

Hospice at Home West Cumbria

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Inspection report

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Date of inspection visit: 18, 19 and 20 August 2015

Date of publication: 16/12/2015

Ratings

Overall rating for this service	Good	
Is the service safe?	Good	
Is the service effective?	Good	
Is the service caring?	Good	
Is the service responsive?	Good	
Is the service well-led?	Good	

Overall summary

This inspection of the Hospice at Home West Cumbria took place over three days 18, 19, 20 August 2015. We last inspected this service in January 2014. At that inspection we found the service was meeting all the regulations assessed.

Hospice at Home West Cumbria (the service) is a registered charity providing 24 hour nursing care with

personal care interventions as appropriate to need and a lymphoedema assessment and treatment service. The service will also support people living in residential or nursing homes or in the acute hospital and community hospital and operates from an office based at Workington

Summary of findings

Community Hospital. The service aims to help both people and their carers during the last few months, weeks or days of their lives. The care and support supplements that given by community doctors and nurses.

The Hospice at Home West Cumbria provides a specialist Lymphoedema service through its clinics and home visits. [Lymphoedema is a chronic condition where excess fluid is retained in the tissues causing a painful swelling]. There is also a patient, family and bereavement support service available before and following bereavement. All services are provided free of charge.

At the time of our inspection the service had 12 people using the home nursing service. Six people were being visited at home by the Lymphoedema nursing team as their condition did not allow them to attend the service's clinics. In addition the service provided Lymphoedema clinics and also made home visits if needed.

The service also offers bereavement support to patients, carers and families (including children as part of the family unit) and complimentary therapies. The complimentary therapies provided included therapeutic massage, Reflexology, Reiki and breathing and relaxation techniques. [Complimentary or 'holistic' therapies are therapies that aim to treat the whole person, not just the symptoms of disease].

The service had a registered manager in post. 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.

Everyone we spoke to whose relatives were or had received care from the service had only positive things to say about their experiences. Comments included, "They are so caring" and "A real community asset" and "So professional". Staff were proud to be part of the organisation and set themselves high standards to deliver.

We found that the service was well run and had measurable and verifiable processes in place to thoroughly monitor and assess the effectiveness of the care and support services it provided. Systems were also in place to ensure that training and development and research activity were given the time and resources

needed to promote the continuous improvement of the service. This approach placed the voices and preferences of the people using the service at its centre. The service also took its expertise out into the broader community through training and educational initiatives. Staff were enthusiastic and showed a deep commitment to providing a high standard of care and expertise.

The staff and management team used reflection and incident analysis to help them make changes to improve the care and support they gave so that they responded quickly to a person's needs. Forward thinking planning and strategic business planning was very clear and accessible to address the diverse and changing care needs of the local population.

The service worked closely with the hospital palliative care team, GPs, the Macmillan team, community nursing services and external agencies such as social services and mental health team. This helped to make sure smooth cross service working to provide appropriate care to meet people's different physical, psychological and emotional needs.

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

People who used the services told us how much they valued it and the high standard of caring and understanding displayed by staff about their needs. They told us that they were involved in planning how they wanted to be cared for and were frequently asked for their views and experiences of the service and were listened to. A relative told us "They give us all the care and support they possibly can, they're so very good".

Everyone we spoke with who worked for the service was very clear about their aims and objectives and their sense of commitment to the people they supported was evident in their enthusiasm and pride in their service.

All staff and volunteers received induction, training and support relevant to their roles and had been tailored to their personal training needs. Training was given a high

Summary of findings

priority and staff were encouraged to realise their potential and develop their skills and knowledge to take the service forward and provide care that reflected best practice.

Staff had received training on safeguarding and all felt they could raise and concerns about safety or practice

with the management team and would be well supported. Effective systems were in place for the recruitment of staff and there were regular registration and security checks to make sure all staff were still suitable to work with people in their homes.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

Staff understood their responsibility to safeguard people and what action to take if they were concerned about a person's safety or wellbeing.

