

Tynedale Hospice at Home

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Inspection report

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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?	Requires Improvement ●

Summary of findings

Overall summary

This announced inspection took place on 22 and 29 September 2016. This meant we gave the provider 48 hours' notice of our intended visit to ensure someone would be available in the office to meet us.

We last inspected the service in August 2014. At that inspection we found the service was not meeting Regulations 10, 13 and 20 of the Health and Social Care Act (Regulated Activities) Regulations 2010, which correspond to Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and relate to governance and management of medicines.

Following our inspection in August 2014, the provider sent us an action plan to show us how they would address our concerns. We undertook this inspection to check that they had followed their plan and to confirm that they now met legal requirements.

Tynedale Hospice at Home is a service which supports people for free, who have life limiting illnesses in the Tynedale and West Northumberland area's and who wish to be cared for in their own homes. The service also provides family services which offers pre and post bereavement support to families (including children), where an individual has been diagnosed with a life limiting illness or has passed away. Free transport is also available for people with life limiting conditions to attend hospital appointments.

The service is registered as a charity. Staff supporting people, consist of nine registered nurses and 11 hospice support workers and over 200 volunteers. The team of staff work closely with local GP's, district nurse teams and also members of staff from a variety of organisations. At the time of the inspection there were 14 people receiving care and support from the service.

The service was supported via three charity shops selling a range of clothes, bric-a-brac and books and also has the aid of people (local and otherwise) to raise funds in other ways, for example, through sponsorships and donations. The service is backed by volunteers who help, for example, within the family support service, the transport service, in the shops, to raise money, and in many other ways across the service. Funding is also sourced through application to, for example, The Big Lottery Fund.

The service did not have a registered manager in post. The previous registered manager had left the service in July 2016, and a new manager had been appointed and was currently in the process of registering with the Commission. 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.

We found that changes had been made to the way medicines were managed and staff were now meeting the regulations and following safe management of medicines practices.

Audits had been put in place to check on the quality of the service and although the regulations were now being met, there were still some areas of improvement needed to be made within the well led section of the report.

Staff were able to describe what it meant to safeguard people and told us how they would report any suspected abuse and there were policies and procedures in place for staff to follow.

Staff followed risk assessments when providing care and support for people in order to maintain people's safety. Accidents and incidents were clearly recorded. Where any incidents occurred these were discussed and reflected upon in order to make improvements. There were procedures in place should an emergency situation arise, for example a protocol for lone working at night.

Safe staff recruitment processes were followed with the appropriate checks being carried out.

There were sufficient numbers of staff on duty to meet people's needs in a meaningful way and the service had a team of volunteers who provided additional support. The hospice had a bank of staff and volunteers who they could contact if they needed additional workers.

All staff received support individually or as a group and annual appraisals were undertaken. Staff and volunteers received an induction and regular training to ensure they had the knowledge and skills to deliver high quality care which they demonstrated throughout the inspection.

The Care Quality Commission (CQC) is required by law to monitor the operations of the Mental Capacity Act 2005 (MCA) and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'. We found the provider was complying with their legal requirements.

People were supported to receive a nutritious diet and sufficient hydration, if this was part of their care and support plan.

When people needed specialist healthcare support the hospice made referrals to specialist services such as occupational therapy and we saw through people's records that staff liaised with other healthcare professionals to ensure that people received the correct level of care and support available to them.

The service was responsive and focused on providing a service which people helped plan and develop. There were appropriate systems in place to ensure flexibility to people so that their care needs could be met.

People told us that staff were caring and listened to them. Staff at the service followed local palliative care guidelines which ensured people's on-going integrated care.

People helped develop their care plans which were person centred. This is when any treatment or care takes into account people's individual needs and preferences. These were reviewed regularly.

People's hobbies and interests were encouraged. One person told us that staff played Scrabble with them and a relative told us, "The staff will read to [person] if they want, it's something they liked to do themselves, but it's difficult now."

