

South Tyneside NHS Foundation Trust

RE9

End of life care

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
	Blaydon Primary Care Centre		RE9X2
	St Benedict's Hospice and Centre for Specialist Palliative Care		RE9W1
	Palmer Community Hospital		RE9GF

This report describes our judgement of the quality of care provided within this core service by South Tyneside NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by South Tyneside NHS Foundation Trust and these are brought together to inform our overall judgement of South Tyneside NHS Foundation Trust

Summary of findings

Ratings

Overall rating for the service	Good	●
Are services safe?	Good	●
Are services effective?	Good	●
Are services caring?	Outstanding	☆
Are services responsive?	Good	●
Are services well-led?	Good	●

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service GOOD |

Overall, we rated community end of life care services as good, with caring rated as outstanding. Incident reporting was effective and embedded across the service. Staff were aware of their reporting responsibilities and there was evidence of learning from incidents. When things went wrong incidents were investigated, and lessons learned were shared. Risks to patients were assessed and managed to ensure safe delivery of care. Staff responded appropriately to safeguarding concerns. There were systems and processes for the monitoring of medication and infection control and they were regularly reviewed and improvements made. Staffing levels were monitored and reviewed to keep patients safe and meet their needs at all times of the day and night. Documentation and care records were completed appropriately. Do not attempt cardio-pulmonary resuscitation (DNACPR) forms were completed consistently. Equipment was available for patients and appropriate safety checks were in place.

Care and treatment followed evidence based guidance and legislation. Patient care was based on the best available evidence. Patients needs were assessed appropriately and care and treatment was planned and delivered in line with current legislation. Staff were appropriately qualified and competent to carry out their roles. There was a multi-disciplinary collaborative approach to care and treatment. Staff worked effectively in partnership with the mental health trust to promote the best outcomes for patients who were subject to the Mental Health Act.

Patients and their families were respected and valued and were empowered as partners in their care. Feedback from patients and their families was continually positive about the way staff treated them. There was a strong person centred culture. Staff always took patients personal, cultural, social and religious needs into account when delivering care. Patients emotional and social needs were valued by staff and was an important part of their care and treatment. Any complaints were dealt with appropriately and any lessons learnt were cascaded to staff.

Patients needs and preferences were important in the planning and delivery of services. The involvement of other organisations and the local community was important to how services were planned to ensure patients needs were met. Patients could access services in a way that suited them.

The leadership, governance and culture were used to drive and improve the delivery of high quality patient centred care. Staff were actively involved in the development of the service. Staff worked in collaboration with other services to provide high quality care. There were systems in place to monitor and audit the quality of care. Patients and their families were approached for their views and feedback was shared and acted upon.

Summary of findings

Background to the service

Information about the service

South Tyneside NHS Foundation Trust provided community end of life care services through St Benedict's Hospice and Centre for Specialist Palliative Care, and specialist palliative care community services. The community end of life care service provided specialist palliative care to adults in their own homes, inpatient beds and day care services at St Benedict's Hospice and Centre for Specialist Palliative Care, and within other nursing and residential settings. It provided support to patients living in the South Tyneside, Sunderland and Gateshead areas.

St Benedict's Hospice and Centre for Specialist Palliative Care inpatient unit had 14 inpatient beds. It also provided Hospice Day care services, a 24 Hour Advice Line, a specialist Nursing Service to hospital, community and care homes (Monday-Friday), a Lymphedema Service, a Consultant Outpatient Clinics, and a Out of Hours Palliative Care Nursing Service (a multidisciplinary team including physiotherapy, occupational therapy, chaplaincy, clinical pharmacist, complementary therapists with access to medical social workers). The Sunderland Specialist Palliative Care team covered a population of 282,00 in Sunderland and 33,000 in North Easington.

Primrose Hill Hospital provides specialist palliative care services in South Tyneside which includes Community Specialist Palliative care nurses who provide care in the community and care homes. Out of hours services are available from Palmer community hospital. St Clare's Hospice, which is an independent hospice, is adjacent to Primrose Hill Hospital.

Blaydon Primary Care Centre provided specialist palliative care services in Gateshead which included a Specialist Nursing Service – for hospital, community and care homes, Domiciliary / Community Visits (Consultant) as required and an Out of Hours Palliative Care Nursing Service. This covered a population of approximately 191,000.