Risks had been appropriately assessed as part of the care planning process and staff had clear information on the management of identified risks.

Medicines were handled safely and people received their medicines appropriately.

Staff had been recruited safely with appropriate pre-employment checks.

Good



Is the service effective?

The service was effective.

The Hospice at Home staff worked closely and collaboratively with hospital, community organisations and health and social care professionals to help ensure people received the right care at the right time.

Staff at all levels received induction and on going personal support and training suited to their roles and responsibilities to help ensure they could meet the individual needs of the people they supported.

Staff understood the requirements of the Mental Capacity Act 2005. People were supported to make their own decisions about care and treatment.

Good



Is the service caring?

The service was caring.

People who used the service received dignified end of life care in line with their expressed wishes. They had received support from well trained and committed nursing and care staff.

Hospice at home staff demonstrated good knowledge about the people they were supporting, their conditions and the importance of holistic care at the end of life.

Information was easily available about the services being provided and also on how to access advocacy and other support services for people who needed this

Good



Is the service responsive?

The service was responsive.

The service planned ahead and reflected upon events to ensure a person centred approach to meeting people's care and treatment choices and needs.

There were effective and clear information channels and communication systems and processes for people to complain if they wished to. Collaborative working between services promoted the continuity of care for people.

Good



Summary of findings

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

Is the service well-led?

The service was well led.

The management team and staff worked in partnership with key organisations to participate in multi-disciplinary processes and research and development to develop, inform and agree best care practice for people's end of life care.

There were clear and effective governance and management strategies that involved people using the service, their carers and other stakeholders in service development and continuous improvement.

A proactive approach had been taken to research and development to continuously improve service provision, staff development and to add to the body of knowledge to progress palliative care.

Good



Hospice at Home West Cumbria

Detailed findings

Background to this inspection

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

The inspection was carried out by an adult social care lead inspector over three days between 18, 19 and 20 August. The inspection was announced as the registered provider was given 24 hours' notice because the service has a management team spread over two sites; we needed to be sure that the appropriate people would be available when we visited.

The first day of the inspection was spent at the main office in Workington Community Hospital. We looked at the records held by the service, its policies and procedures, the assessments they carried out and the service's governance structures. We also spoke with the registered manager, the home nursing lead nurse, the lymphoedema lead nurse, the head of care and quality and the palliative care consultant based at the hospital.

The second and third days of the inspection were used to speak with the family members of six of the 12 people who were using the service at the time of the inspection and also with staff. We obtained the permission of people who

used the service and their relatives to speak with us before we contacted them. Given the nature of the services being provided relatives provided us with the information about the care, service provision and support given.

Before the inspection we reviewed the information we held about the service, such as the statement of purpose for the service and notifications we had received from the registered provider. A notification is information about important events which the service is required to send us by law. We planned the inspection using this information. We looked at all the information and survey responses we had received about the agency.

We did not have a Provider Information Return (PIR) when we visited. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The registered manager received the request for a Provider Information Return (PIR) 10 working days after the inspection and they completed and returned it to us when they got it. The registered manager was able to provide all the information required for the PIR when we inspected as they were already preparing it as part of their own quality monitoring systems and following the recent changes in legislation.

Before the inspection we sent questionnaires to people who received support from the service, their relatives and social and health care professionals who supported people who used the service.

Is the service safe?

Our findings

People we spoke with and their relatives who received support from the Hospice at Home told us they felt “safe” and “reassured” by the care and support being provided. We were told “I definitely have no doubts about having them here to help, they (home nursing team) give us all the support they possibly can and we both feel better just knowing there are there when we need them”. One person said “It’s especially reassuring at night to have someone there with us” and relatives told us, “We all trust them and have faith in them” and “They have never let us down, no matter what”.