People were confident expressing any concerns to staff at the service and knew who to approach if they

were not satisfied with the response. There had been one complaint over the inspection period which had been dealt with appropriately.

Staff and volunteers shared similar values and worked closely with each other in a mutually respectful way. There were regular team meetings. There was also a newsletter for anyone involved with the hospice, including staff and volunteers. This gave details of events and stories of people and families involved with using the service.

We have made two recommendations regarding quality assurance checks and audits and communication.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Staff used safe working practices and followed risk assessments when providing care and support for people.

Staff were able to describe what it meant to safeguard people and told us how they would report any suspected abuse.

Staff were recruited safely and there were sufficient staff on duty to meet people's needs.

People had their medicines managed safely.

Is the service effective?

Good ●

The service was effective.

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

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 worked within the principles of the Mental Capacity Act where appropriate. People had choices about their care and their consent was sought by staff.

Is the service caring?

Good ●

The service was caring.

People told us that staff were caring. Good support was provided to people and their relatives by a team of staff and volunteers.

People told us that staff took the time to build a rapport with them.

People's needs were supported and they felt respected. Privacy and dignity was maintained.

People made decisions about the care and support they received and told us that staff at the service communicated well with them. Care was person centred.

Is the service responsive?

Good ●

The service was responsive.

People were involved in developing their care plans which were person centred and clearly described the care and support people needed and these were reviewed regularly with the person and their family.

People told us that they would be confident expressing any concerns to staff at the service and knew who to approach if they were not satisfied with the response.

Is the service well-led?

Requires Improvement ●

The service was not consistently well led.

There was willingness by everyone connected with the hospice to improve and develop. However, information was not always shared and communicated with staff in a timely manner.

Audits and checks were in place, but staff training was not monitored as fully as it should have been to ensure that records were up to date.

During a time of organisational change the service had ensured this did not impact on the care people received and high quality care and support was provided.

Tynedale Hospice at Home

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.

This inspection took place on 22 and 29 September 2016 and was announced. The inspection was carried out by two adult social care inspectors, a pharmacist inspector and an expert by experience. One of the inspectors was also a specialist advisor in hospice services. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We did not request that the provider complete a provider information return (PIR). A PIR is a form which asks the provider to give some key information about their service; how it is addressing the five questions and what improvements they plan to make.

We reviewed other information we held about the service, including the notifications we had received from the provider about deaths. We also contacted the local authority commissioners for the service, the local Healthwatch and the clinical commissioning group (CCG). We used their comments to support our planning of the inspection.

We spoke with 10 people who used the service and 16 family members/carers. We also spoke with the manager, the hospice director, two trustees, five nurses and seven members of care and support staff. We also spoke with one of the administrators at the office base. We looked at a range of records which included the care and medicine records for seven people who used the service, five staff personnel files, health and safety information and other documents related to the management of the service.

Is the service safe?

Our findings

At our last inspection we found that the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to part of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and related to safe management of medicines. We found staff had not followed safe practices and had put people at potential risk of harm. At this inspection our pharmacist inspector found that the provider had taken sufficient action to address this.

People and their relatives told us that staff supported them with medicines administration if it was needed and knew how to follow procedures and record information correctly. One person told us, "I take medication myself but when they are here they make sure I take it because my husband has told them what I need and it is all written down in the plan and the log book where they record everything." A relative told us, "She [nurse] helps with medication and records everything she gives to [person] on the MAR (medicine administration record) chart which is with the care plan and all the other information about my [relative]."

Medicines were handled safely and people received their medicines appropriately. We found that medicines 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. Since our last visit, the Provider had introduced a more detailed 'Administration of medicines policy' that covered all aspects of medicine administration by staff. Registered nurses and care staff occasionally administered medicines that had been prescribed and that was stated in the person's care plan. Where medicines were administered, we saw that a record was made to say what had been administered. At this visit we also saw that a list of medicines that people were taking was included in the care file and that where medicines were changed, the list was updated to reflect the changes. Maintaining an up to date list of each person's medicine requirements helps make sure that all the medicines needed are administered correctly. We found medicines were stored safely in people's homes.