Between April 2014 and March 2015 community end of life care in the South Tyneside area had 224 deaths, in the Sunderland area there were 332 deaths and in the Gateshead area there were 254 deaths. St Benedict's Hospice and Centre for Specialist Palliative Care had 119 deaths.

During our inspection we spoke with 27 staff including palliative care consultants, specialist palliative care nurses, managers, ward staff and allied health professionals. We spoke with 22 patients and their relatives and looked at 11 care records. We reviewed 27 comment cards received from patients.

Our inspection team

Our inspection team was led by:

Chair: Trish Rowson, Director of Nursing - Quality and Safety, University Hospitals of North Midlands NHS Trust.

Team Leader: Amanda Stanford, Care Quality Commission

The team included CQC inspectors and a variety of specialists: Health Visitors, District Nurses, Physiotherapists, Occupational Therapists, Community Matrons, Dentist and Expert by Experience (people who had used a service or the carer of someone using a service).

Why we carried out this inspection

We inspected this core service as part of our comprehensive acute and community health services inspection programme.

Summary of findings

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about this core service and asked other organisations to share what they knew. We carried out an announced visit between 5 and 8 May 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services.

What people who use the provider say

Patients told us they were happy with the care and treatment they received. Patients told us staff were very caring and listened to what patients and their families said. Patients felt safe and well looked after by staff. Staff are polite and friendly. Excellent care and all staff treat patients and their families with care, respect and dignity.

The specialist palliative care team sent out Families and Friends Test questionnaires to families and these are

reviewed quarterly. In January and March 2015 100% of respondents would recommend the service to family and friends. St Benedict's hospice completed real time reports – Family and Friends Plus for patient feedback. 100% of respondents in January and February 2015 were satisfied with the care and treatment they received.

Good practice

Outstanding Practice

- 100% of patients at the hospice died at their preferred place and for the out of hour's team at the hospice 399 out of 404 (99%) patients died at home. For patients cared for by the Gateshead out of hours team 246 (98%) patients in the Gateshead area died in their preferred place of care.
- There was a bereavement ward specialist nurse who held bereavement meetings and the chaplin was also a trained psychotherapist who would also provide support to the patient and their family.
- Patients and their relatives were truly respected and valued as individuals and were empowered as

partners in their care. Feedback from patients and their families was consistently positive about the way staff treated them. Patients thought staff went the extra mile in providing care, treatment, and support.

- The hospice completed carers assessments for all families. We observed hospice and community staff spending time with patients and their families to establish emotional support needs and provide appropriate support and advice..
- There were four weekly carer group meetings for carers which were positively received by patients and their relatives.

South Tyneside NHS Foundation Trust

End of life care

Detailed findings from this inspection

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Incident reporting was effective and embedded across the service. Staff were aware of their reporting responsibilities and there was evidence of learning from incidents. When things went wrong incidents were investigated, and lessons learned were shared. Risks to patients were assessed and managed to ensure safe delivery of care. Staff responded appropriately to safeguarding concerns.

There were systems and processes for the monitoring of medication, and infection control and they were regularly reviewed and improvements made. Staffing levels were monitored and reviewed to keep patients safe and meet their needs at all times of the day and night. Documentation and care records were completed appropriately. Do not attempt cardio-pulmonary resuscitation (DNACPR) forms were completed consistently. Equipment was available for patients and appropriate safety checks were in place.

Safety performance

- A range of safety information was being recorded and used to monitor safety performance within the hospice and specialised palliative care teams. We reviewed

information in relation to safety thermometer information which demonstrated high levels of compliance in terms of occurrence of pressure ulcers and falls.

- There had been no healthcare acquired infections in the previous 6 months.

Incident reporting, learning and improvement

- Serious incidents and Never Events have been taken from STEIS (Feb'14 – Jan'15) and the extract was completed on 2nd February 2015. The trust had reported no never events and had reported one serious incident requiring investigation which was reported and classified as a Slip/Trip/Fall. There were no incidents reported for end of life care.
- Staff understood how to report incidents and feedback from incidents were discussed at team meetings. Patients and their families were informed of the incident and kept informed about the investigation.
- Staff were aware of their responsibilities in relation to duty of candour and being open with patients when incidents occurred.
- During 2014-2015 there were 175 incidents recorded and the top three themes were falls, pressure damage and medicine related.