We spoke with the palliative care consultant who worked closely with the service. We were told that the home nursing team “Picked up on risks and changing situations quickly” and were “Very skilled at this”. In their experience the service’s nursing leads were “proactive” and managed risk in a “sensitive way”. In this way any risks and changes in a person’s condition could be brought to the medical team’s attention and action could be taken straight away.

Nursing and care staff we spoke with told us that the management team took their safety “very seriously” as lone workers in people’s homes. They told us about the lone workers procedures in place. One staff member told us they once forgot to call in when arriving at a person’s home and they were called by the office to find out where they were and make sure they were safe. The staff member told us “If they had not been able to get me on the phone they would have sent someone out to check on me. I have always felt safe no matter where I have gone”.

Staff we spoke with were clear about their responsibilities to protect people from harm and abuse and about their responsibility to report any poor practice they encountered. Training records we looked at showed that nursing and support staff had received recent training on safeguarding vulnerable adults and children. We saw procedures were in place for dealing with allegations of abuse for both adults and children. We found evidence that the service had acted quickly and appropriately when a member of staff had raised a potential safeguarding issue encountered during their practice. These things helped to make sure that all staff had the necessary knowledge and information to help protect people from the risk of abuse.

We found that medication for people who used the service had been prescribed by their own GP’s, out of hour’s doctors or by the palliative care team. Medication was kept in the person’s own home and remained their property and there were risk assessments in place to help identify any potential risks. We saw that there was information around the control measures in place to reduce risk. We saw that the management team evaluated this process to look for ways to reduce risks further. For example they had identified the need to redesign aspects of their medicines records to clearly reflect the increased risks using a complex drug regime in a community setting.

There were clear protocols in place for the use of controlled drugs [medicines liable to misuse] and what staff should do if they had any concerns about the safety of medicines in someone’s home. Registered nurses were responsible for advising on administration and for the safe disposal and the safe storage of prescribed medication. They administered medication that had been prescribed and that was stated in the person’s care plan.

We looked at the recruitment procedures in use by the service. The registered manager had good systems in place to ensure nursing, care and volunteers staff were only employed if they were suitable and safe to provide care and support to people and their families at home. We looked at the records of four staff that included the newest staff members. We saw that all the checks and information required by law had been obtained before the staff were offered employment. Checks were made to ensure that nurses working in people’s home were registered with their professional body and fit to practice. It was the service’s policy to renew Disclosure and Barring Service [DBS] checks three yearly and this had recently been done. This helped to make sure there had been no changes since the initial checks.

We saw that the registered manager had a ‘business continuity plan’ and arrangements in place to deal with foreseeable emergencies and incidents. The service had staff who could work at short notice or ‘bank staff’ to cover for unexpected absences. The service planned ahead to cover annual leave and planned absences. Relatives using the agency told us that they were told if there were to be any changes to the people who supported them. There was

Is the service safe?

a stable staff team with very little turnover of staff and very low sickness levels. Staff told us that they were well supported by the management team if they had any health problems.

All staff were issued with a handbook that contained the policies and procedural guidance they needed to follow. This covered how the organisation dealt with all kinds of absences by staff and the support available. The service also had a contract with an NHS occupational health advisor for all staff who were screened before they began work and staff could access the service at any time for help and support.

The business continuity planning was currently under review to make sure it was up to date and covered all reasonable contingencies. Records had been kept of any incidents, accidents or 'near misses' affecting people who used the service and staff. These had been analysed for any lessons that might be learnt using a structured and graded approach in working groups. For example this had been done where there had been a breach of the lone worker policy and also following a discrepancy with information management. In this way 'lessons to learn' were quickly identified and the necessary actions had been taken promptly.

Is the service effective?

Our findings

All of the family members of people being cared for by the service had only positive things to say about the service they had received. This included, “If it was not for them [relative] would not be able to stay at home as we both want, I cannot speak highly enough of them.” They told us “We have plenty of information to help us consider what’s available” and “I definitely have no doubts about their skills. [Relative] gets the treatment here they otherwise they would go into hospital for from very experienced hospice nurses”. Other comments included “I am confident about their skills, everyone we have come across has been very knowledgeable and answered any questions we had” and “I rate them as excellent and exceptional” and “very professional”.