We saw that care plans had been introduced for any 'as required' medicines that staff may have needed to administer on their visits. 'As required' medicines are used for intermittent health conditions, for example pain relief. This information helped to ensure people were given their medicines in a safe, consistent and appropriate way. Any medicines errors or incidents were fully recorded for the purpose of review and learning for staff. Any changes in people's prescribed medicines were logged via a call into the office and recorded in the person's daily notes. We spoke with the manager and they agreed that a separate section for updates on medication was going to be put in place, both to be held at the office and also in people's home records.

People told us they felt safe using the service and their relatives confirmed they thought the same. Comments from people included, "I feel safe with the staff who come"; "The staff are great" and "Nothing could be improved". One relative told us, "I have no issues with safety. I can leave [person] and go out, knowing that they are in capable hands." Another relative told us, "There are a number of people that have been coming for a long time and we are familiar with them and they all know what my [relative] needs."

Members of staff we spoke with clearly articulated a range of sign and symptoms of abuse and potential

risks to people who used the service, as well as the correct actions they would take if they suspected any form of abuse occurring. Policies and procedures were in place and available to all staff members. Staff had received training in safeguarding vulnerable adults with refresher training waiting to take place. We were satisfied that people would be protected from avoidable harm because staff understood their responsibilities to report issues of concern.

Records demonstrated that people were assisted to make informed decisions about their care and supported appropriately where risk was involved. There was evidence of risk assessments completed for people, with family and carer involvement where appropriate. Risk assessments described the actions staff were to take to reduce the possibility of harm without applying any unnecessary restrictions. For example, individual risk assessments included measures to minimise the risk of falls and to mitigate against the risk of particular equipment and safe handling of people. This meant that risks were identified and action taken to mitigate the risks and keep people as safe as possible.

We reviewed the critical incident/accident log and saw that all incidents were documented comprehensively alongside any actions taken. This meant that people using the service were protected from the risk of individual incidents not being managed effectively and potentially recurring. These were monitored and discussed with senior staff and any lessons learnt noted with actions or recommendations being followed.

People and their relatives told us that there were enough staff on duty to meet their needs and that care and support staff were always on time. However one relative told us that on one occasion a staff member had been delayed unexpectedly and had called to apologise and another member of staff had taken their place. They told us, "These things happen I suppose and cannot be helped. People and their relatives told us that they usually had the same staff attending to their needs. Staff were asked by the provider to send in their availability on a two weekly basis, this allowed administration staff to work out a schedule of care visits for people, generally being able to utilise the same staff for individuals unless they were on holiday or off sick. The service had a bank of staff and volunteers they could utilise. This meant that the provider tried to ensure that people had continuity in the care they received.

We noted that staff had an on call system in place outside of normal working hours which was also used as a trace for their movements to ensure they remained safe while at work, particularly while lone working at night. Staff contacted the on call person at the beginning and end of each visit and a handover was also given, which would be passed on to the day staff if relevant. During the day, a white board in the office was used to monitor the whereabouts of staff on duty to ensure their safety. The service also had a continuity plan in place to ensure that any disruption to the possible staff cover arrangements would be minimised, for example, in poor weather conditions or staff sickness.

The service had a recruitment policy, which provided a good framework for the recruitment and selection of staff and volunteers to work with vulnerable people. A range of checks were carried out including proof of identity, written references, and checks with the Disclosure and Barring Service (DBS). Further verification was undertaken for nursing staff through the Nursing and Midwifery Council (NMC) regularly to verify their continued registration as nurses. All staff had completed an application form and had been interviewed. The hospice used a number of volunteers in the services and volunteers also went through a stringent recruitment process to assess their suitability.

All staff who cared and supported people in their own homes had been issued with a pack of equipment to prevent and control infection. The pack contained personal protective equipment, including gloves and aprons and hand gel. This meant the provider had taken additional measures to protect staff and the people they worked with from the risks associated with infection control issues.