Are services safe?

- Incidents were reported into the Trust system via Datix, an electronic reporting system. The hospice had high rates of reporting, and operated an open and transparent system. Staff had changed practice as a direct result of learning from incidents.
- There was an example of learning from an incident in January which included a full investigation and review of policies. This resulted in the introduction of yellow/red stickers on Kardex to highlight which medicines were prescribed regularly and which were prescribed PRN. We saw evidence of these in use. The service reviewed the single nurse administration policy and had a day out to look at all medicines processes and policies in use.

Safeguarding

- There were trust policies and procedures for safeguarding vulnerable adults and children.
- Staff were aware of the process for raising concerns for vulnerable adults and children. Staff could explain when they would escalate and refer concerns to safeguarding.
- Palliative care staff told us they received safeguarding training. We reviewed the safeguarding training for specialist palliative care nurses and found all staff had received safeguarding training, including adult and children's safeguarding training Level 1, and Level 3.
- There was a safeguarding resource file available for staff in the nursing offices at the hospice.

Medicines

- There were clear, comprehensive and up to date policies and procedures covering all aspects of medicines management. Nursing staff told us that these were readily accessible along with regular access to pharmacist advice.
- Medicines were kept securely. Records were kept of room and fridge temperatures to ensure they were safely kept. Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Additional records were kept of the usage of controlled drugs so as to readily detect any loss.
- Arrangements were in place to ensure that medicines incidents were reported and fully investigated and we found there was an open culture around reporting medicine errors.
- Patient Group Directions (PGDs) are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a

written prescription. We checked a sample of PGDs in the community clinics and district nursing team and saw that they were up to date and had been authorised appropriately.

- We saw a system in place for managing national alerts about medicines such as safety issues. Records showed that the alerts were distributed to community teams who highlighted them at meetings and emailed them to relevant staff.
- Nurses were trained and assessed in the safe handling of medicines. Training was competency based and could be provided for specific identified needs.

Environment and equipment

- The trust used a McKinley syringe driver across the trust for administration of end of life medications.
- The hospice and community services had access to equipment to keep people safe and comfortable. Equipment was maintained and checked to ensure it was safe to use.
- Community staff told us equipment was available for patients who were at end of life and it was available promptly when requested.

Quality of records

- All staff had access to an electronic patient record. However the GP practices in the area were unable to access the record. There were paper hospital records which were stored securely in the team office.
- The service completed yearly integrated audits which reviewed the completion of patient records.
- Do not attempt cardio-pulmonary resuscitation (DNACPR) forms were completed for patients if indicated and were kept with the care plans.
- Care plans and DNACPR forms were kept in a yellow envelope on discharge and sent with the patient to ensure information was shared appropriately between all services including GPs and the ambulance service. Also Drug information was also shared via a green envelope system.
- We looked at 11 patient records and found they were clear and fully completed, including DNACPR forms. They provided an audit trail of decisions, treatment and care. Notes were easy to follow and included detailed and sensitive discussions about end of life care.
- The integrated audit for 2014 showed 100% of care plans were underpinned by relevant research and local/national guidelines.

Are services safe?

- The service completed monthly safety thermometer audits which reviewed pressure ulcers, and falls and the results were clearly displayed in the ward areas. Pressure areas were risk assessed every three days and we saw evidence of this in patient notes. Staff at the hospice completed 2 hourly intentional rounding for high risk patients.

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean. We saw information about hand hygiene displayed within the hospice and other relevant areas.
- The hospice scored 97.90% for cleanliness in the PLACE assessment in September 2014. The hospice ward and clinics were clean and tidy.
- The service also completed an integrated audit which asked questions about infection control, use of equipment and hand washing. The service demonstrated high levels of compliance in relation to infection control.
- We spoke with staff about infection control and all staff had a good understanding of infection control practices.
- There were daily, weekly and monthly cleaning schedules in operation which were up to date.
- We observed staff using Personal Protective Equipment (PPE) such as aprons and gloves.