These sentiments were echoed in the surveys we (CQC) sent out and the service’s own three monthly satisfaction surveys. The palliative care consultant we spoke with confirmed that feedback they had on the service provision was “very good”.

The hospice at home service also provided assessment and treatment and support for people and families through its lymphoedema nursing service at clinics and in people’s homes that were housebound and/ or very poorly. Complimentary or ‘holistic’ therapies have been shown to be highly effective in relieving stress and anxiety and to help with relaxation. There were also local support groups where people could meet others going through the same experiences, get information, share thoughts and access support networks. The records of survey results and feedback about these services were all highly complementary and praised their value to people.

The service had policies in place in relation to the Mental Capacity Act 2005 (MCA). The MCA provides legal safeguards for people who may be unable to make decisions about their care. We spoke with staff that showed a clear awareness of the importance of supporting people to decide about their care and treatments. One relative told us “They never try to take over; they talk with us and listen to what [relative] wants, its [relative’s] choice. They [staff] work with us to get what [relative] wants”.

As part of the service’s information pack there was information for people, their relatives and carers on difficult topics such as ‘Do not attempt Cardio Pulmonary

Resuscitation’ (DNACPR) and advance statements. This information and leaflets went out to GPs and district nurses and was overseen by the service’s ‘Deciding Right’ facilitator.

The facilitator’s role was an educational and supportive one enabling people using the service and their families and carers to make informed decisions about care and treatment choices. They were employed by the service and worked with any organisation to help and support them. The facilitator focused on close working with medical and nursing professionals to try to improve outcomes for people and reduce anxiety. This was through providing information on such things as what cardiopulmonary resuscitation and advance care decisions were and if it might be relevant to them and how decisions about it were made.

The registered manager provided us with access to the electronic records for all staff training. Staff told us that they had good access to training and support and confirmed that they received regular supervision and annual appraisal in addition to their six weekly staff support meetings. We were told by staff members that the support for staff was “amazing” and that “The support systems and networks are phenomenal” and included access to counselling and debriefs for staff dealing with complex situations.

Staff told us their regular support sessions were “really useful” and allowed staff to discuss any problems. We were told the next learning session at the meeting was on managing syringe drivers so they could all keep up to date on their use and any problems to look out for. [A syringe driver is a pump that delivers a measured dose of a medication] for the provision of effective symptom control in palliative care].

We saw that all staff had received a ‘core’ induction when they joined the service. Following that further and continuing training had been tailored around the person’s role and responsibilities and the needs of the people they would be supporting. There was a robust system in place for the recruitment, selection, training and education of volunteers.

To make sure health care assistants could respond quickly to people experiencing pain a programme of training, competency assessments and protocols had been put in place. This was to allow them to quickly provide low doses

Is the service effective?

of strong pain relief when a registered nurse was not there. They told us they had worked with registered nurses who supported them and had formally assessed their competence to carry out the task if needed. This practice was only done for specific people and only in certain situations to respond quickly to increased pain. The health care staff we spoke to who had done the training had found it to be of value to the people they were caring for.

A programme of mandatory training was in place, including moving and handling, infection control, fire safety, safeguarding children and adults, basic life support and syringe driver/ medication training and information governance. Staff also attended a range of other training such as bereavement support training, training on core drugs in palliative care, dementia awareness, consent, capacity, powers of attorney and communication skills to support them in providing holistic care to people. Registered nurses undertook training to carry out specific procedures so people could receive certain treatments or clinical procedures people needed at home.

As a member of 'The National Association of Hospices at Home' and the 'National Council for Palliative Care' senior clinical staff also regularly contributed to the 'on line forum'. This can be used for discussing clinical issues and to share policies and best practices. This helps the spread of knowledge and good practice. It was evident that there was a clear culture of developing staff and person centred care to enhance the practical support people received from the hospice nursing team.