Is the service effective?

Our findings

People thought that staff had the knowledge, skills and attitude to provide them with good care and treatment. Comments from people included, "[Nurse name] is brilliant. I could not ask for a better nurse. She is well trained and knows exactly what is needed"; "They are all well trained"; "They are very qualified" and "My [relative] has said that he is fully confident at going out knowing that I am in safe and capable hands and if he didn't think this he wouldn't go out. She [nurse] is well trained and has been doing the job a long time and you can tell that by the way she does it".

Comments from relatives included, "We are lucky to have them they are first rate nurses who work in difficult circumstances and are very professional"; "They all know what they are doing. She [care worker] points me in the right direction. She has the right experience"; She [nurse] is very courteous towards her and very cheerful and absolutely well trained"; "I go shopping on that day and I have every confidence that my [person] is being well cared for with a person who is very knowledgeable about medical matters".

We received a copy of the providers training matrix, which showed that all staff had received a range of training, including for example, safeguarding vulnerable adults, medicines management and moving and handling. We also saw that the provider had utilised other organisations training events to enhance the knowledge of their staff team, including specialised training at other hospice providers, in connection with a variety of palliative care related subjects. Staff that we spoke with told us that they could request particular training if they thought they needed it, for example, one staff member had requested an update in safeguarding because they needed to be refreshed. This meant that people were supported with their needs by suitably trained staff.

Another member of staff had recently attended pre-bereavement training and reported their findings of the course to the board of trustees. The training had included strategies for supporting families of someone who was dying, the fears of a dying person and useful discussions and exercises. The staff member had commented in the feedback, "Our knowledge of pre-bereavement is already excellent." We were told by staff that this training would be cascaded to other staff involved with the family support department of the service.

We saw that induction was aligned with the Care Certificate. The Care Certificate was officially launched in April 2015. It aims to equip health and social care workers with the knowledge and skills which they need to provide safe and compassionate care. It replaces the National Minimum Training Standards and the Common Induction Standards. One staff member told us they had induction and had shadowed an experienced worker until they felt competent when they started to work at the service. They also told us, "I have supervision with the nurse and training is discussed." All staff had received regular supervision and annual appraisals from the records that we checked. Staff told us they felt supported and regular meetings took place to allow them to discuss best practice and to communicate with each other about issues within the service or the people they cared for.

A healthcare professional we spoke with stated "The nurses understand palliative care very well" and "They

do a very good job." They agreed that staff had a good knowledge of the needs of the people they cared for. This meant that people with specialist knowledge considered staff at the Hospice at Home service had the necessary skills to perform their role.

Staff at the service attended multi-agency meetings to discuss the needs of individuals in their care. This ensured that a 'joined-up' approach to people's care was maintained and any issues arising were discussed in full with the most suitable outcome sourced for people.

Communication between people and the staff who cared and supported them was good. One person told us, "We [staff and person] discuss everything. We have open discussions about what I want. I want to stay here [at home] when the time comes."

Care records included an assessment on people's consent to receive care and support from staff at the service. We saw that records were signed by the person or their relative or representative, if they were unable to sign.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met and found they were.

Where staff provided people with support in their dietary and hydration requirements, this was documented in their care records. We checked one person's care records and found information was detailed about their dietary needs and preferences. For example, they required thickened fluids to reduce the risk of choking. We read that the person's food needed to be cut up. The person's relative confirmed, "They [staff] chop [person's] food up small and [person] has a beaker with a straw." This meant that staff had detailed information about people's individual nutritional needs and followed instructions in documented care records.

People's general health care needs were met. People's records included details of appointments with and visits by health and social care professionals. Examples included GP's occupational therapists and palliative care nurse specialists. This demonstrated that people could access a range of healthcare professionals to meet their care needs and maintain their health.

Is the service caring?