Mandatory training

- Staff received mandatory training during 2015. For example, 75% of staff had received moving and handling training, 95% had received information governance training, and 80% of staff had received health and safety and health record keeping training. There were plans in place to ensure that all staff received mandatory training during 2015.
- We saw a Medicine management competency based assessment workbook 2014 (designed by the hospice pharmacist and changed each year) which included learning from incidents. It is compulsory to pass core sections and the pharmacist will support staff until they pass it. Core sections include: medicine calculations, medicine conversions, syringe drivers, and end of life care. There are Clinical sections for all teams (except lymphedema teams where a separate clinical scenario exists for the lymphedema team). Then there are specific practical sections with a variety of scenarios depending on staff role.

- The service developed master classes in response to gaps in knowledge highlighted by staff completing the workbook.

Assessing and responding to patient risk

- Staff assessed and managed patients risks as part of an ongoing process. We observed good use of general risk assessments for patients receiving end of life care. This included the assessment of risk in relation to nutrition and hydration, falls, the use of bed rails and the potential for pressure area damage.
- These risk assessments were audited in terms of completion and review. These audits demonstrated that risk assessments were completed correctly.
- Patients received a holistic assessment when first admitted to the hospice.

Staffing levels and caseload

- Staffing levels were sufficient at the hospice and in the community to ensure patients received safe care and treatment.
- Between April 2014 and March 2015 the hospice had an average vacancy rate of 2% and the Specialist Palliative Care teams had no vacancies.
- The service used the national hospice acuity tool and e-rostering to manage and monitor staffing levels.
- Between April 2014 and March 2015 sickness absence rates for the hospice were 4.3% and for the Specialist Palliative Care teams it was 4.9%.
- Palliative care was provided seven days a week. There was an out of hours service which provided care seven days a week.
- Medical cover was available out of hours with an on call consultant and a foundation year 2 doctor on call at night. The hospice and community services could also access a senior nurse from the out of hours service when needed.
- There were four training and education staff based at St Benedict's Hospice who provided training across the trust.
- The hospice employed three consultants in palliative care. There was an on call consultant telephone advice cover provided by St Benedict's Hospice out of hours and at weekends.

Managing anticipated risks

Are services safe?

- Major incident plans were in place. Staff had access to these plans and could describe actions that would be taken in the event of a major incident.
- There was a lone worker system in place for staff. Staff felt this worked well. Staff would speak into the device the address they were at / entering and if the emergency button was pressed the conversation with the patient could be listened into. If required and the staff member was in a difficult situation an escalation process would be initiated. Police could be made aware of the address also.
- The hospice monitored the security of the building and patient access to the courtyard was restricted in the evening and at night.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

Care and treatment followed evidence based guidance and legislation. Patient care was based on the best available evidence. Patients needs were assessed appropriately and care and treatment was planned and delivered in line with current legislation. Staff were appropriately qualified and competent to carry out their roles. There was a multi-disciplinary collaborative approach to care and treatment. Staff worked effectively in partnership with the mental health trust to promote the best outcomes for patients who were subject to the Mental Health Act.

Evidence based care and treatment

- End of life care followed national guidance and information was available on the trust intranet.
- End of life services followed National Institute for Health and Care Excellence (NICE) Quality Standards for End of Life Care Guidance, 2011, updated 2013. There was a specialist palliative care team and an out of hours service which provided support 24 hours a day.
- The trust had reviewed their documentation in response to the national review of the Liverpool Care Pathway and had introduced regional care of the dying documentation and priorities of care in the last days of life.
- Priorities for the last day of life care plans were developed with patients and their families.
- They had a CQUIN around 'Deciding Right' implementation for which they had achieved full compliance.
- The service had developed with commissioners care home standards and 31 care homes in the region were involved and the service was working to set up a network for care homes.
- An evaluation of the care homes involved showed a change in practice as a result of the training in care homes. It had shown that patient information had improved and care home staff attending and linking into GP multi-disciplinary team meetings had also improved.
- There had been an independent review completed by Care Alliance which showed improvements in care provided following training of care home staff.

- The hospice had undertaken several Kaizen workshops: a methodology for continuous service improvement involving a range of opportunities including quality, technology, processes, culture, productivity, safety and leadership. The service had developed action plans as a result to improve the service. Actions identified included getting patients to and from day services, which can be a challenge, so the service had appointed a volunteer driver co-ordinator and was piloting a booking system and using a minibus to transport patients to the hospice for appointments rather than patient transport services.