Nutritional assessments were carried out by the district nurse and formed part of the care plan in the person's home and was accessible to hospice staff. Hospice staff evaluated nutritional intake at each episode of care and recorded this on the Hospice Progress sheet. This helped to ensure that all relevant information was available and assisted in the district nursing re-assessment. Any significant concerns regarding nutrition e.g. swallowing risks were fed back to the Hospice Team Leaders. This

information was reported to district nurses for action as part of collaborative working. We saw that nursing and care staff received training on maintaining nutrition and hydration and issues around nutrition and hydration for people being supported by the hospice team had been discussed in detail at the two multi-disciplinary meetings that were held each week.

Hospice staff were not usually involved in food preparation or giving support at mealtimes. We found that they did advise people on healthy eating, usually earlier on in their illnesses and the most effective ways to boost their intake to help keep them strong and healthy especially whilst having treatments. We could see that staff had made referrals to speech and language therapists where it had been assessed as needed.

Most importantly the hospice at home provided support and information to people and their families on understanding the place of nutrition at the very end of life and when food was no longer high on the person's needs. They also supported people with mouth care and helped relatives with this important aspect of care to keep people's mouths' healthy and comfortable. All staff were trained on this important skill.

Those we spoke with in the community and palliative care teams told us how well the hospice at home services worked as part of the broader team to make sure care and support was effective and "seamless". We were told that the service was "very flexible" and "innovative" in developing networks and relationships with professionals and educational bodies. We were told how the hospice at home team "Work so well in conjunction with the community and hospital teams". A relative also told us "They are brilliant, the Macmillan nurse, the district nurse and the hospice girls all work so well together". Staff working for the service also told us that they felt well supported by the broader team and one said "The district nurses are great and really support us".

Is the service caring?

Our findings

All the people we spoke with praised the caring approach of the staff and managers at the service. We were told by family members that the service had been “A ray of sunshine in all of this blackness” and “So compassionate, an outstanding bedside manner, they have treated [relative] with such dignity and in a caring manner, so understanding of all our problems”. More than one person told us they could not fault the service or praise it enough. Relatives we spoke with told us that staff were “always polite” and “considerate” and that it was “reassuring” to have with them with them.

We were told by a family member “They [hospice staff] help us all in so many ways. From my point of view they have been life savers, I can get some sleep and it allows the family time for each other”. People also spoke of other aspects of the service “We’ve had the complimentary therapies and they have been absolutely great for us both. [Relative] gets a real lift from this”.

Staff we spoke with knew the people they were supporting well and their different individual and family needs and preferences. Staff demonstrated knowledge of people’s diverse needs and a deep commitment to the service. One staff member told us “I feel so privileged to do this work, to be able to help and make a difference”. Other staff we spoke with told us “Sometimes it’s important just to be there for people. We are here for the family as well”.

Relatives told us they knew the staff that came to support them in their homes and had always been introduced to them before they started coming to their home. We were told “We all know each other really well, they enable us and I can’t really put in words just how much they have meant to us”. Another comment was “[relative] finds them very attentive and is very relaxed with them”.

Bereavement support was available to people using the service, their carers and their families. This was provided by a team of staff and volunteers who had undergone specific training in this role to be able to support people in this way. This could be one to one support, family support (to include children) or group support. There was also access to spiritual and pastoral support for people and their families if they wanted this.

There were safeguarding and equality and diversity leads amongst the nursing staff that were a resource for others and helped to advise staff. All those we spoke with who had used the service said it promoted dignity and choice and “always” maintained people’s privacy and “respect our home”. A recent survey response said “I am so pleased to know there are people out there that really do care and that will continue to care for [relative] as the illness progresses. Thank you so much”.

The service had a ‘Six Steps to Success Facilitator’ that delivered training on end of life care to nursing, residential and domiciliary care services [This programme aimed to enhance end of life care through facilitating organisational change and supporting staff to develop their roles around end of life care].