Our findings

The feedback we received from people using the service, relatives and healthcare professionals was positive. For example, when we asked people what the Hospice at Home service did well their comments included, "The staff are familiar and regular, which has great merits and they have become friends. They are nearly all trained nurses who have great empathy"; "They are absolutely wonderful, very kind and they have become friends and they will help me at short notice if needed"; "[Nurse name] is the main one and she sits and chats with me and she is a nice welcoming person who is fantastic with me and I couldn't wish for anyone better. She is marvellous, homely, funny and she brings a brightness to my day"; "[Staff name] is kind, helpful and she makes conversation and massages my feet and ankles and puts cream on them. She is very cheerful and always asks me what I want and lets me decide"; "Nothing is a trouble and they [all staff] are a Godsend. It is a great resource" and "She [nurse staff] respects my privacy and dignity at all times when she gives me a shower and I am comfortable with her and she is A1 [great] I have no concerns at all I am very happy".

One relative told us that staff involved their family member who had communication difficulties, in developing their own care package. They explained, "My [relative] has difficulty speaking so [staff name] uses email, cards and the alphabet in order to make conversation which [person] appreciates." This meant that staff supported people to express their views in different ways other than verbally.

We asked relatives what the Hospice at Home service did well and their comments were as follows, "They are good at keeping her morale up when she is feeling down"; "They are all really dedicated"; "They are so caring and understanding"; "[Staff] asks my [relative] what she wants to do and is always encouraging her as best as she can"; "[Staff name] is fantastic and she even went to visit my [relative] when they were in hospital which was great"; "The service is excellent I would give it five out of five and they are flexible with us and it is not a hurried approach and they are very sensitive to our emotional needs as well" and "[Nurse staff name] is intuitive and gentle, quiet, kind and has a natural propensity to know how to deal with people with dementia".

Relatives told us the staff also considered their needs as one relative explained their own health related issues and told us that staff were looking at ways in which they could support them further. In their feedback one healthcare professional said, "Good caring service for people requiring palliative care and not just for the patient but for their family too with the other interventions they do."

The care planning process included the person's history and views. The staff said they used this information to support people in a way that met their individual wishes and preferences. Records demonstrated that staff engaged people in decisions about their care and treatment, but if they did not want to express their wishes this was also respected.

People and their relatives told us that staff at the service treated them with privacy, respect and dignity. Comments included, "[Nurse staff name] has got a cheerful personality which we both like. She [nurse] treats us both with respect" and "If [relative] gets distressed because pads needs changing, [staff name]

speaks gently to [relative], verbally calming them down and reassuring them and always respecting their privacy and dignity" and "The girls [all staff] are brilliant with [person] and ask her if she wants a wash and don't presume and treat her with dignity and respect".

One person told us, "They [staff] have given me all the information I need. They also do bereavement counselling. They have chatted to [name of relative] but he doesn't want to talk about it."

Discussion with the staff revealed there were no people who used the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010; age, disability, gender, marital status, race, religion and sexual orientation. We saw and were told that some people had religious needs, but these were adequately provided for within people's own family and spiritual circles. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Staff told us that no one at the service was currently receiving support from an advocacy service and that any support was provided by people's families. One staff member said, "If someone needed help, we would just make sure they got it. Like anything else they needed." An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions.

With regard to end of life care, people and their families were involved in planning. One relative told us that only because "The support has been so sensitive" did they feel able to discuss end of life planning decisions. We saw that, where Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were in place this had been discussed with people, their families and relevant healthcare professionals. A DNACPR is an advanced decision not to attempt cardiopulmonary resuscitation in the event of cardiac arrest. This meant the service involved and enabled people and their families to fully contribute to advance decisions about their end of life care through sensitive, respectful discussions.

Community nurses confirmed that staff at the service attended regular "Palliative care partnership" meetings. Nursing staff at the service explained the support system used for palliative care 'patients' in their area was called, "Care for the dying patient" and they used this documentation. This meant that people's care was integrated with local healthcare teams using locally recognised palliative care guidance.