Pain relief

- Patients who were identified as being at end of life were prescribed anticipatory medication. Anticipatory medications were prescribed in advance to manage changes in symptoms and pain.
- There was an out of hours advice line available in Sunderland, South Tyneside and Gateshead via St Benedict's Hospice and Centre for Specialist Palliative Care, St Clare's Hospice and Marie Curie and St Oswald's respectively which provided prescribing guidance and advice.

Nutrition and hydration

- Risk assessments and care plans showed how to support a patient who was at nutritional risk. In care plans we looked at we saw food and fluid charts were completed to monitor input and output effectively.
- The integrated audit for St Benedict's 2014 showed that 100% of patients said they could access replacement meals outside of regular mealtimes and they could access snacks at any time.
- Specially formulated diets were provided on request for example correct texture and consistency to suit individual people's needs. 100% of patients in the integrated audit 2014 confirmed that a choice of food and drink was provided to ensure that their personal preferences were met for example for cultural/religious preferences.
- Menus were available for patients to choose a varied diet, according to their specific needs.

Are services effective?

Patient outcomes

- Outcomes for patient care and treatment were routinely monitored and recorded. 100% of patients at the hospice died at their preferred place and for the out of hours team at the hospice 399 out of 404 (99%) patients died at home. For patients cared for by the Gateshead out of hours team 246 (98%) patients in the Gateshead area died in their preferred place of care.
- The service was involved in research with South West Scotland University to improve care and treatment and patient outcomes for patients and their relatives.
- The service participated in the National Survey of Bereaved People. The aim of this survey was to assess experiences of care in the last three months of life for adults who die in England. Overall, the quality of care that was rated as outstanding/excellent for the 3 localities was between 43% and 48%, with privacy and dignity being rated as excellent at between 78% and 80%.

Competent staff

- Training was offered to non-specialist and specialist staff by the palliative care education team and staff based at St Benedict's Hospice. Training included Foundations in palliative care (6 day programme), stepping into palliative care, Sage and Thyme, deciding right awareness (regional initiative covering making decisions in advance, ADRT, advance statements, emergency health care plans, MCA and DNACPR) and master classes covering a range of topical areas, including subcutaneous fluids, McKinley syringe drivers, verification of expected death, Lymphedema care, and end of life care.
- The education team and specialist palliative care team at the hospice would also deliver bespoke training to staff and teams on request. For example they would lead reflective practice in ward areas.
- There were training sessions provided by a social worker for allied health professionals on the completion of continuing health care fast track applications for patients who were at end of life.
- Clinical supervision was informal and staff told us they accessed supervision and felt it was good.
- There were monthly meetings for staff at the hospice. Meetings discussed incidents, complaints and learning. Staff would also share training attended with presentations.

- There were also regular facilitated reflection meetings for staff and recently there was a reflection meeting facilitated by a mental health consultant from the nearby mental health trust following an incident when a patient had self-harmed.
- Two staff were certified as Sage and Thyme Train the Trainers for advanced communication skills.
- Staff had opportunities to shadow as part of their professional development. For example a member of staff was shadowing a consultant dermatologist to familiarise themselves with different skin conditions.
- Staff attended full day training in spiritual care.
- Appraisal rates for the Hospice staff and the Specialist Palliative care teams ranged from 100% and 67%. There were action plans in place to ensure that all staff received an appraisal.

Multi-disciplinary working and coordinated care pathways

- There was a good approach to multidisciplinary working in community end of life care.
- There were GP palliative care meetings attended by GPs, district nurses, and specialist palliative care nurses to discuss patients who were receiving end of life care.
- There were quarterly palliative care "link nurse" meetings led by the education team at the hospice. The meeting had been used to keep staff up to date with the care of the dying documentation and to support link nurses to roll out the documentation to the district nursing and intermediate care teams.
- There was an active end of life network which the service attends.
- The service had developed training for care home staff and the training incorporated medicines management and safety, drug combinations and dosages.

Referral, transfer, discharge and transition

- Patients were referred and transferred appropriately.
- The discharge or transition to an alternative place of care was a multidisciplinary process which included the input of nurses and doctors, therapists and external support agencies who would be involved in providing end of life care at home.
- GPs were kept informed of patient conditions and discharge information. Specialist community nurses liaised with GPs regularly.

Are services effective?