Information was available to people on the care and support that the service could provide and families we spoke with confirmed they had been this given when they were first introduced to the service. Relatives also told us “We have the information booklets and if we want to know anything about the illness or what’s happening we just ask and I think we work well together”. We saw that a project was underway to combine all the information about the different aspects of the service into one concise document for easier use by people using the service. This was also going to be placed in local GP surgeries and with support services so information could be easily accessible.

The service had an information pack on this to help people and this was going out to doctors surgeries and to district nurses and their ‘Deciding Right’ facilitator took the lead on this. This helped to make sure information for people, their families and carers was easily available.

Policies, procedures and staff training were in place regarding maintaining confidentiality and on information governance to protect people’s personal information and privacy. We saw that all personal records about staff and people were held securely within a locked office or in lockable filing cabinets in the general office

All the staff we spoke with told us about the importance of having trust between them and the people they cared for and that this was “the basis of our relationship”. Relatives told us they trusted the staff that came to help them and one said “We all feel we can talk to them and know they will keep our confidences”.

Is the service responsive?

Our findings

Relatives told us that the hospice home nursing team responded quickly when people needed them. One relative told us “We have needed them quickly twice and they have been brilliant. When we have got to a stage where we need them they have been here straight away”.

We were told how the service had acted quickly to make sure a person had everything they needed for their care at home. A relative described when their loved one had needed a particular kind of ‘slide sheet’ and this had been obtained “that very day”. These were for staff to use to aid a person’s mobility in bed. The relative told us “It was great, they got it straight away. They really do their best, always”. We were also told how staff had reported back that a person they had gone to see in the morning had lymphoedema the lymphoedema nurse had visited straight away and everything the person required had been provided that day.

The hospice home nurses worked directly with people and their families from the point of referral and did their own risk assessments. Nursing staff visited the person in their homes and carried out a detailed assessment with them and their family to plan how the care they wanted would be provided. People told us the nurses “talked through everything” with them. The service planned the care around the individual’s specific needs and what they wanted and what was most beneficial to them. Contact was on a daily basis either by nursing staff for clinical issues or office staff for general enquiries. One person who used the service told us “I believe their [Hospice at Home] ethos is to say what you need, let’s get it done, that’s my view. [Relative] had expressed a wish and they made it happen. It’s is great, a ‘can do’ attitude, it’s doable so let’s do it”.

The service had a complaints procedure which was made available to people they supported and their family members. All the relatives we spoke with said they had been given a copy of the complaints procedure when they had started using the service. We were told “I have no worries, we have never needed to make a complaint about anything”. We were also told “They are all so approachable; I can just talk to them. If I was not happy I am sure I would be listened to without having to make a complaint”.

The registered manager told us the hospice at home team worked very closely with people and their families and any

comments were acted upon straight away before they became a concern or complaint. The service had not received any formal complaints relating to the provision of care since our last inspection. Feedback from the service’s quality monitoring had indicated some people were unsure of the formal complaints procedures. As a result the individual teams had worked together to update the complaints procedure and the ease of information access and clarity.

Hospice staff worked from their own documented risk assessments and care plans but also had access to the community nursing notes that were kept in the person’s home. There were eight hospice registered nurses who have had additional training to undertake the Hospice at Home assessments in addition to the clinical lead nurse. We found that people using the service had a needs assessment done with them and their families and that risk assessments had been done within 72 hours of starting the service. This was in addition to the district nursing care management plans.

Staff had been involved in the development of the risk assessments in use and a review of these had just been done to try to make sure that changes in regulations that applied to the service were incorporated into assessments. This included developing better assessments of people who may be living with dementia. This was to help staff identify people who might need more support to meet their needs and required additional risk assessments to maintain their safety.

