by four trustees and the executive director. All aspects of compliance, risk assessments, recruitment and quality were discussed. Service improvements were also discussed at the clinical governance sub-committee.

Staff held monthly team meetings. We reviewed minutes from July, August and September 2019 meetings and saw staff discussed processes involved in the cleaning of syringe drivers, staff supervision and referral times.

There were mechanisms to provide staff with the development they needed and the service monitored appraisal rates. Appraisals are important as they provide the opportunity to acknowledge the work staff have done and offer encouragement for them to strive to high levels of achievement as well as manage their performance.

Day to day operations were led by the executive director (ED). The ED and other senior managers met and communicated regularly with colleagues from other care and end of life care services via the collaborative network to discuss cross hospice working and potential development and to share experience and learning.

Care team meetings took place regularly so that staff could share learning from training and to identify and resolve problems collaboratively.

Managing risks, 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. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had a risk register. The ED described the main risks to the service which were on the risk register. Main risks included; recruitment and retention of nursing staff, potential medicines errors and lone working. Mitigating actions and responsible person in charge of the risk had been clearly noted, along with review dates.

The risk register was also regularly reviewed by the senior management team. Trustees had oversight of all SHN activity and met as a board to review activities and the corporate risk register three monthly.

Staff understood what the service's key risks were and there was good oversight of them. The service reviewed compliments, complaints and any concerns that had arisen. Concerns were discussed by the clinical lead and actions identified and assigned to senior staff members.

There were clear lines of accountability in the service. The service had nominated leads in areas such as safeguarding and infection prevention and control. These leads reported on these areas during meetings.

The senior management team within the service ensured that the board of trustees were made aware of any incidents or issues.

The service had an up to date lone working policy in place. All staff carried a sky guard technology (a personal safety device) as part of lone working safety which gave them immediate access to help, support and the emergency services should they require it.

Managing information

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.

Good

Hospice services for adults

The information used in delivering quality care was accurate, valid, reliable, timely and relevant, with plans to address any concerns.

Policies and procedures were available and accessible on the service's shared drive and in files in the nurse's offices. Important information such as safety updates and performance reports were shared in team meetings and handovers.

Information governance training formed part of the mandatory training programme for the service, and staff we spoke with understood their responsibilities regarding information management.

All IT systems were protected by security measures, all staff including bank staff had individual log on details and access to patient information was restricted depending on staff role.

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 engaged well with patients, staff, volunteers and the public and local organisations to plan and manage appropriate services and collaborated with partner agencies effectively.

In 2018 the charity was re-branded to include hospice at home in their logo and to make the brand more current. The re-branding included their website being re-designed to move the bias from fundraising to care and to simplify the way in which the service helped patients and families directly or signposted them to other agencies.

Staff actively engaged with local community members and relatives of patients soliciting their thoughts and advising on how to further improve services. They held focus groups for published written material, user testing of the redeveloped website and improvements in the way post-bereavement support was provided.

The SHN website provided the opportunity for any members of the public to provide feedback about all services.

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. Leaders encouraged innovation and participation in research.

The service was committed to improving services by learning from when things went well or not so well and promoted training and innovation.

The service had developed effective working relationships with other hospices in the area. Managers had met with a nearby hospice to share good practice

The service had recently carried out the following improvements;

- Recruited a head of nursing services with existing community nursing experience.
- Carried out a general organisational upskilling for staff and trustees through identifying group and individual skill gaps and training needs. For example, provision of specific training for trustees carried out in March 2019 and communications training for all staff in July 2019.
- Increased attendance by relevant members of the leadership teams at relevant meetings, forums, and conferences to share and learn best practices.
- Improved communication with trustees, staff, volunteers, sponsors, healthcare partners and the wider community to inform, generate ideas and receive feedback.
- Recognised ongoing challenges to improve the care model, in particular to provide interim support for hospital discharges where care packages were pending but not in place.

The service was committed to providing regular training opportunities to staff. We saw information about education sessions including last days of life, symptoms management and drugs in end of life care.

The service had introduced pro re nata (PRN) subcutaneous (under the skin) lines for symptom control for patients following specific feedback from a family member and this practice was being rolled out across a neighbouring NHS trust. PRN medicines are medicines which can be administered as required by the patient.

Good

Hospice services for adults

As part of an NHS/local charity rapid response pilot steering group, patients who used the service were able to receive emergency care from 8 pm till 8 am 365 days annually.

Outstanding practice and areas for improvement

Outstanding practice

- Staff in the service demonstrated compassion and dedication to finding innovative ways to support patients with their end of life care. Staff and patients could provide many examples of how the service had ensured patients received care individualised to their holistic needs.
- People's individual needs and preferences were central to the delivery of tailored services.
- The service had introduced pro re nata (PRN) lines for symptom control for patients following specific feedback from a family member and this practice is now being rolled out across a neighbouring NHS trust.
- Staff within the service completed comprehensive and holistic end of life care plans. The care planning within the service focussed on all elements of the patients care including their spiritual and emotional needs.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that robust audit systems are in place.