- Patients were reviewed formally weekly and their preferred place of care and death was discussed. Doctors saw patients daily and any changes were updated to ensure patients were able to be discharged quickly if the patient wished to return home.
- Equipment and care packages were put in place in a timely manner and any delays in provision of equipment would be reviewed and other options looked at to allow the discharge of the patient to their preferred place of care to proceed.
- Fast track discharge was in place to allow patients who wanted to return home to do so safely.
- There were processes to flag on the ambulance services when a patient was at end of life which helped facilitate a rapid discharge if required. Also the ambulance service could also access the out of hours service for advice about transfer of a patient and the appropriateness of the transfer to hospital.

Access to information

- Staff had access to relevant patient information. We saw that risk assessments and care plans were in place for patients at the end of life.
- Priorities for the last day of life care plans were developed with patients and their families.
- Do not attempt cardio-pulmonary resuscitation (DNACPR) forms were completed for patients if indicated and were kept with the care plans.
- Care plans and DNACPR forms were kept in a yellow envelope on discharge and sent with the patient to

ensure information was shared appropriately between all services including GPs and the ambulance service. Also Drug information was also shared via a green envelope system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff considered the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS) during multidisciplinary working.
- Staff including care assistants attended MCA and DOLS training. Two staff at the hospice had attended 2 day intensive MCA training.
- The integrated audit 2014 for St Benedict's hospice found 100% of staff were aware of and able to access the current 'Consent Policy' and Staff understood the procedure to follow to obtain valid written consent in practice.
- Staff worked with the local Mental Health Services to provide appropriate care to patients with mental health needs.
- Consent to care and treatment was obtained in line with legislation and guidance. Patients were supported to make decisions and where appropriate their mental capacity was assessed and recorded. We saw evidence within patient notes of an assessment of mental capacity and best interest decisions were made in accordance with legislation.



Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

Patients and their families were respected and valued and were empowered as partners in their care. Feedback from patients and their families were continually positive about the way staff treated them. There was a strong person centred culture. Staff always took patients personal, cultural, social and religious needs into account when delivering care. Patients emotional and social needs were valued by staff and was an important part of their care and treatment. Any complaints were dealt with appropriately and any lessons learnt were cascaded to staff.

Emotional care for patients was excellent. There was a counselling service available at the hospice for all patients in the community requiring end of life care. This had been evaluated with positive feedback being given by both patients and their carers. The hospice completed carers' assessments for all families. We observed hospice and community staff spending time with patients and their families to establish emotional support needs and provide appropriate support and advice. There were four weekly carer group meetings for carers which were positively received by patients and their relatives.

Compassionate care

- Patients and their families were treated with dignity and respect. Patients who were receiving end of life care had a single room at the hospice. Staff ensured doors were closed at the hospice to protect patients privacy and dignity when personal care was being given.
- Patient records we reviewed showed detailed discussions with the patient and their families. Discussions were recorded in a sensitive way.
- We observed staff approaching patients and speaking quietly and gently saying who they were and explaining what they were doing.
- Patients and their families spoke positively about the compassion and care they received from staff at the hospice and in the community. We observed kind and caring interactions between staff, patients and families.

Understanding and involvement of patients and those close to them

- Patients and families felt involved in their care and treatment. Patients told us staff took time to ensure patients and their families were fully involved in their care and understood their diagnosis, care and treatment.
- Results from the Real Time Questionnaire- Friends and Family Test Plus January and February 2015 showed that 100% of patients felt well informed and they were information given in a way you could understand. They also felt they could challenge decisions made about their care and treatment.
- The out of hours service family and friends test for quarter 4 January to March 2015 showed that 100% of respondents felt involved in decisions about their care.
- Care plans and care was person centred. All patients and their families we spoke with told us they felt able to ask questions because they had good relationships with the staff who were delivering their care.

Emotional support

- Chaplaincy services were available to patients and their families. There was a chapel and multi-faith room available for patients and their relatives to use. The multi-faith room had equipment and resources for other faiths.
- There was a counselling service available at the hospice for all patients in the community requiring end of life care.
- An evaluation of this service was completed in December 2014 which demonstrated that 82% of patients stated that the service was beneficial and 95% of patients who stated that they felt heard and understood by their counsellor.
- There are identified ward staff who are involved with the bereavement service and meetings.
- Staff always took patients personal, cultural, social and religious needs into account when delivering care.
- Staff in the community and in the hospice had a good knowledge of local support networks. There was information available for patients and their families.
- The hospice completed carers' assessments for all families. Staff told us they spent time with patients to



Are services caring?

support their emotional needs. We observed hospice and community staff spending time with patients and their families to establish emotional support needs and provide appropriate support and advice.