Any health professional can make a referral to Hospice at Home West Cumbria. All people who had been referred had ongoing involvement in their care from a range of community services which included Macmillan nurses and community district nursing teams. Relatives we talked with told us that that once referred they could contact the service when they needed to “anytime”. The home nursing lead or a senior nurse took responsibility for liaising with the other professionals involved in a person’s care and support package to make sure there was smooth joint working. Relatives told us their family members could access the service when they needed it and if they needed extra support.

All clinical treatment was prescribed by either a person’s GP, palliative care consultant or a member of the specialist palliative care team. People who used the service and their families had been involved in the risk assessment process

Is the service responsive?

and deciding on what they wanted and needed the hospice staff to do for them. The Hospice at Home nursing care complemented care provided by other services but was not intended to replace it. A relative told us “It’s [relatives] choice, we work together to make sure [relative] has just what they want”.

We found that the service was continuously looking at ways they could develop and improve the service to improve people’s experience and support. We saw this demonstrated in practical ways. For example the service was signed up to the ‘I Want Great Care’ initiative. This is a charitable initiative to provide people with a forum to leave meaningful feedback on their care either in writing or electronically. It used people’s individual experiences to help build an anonymised national picture of the quality of care within the UK.

Hospice at home staff followed the district nursing end of life plans in people’s homes and monitored pain management as part of that. We could see that they home

nursing team were very involved with working with the district nursing team. As a result of this close working between the services a project had been undertaken to assess how frequently the health care assistants had needed to call out the district nurse for issues such as pain relief.

We saw that the staff and management had reflected on situations where people had needed additional pain relief. Feedback from people who used the service indicated there may be situations where this was needed quickly to make sure they stayed comfortable. An initiative had been developed with some health care assistants in response to this expressed need to help make sure people did not have to wait for analgesia for ‘break through’ pain. [This is a pain that “breaks through” the ceiling of pain relief that is provided by other means]. In this way people who used the service had influenced the way things were done to improve their experiences and to enable staff be more responsive to individual needs.

Is the service well-led?

Our findings

Everyone we spoke with had positive things to say about the way the service was organised and run. People who received support from the service told us that they received a high standard of care and said they would recommend the service to other people. Relatives told us that the registered manager was “very approachable” and “I would rate the management as excellent”.

The service had a registered manager in place as required by their registration with the Care Quality Commission (CQC). The staff we spoke with talked about a “supportive” and “open” culture that “encouraged” and “expected” training and continuous professional development. Staff told us that the registered manager was approachable and that they “set high standards”. We were told “I would never hesitate to speak to the manager, they are very aware of the difficulties and pressures we can face and don’t let it get too much. It’s a lovely organisation, we are a good team and we know we are valued by management”. They were evidently proud to work for the hospice at home team and believed they made real difference in the local community. Staff said they had regular staff and support meetings to discuss practices, share ideas and consider any projects and areas for development.

We saw that the Hospice at Home West Cumbria had a clear management and governance structures in place. There was also a Clinical Governance Advisory Group (CGAG) that reported directly to the Board of Trustees. At these meetings department leads had presented their clinical reports and papers/correspondence from community partners and networks had been discussed. We looked at the last journal article debated at the meeting that had a bearing on service development.

A strong emphasis on continuous improvement was evident as was the enthusiasm of the management and staff. As part of the service’s annual priorities for the year the advisory group was extending and improving patient safety by improving clinical audits to make them more comprehensive. A full time Head of Care and Quality had been appointed with responsibility for overseeing the audit programme against the CQC’s Key Lines of Enquiry (KLOE).

We saw that the management team had done their own compliance self-assessments and detailed audits against the regulations. These clinical audits against the KLOE’s

promoted a proactive approach to quality assurance and encouraged continuous improvement. We could see that a large body of work had been done on making sure the service was promoting the five domains or questions that CQC ask. Where needed action plans had been developed and were monitored to track improvements identified from internal audits. This included as medication, care and pain assessments, health and safety, training, recruitment, incident analysis and feedback from people using the service, their families and professionals involved in care.