- Relatives were able to stay overnight with patients.

There were reclining chairs available for relatives and sofa beds were available in each room and there was a separate overnight room with shower facilities for relatives.

- There were four weekly carer group meetings for carers which were positively received by patients and their relatives.
- Staff described how pets were able to visit the ward should patients find this therapeutic. A patient's relative described how a patient's dog had visited a patient who missed them and how they had found comfort from seeing them.
- The hospice provided complementary therapies such as hypnotherapy to help patients manage their own health and wellbeing, to maximise their independence.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

Patients needs and preferences were important in the planning and delivery of services. The involvement of other organisations and the local community was important to how services were planned to ensure patients needs were met. Patients could access services in a way that suited them. Any complaints were dealt with appropriately and any lessons learnt were cascaded to staff.

Planning and delivering services which meet people's needs

- The trust met with commissioners, and other providers to review, design and deliver end of life care to meet the needs of patients.
- Services provided were person centred and discharge was planned to ensure patients were cared for in their preferred place of care.
- There was a discharge team which could fast track patients discharge to their preferred place of care (PPC). There was a rapid discharge process to enable patients to be discharged home from hospital in their last hours/days of life.

Equality and diversity

- We observed patients and their families were treated as individuals.
- There was a chapel and a multi-faith room at the hospice which was neutrally decorated to provide a space appropriate for the use of people from multiple faiths.

Meeting the needs of people in vulnerable circumstances

- The end of life team liaised with GPs, district nursing and community nursing teams to provide support and advice.
- Patients individual needs and preferences were reviewed and the service was flexible, and provided choice to ensure continuity of care. For example a patient needed to come into the hospice but because there was not a bed available the service had arranged for the patient to attend days services to provide care and treatment until a bed did become available. The

hospice had arranged for a patient to renew their wedding vows at the hospice with a reception for family and friends so that they had a day to remember and they were still able to receive care and treatment.

- There was a proactive approach to understanding the needs of different patients, which included patients who had complex needs. For example, hospice staff worked with mental health staff when a patient who had been sectioned under the Mental Health Act was admitted to the hospice to ensure there was an integrated approach to their care.
- The hospice was responsive to the needs of an anxious patient who needed blood transfusions but did not want to go into hospital. Staff arranged for them to access the treatment at the hospice.
- Patients and their families at the hospice were able to access an enclosed courtyard from their rooms.

Access to the right care at the right time

- Patients could access day services easily and there were minimal waiting times and access to services took account of patient needs. For example a patient accessed the day service within 24 hours of the need being identified.
- Access to translation services was available. Signers were available for patients with a hearing impairment.
- The service provided interventions for patients both in the home and in the hospice setting which traditionally would have had to be undertaken in a hospital setting. For example, the end of life team arranged for a patient, who had deteriorated and who needed a hospital admission, (but did not want to go into hospital) to receive care in the hospice..
- The service made adjustments to services to ensure action was taken to remove barriers if patients found it hard to access the services. For example the hospice had introduced a mini bus service for transporting patients to allow for flexibility in service provision. This allowed patients and their carers to access the service for a morning or afternoon only rather than having to attend for a full day. For example, it was arranged for a new patient to attend the hospice for 2 hours rather than waiting for patient transport which would have meant a full day visit to the hospice.

Are services responsive to people's needs?

- We observed care being delivered in the community. We saw staff made every effort to ensure that patients needs were met, including medicines being delivered, equipment being provided and support for relatives being put in place.
- Palliative care staff did community visits or joint visits with the community nursing teams. It also provided professionals, patients and carers with an out of hours on-call service for specialist advice seven days per week.
- There was an out of hours service available for patients and their families to access. We observed a phone call to a family by the out of hours team to ensure the patient was comfortable and to ask if they needed an evening visit.
- There was close liaison with the hospice, GP practices, the local authority and the ambulance trust which allowed for a very flexible community service that adapted to meet the needs of people approaching the end of their life.
- The service would arrange joint visits with mental health key workers if appropriate and there was access to IAPT services for patients.

Learning from complaints and concerns

- The Trust had a complaints policy. In quarter 4 the palliative care services (Out of hours services) had been asked to respond on two occasions to specific points within formal complaints to other services. The service hadn't directly received any complaints. Staff told us they would review complaints in line with the trust policy.
- The service told us they received low numbers of complaints. Staff told us they try to address any issues and concerns at a local level before they became complaints.
- Complaints were discussed at the monthly governance meeting and any themes, trends and lessons learned were shared with staff.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

The leadership, governance and culture were used to drive and improve the delivery of high quality patient centred care. Staff were actively involved in the development of the service. Staff worked in collaboration with other services to provide high quality care. There were systems in place to monitor and audit the quality of care. Patients and their families were approached for their views and feedback was shared and acted upon.

Service vision and strategy

- The service had a strategic business plan for 2014 to 2019. The plan included the six objectives for the trust with actions for the service to support the delivery. For example, the service had identified a minimum of 5% cash releasing CIPs with any significant changes in income or expenditure, and any potential risks identified.
- There was not an end of life strategy in place. However we were told there was a steering group which was looking at the development of a strategy across all services, including Governance, risk management and quality measurement
- Governance systems were in place to ensure learning and improvements were shared across the service.
- The service attended a regional network and national cancer network meetings.

Governance, risk management and quality measurement

- There was a palliative risk register which was monitored and controls were in place and reviewed to reduce the impact of risk.
- There were systems in place to monitor and audit the quality of the palliative care service. These were discussed at monthly governance meetings.
- St Benedict's Hospice and Centre for Specialist Palliative Care, and specialist palliative care community services had a programme of planned quality audits for 2014/15. This included safer management of controlled drugs, a discharge letter audit and community referrals and waiting time audits.

- Staff understood how to raise and report incidents. Sharing of lessons learned was used to improve practice and quality across the service.

Leadership of this service

- There was good leadership at local and service level for the hospice and community services. The leadership structure was clear to all hospice and community staff.
- All staff we spoke with valued the expertise and leadership provided by the specialist palliative care team.

Culture within this service

- Staff were committed to providing high quality care for patients who were in the last few days of life.
- Palliative care staff worked collaboratively with other community staff, for example, district nurses, to provide high quality care to patients.
- Staff worked to ensure patients had positive outcomes in their care and it was provided in their preferred place of care.
- Staff told us there was a culture of sharing knowledge through formal and informal training.

Public engagement

- The specialist palliative care team sent out Families and Friends Test questionnaires to families and these are reviewed quarterly. In January and March 2015 100% of respondents would recommend the service to family and friends.
- The hospice completed real time reports – Family and Friends Plus for patient feedback. 100% of respondents in January and February 2015 were satisfied with the care and treatment they received.
- The trust was holding a 'Dying Matters Awareness Week' in May 2015 to raise awareness about dying, death and bereavement and planning for end of life.

Staff engagement

- Staff felt actively engaged with senior managers and felt their views were reflected in the planning and delivery of the service.

Are services well-led?

- Staff felt they could raise concerns with senior managers and appropriate action would be taken as a result of concerns raised.

Innovation, improvement and sustainability

- The service had introduced a card with prompts for staff on the five priorities of care in the last few days of life.
- The Chaplin for the hospice had been recognised for their work as a hospital chaplain and was installed as an Honorary Canon of Durham Cathedral.
- There was a commissioned end of life care practice development project in the Sunderland Clinical Commissioning Group to look at training gaps for other health and social care organisations. The project commissioned the service to provide and deliver training on “deciding right and the five priorities cone chance” to all health and social care across the Sunderland area.
- The service presented their work on patient and public involvement at national conferences for end of life care.
- A senior nurse had previously been nominated for the RCN palliative care nurse of the year award and recently patients had nominated staff in the local press for recognition awards
- There was a commissioned end of life care practice development project in the Sunderland Clinical Commissioning Group led by St Benedict’s Hospice and Centre for Specialist Palliative care to look at training gaps for other health and social care organisations. The project aims to work with partner organisations across Sunderland to ensure that the health and social care workforce and any voluntary sector teams are provided with the education & development to ensure they have the necessary skill and knowledge to provide high quality end of life care.