We saw that a variety of approaches had been taken to auditing and information gathering. Some audits had been office based with monitoring of records and collating data to get a clear picture of what was happening. Some audits were on a more ‘action research’ basis as they were dynamic and on the spot involving home visits and ‘live’ medication audits. The hospice staff were also involved in audits and information gathering. The care and nursing staff on night duty were involved in mapping their activities and call outs to see if they could improve on and plan ahead to react quicker when some one’s condition changed. Some audits involved checking notes and to make sure they were correct and taking data from them. The service tried to build the audit process into all their activities so the information they gathered and records kept fitted into the process.

We looked at the ‘Quality Account’ produced by the service covering the year 2014/15 with statistical, pictorial and qualitative information. This was a report to provide information about the quality of the service they were delivering to the people of West Cumbria. This was available to anyone who wished to see it and asked anyone doing so to give feedback as this was “welcomed”.

People using the hospice at home nursing team, the lymphoedema services and support services were asked for their views regularly during episodes of care. Questionnaires were sent out to people using the home nursing service after four visits to get feedback. The lymphoedema service sent out its own surveys to all newly referred people at six monthly intervals.

The lymphoedema and complimentary therapies service also monitored how long people waited from being referred to their initial assessment. This was so they could help make sure people were seen quickly following referral.

Is the service well-led?

All quality surveys the service used asked for people to make their own comments about their experiences. The Service User Guide also asked for people to give them written feedback.

Patient experience feedback can be used to support, research and improvement programmes within an organisation. This demonstrated to us that this was an open and aware service. It demonstrated a focus on people's experiences as a central part of delivering good care. Staff and volunteers had feedback forms and training in how people should use them. This initiative also built upon the work the service had been doing itself to capture the effectiveness and value of the service provision from the perspective of people using the service. Originally started as a project from 'Hospice Week' the service now supported people who wanted to tell their stories in their own words.

Another example of how the agency worked to continuously develop best practice and service improvement was through participation in research. The manager, nursing, care and volunteer staff were encouraged and supported to take part in education, research and development to inform, influence and improve people's care. The Hospice at Home West Cumbria was participating in an international study being done under a European Union framework at Lancaster University: 'Researching Integrated Palliative Care'. This was looking at patient centred integrated palliative care pathways in advanced cancer and chronic diseases. Its aim was to gather people's experiences along their journeys and to contribute to finding out and understanding what worked best for people. In addition the service had taken part in a study to implement the Carers Support Needs Assessment Tool (CSNAT). This was a tool for use in the measurement of carer's support needs for use in practice and as a research tool.

The service had also sought support the Cumbria Partnership Foundation Trust research nurse to assist with recruitment to the study. This has formed a valuable link for future collaborative working.

We saw that the management team acted upon any comments made or on themes identified from surveys and comments. For example feedback indicated people were often confused Hospice, MacMillan and district nurses during this difficult time. As a result hospice nurses now gave feedback forms directly to people and could discuss this with them.

Staff surveys were done annually and asked staff to tell them about their work satisfaction, their training how well they had been supported and if they had been able to deliver a high level of care they were satisfied with. The last survey result showed 100% of nursing and care staff said they would recommend the Hospice at Home West Cumbria as a place to receive treatment.

We found that the senior management team and lead nurses made themselves accessible to all staff and encouraged staff in the development and forward planning of the service. All staff we spoke with described a caring and dynamic organisation. They said that it was constantly looking at ways to improve the care people received and the smooth collaborative working with other professionals involved in people's care.

The management and senior nursing team and the nursing and healthcare staff we spoke with expressed a clear vision of their roles and responsibilities in providing a high standard of palliative care to people in their own homes. This commitment was also reflected in the organisations strategy for 2015 to 2018 where the focus was upon "Consolidation, Communication and Leadership". A review of all aspects of the service and the care and support provision over this three year period was central to their strategy. This review was to help ensure that the service was meeting people's needs locally and that high standards and agreed good practice were maintained and that they continued to work effectively with other health and social care providers locally.