Is the service responsive?

Our findings

Everyone we spoke with confirmed that the staff team were responsive to their individual needs. Comments from people included, "They sorted the care plan when I started and there are other people involved like district nurses. But it is all organised and there for people to read" and "They [staff] also support me – they are wonderful".

Comments from relatives included, "[Nurse name] is very familiar with our circumstances and the care plan is constantly reassessed and the log book is completed every time they [staff] come"; "When [person] was in hospital they offered to stay with them in hospital to give me a bit of respite which was lovely and it helped my [other relative] because there were people with [person] that they knew"; "The managers ring up weekly to see how we are going on and the care plan is reviewed every few weeks. It takes about two hours to do and I ring up if there is anything I need" and "The girls [staff] are fabulous. I can't say enough good words about them. They are very caring, sympathetic, and try to talk to [person] as best they can and discuss the papers or the Olympics with [person] to try and stimulate a response".

Where a rapid referral was required and the person was registered on the palliative care register for the area in which they lived, this referral was telephoned in to the service and arrangements were made as quickly as possible. Pre-admission assessments had been carried out with people and their families to determine their needs and the support they required from staff, including those in relation to breathing, communication, personal care and sleep routines. Care plans and assessments were detailed and specific to the person receiving care, including for example, a section named 'A little bit about me', which asked staff to record details of the person's family, occupation, hobbies, social situation and any other important details in relation to the person. We noted that care plans included details about people's preferences. We read one care plan which stated under the question "What is important to you at this time?" The person had stated, "To remain at home if possible."

We saw, and people confirmed that care records, including risk assessments, were regularly reviewed. One person told us, "The care plan is regularly reviewed and they [staff] are very thorough and detailed in what they do. We have a folder with the log book and all the other information there for people to read and consult"; "[Senior staff] rings regularly to see how we are going on and to see if anything needs updating on the care plan and review anything else that we might want". This meant that any changes to people's care and support needs would be quickly identified and actions taken to ensure that people's needs continued to be met.

Health and social care professionals completed a referral form, which included details about existing or potential risks to ensure the safe transition of care. People's needs were now classified using a RAG system. This is a popular method of rating, based on red, amber and green colours used in a traffic light rating system to denote the level of risk and therefore prioritise accordingly. Red being higher risk and referring to people who are generally at the latter stages of palliative care. This process was currently under review. This meant that people with more urgent needs were prioritised to ensure they were addressed quickly.

A community nurse told us how staff at the service dealt with the person and their family as "one unit". They told us, "Sometimes people might need taken to a hospital appointment, sometimes a family member might be struggling and need someone to talk to. This is on top of providing the patient with nursing care when it is needed. I just wish there was more of them."

Care records made reference to people's interests and from daily notes we saw that staff tried to engage people in social interactions that were meaningful to them. One relative told us, "My [relative] cannot stand and the [staff] sits with her in the lounge and they play scrabble and other games on the computer. They watch TV and chat and [staff name] is excellent."

People and their relatives knew how to complain if they felt they needed to. One person told us, "I've had information about how to complain, not that I need to, they couldn't be kinder or more helpful" One relative told us, "They [staff] are very respectful with [person] and chivvy [person] up when [person] is a bit down. I have no complaints about them at all." Another relative said, "They [staff] do a good job I have no complaints." A third relative told us, "They [staff] are like family, they try to find a solution to any problem and we couldn't do without them." There had been one complaint between the last inspection and this one, and we saw evidence that this had been investigated by the manager, communication had been made with the complainant and the matter dealt with appropriately.

The staff team worked flexibly to provide consistent coordinated, person-centred care as people moved between services, including for example, admission into hospital. We saw this on records that we checked. One health care professional confirmed this to be the case and said, "If patients do have to be admitted to hospital for any reason, the staff at the hospice will work closely with others to ensure a safe transition."

Is the service well-led?

Our findings

At our last inspection we found that the provider was in breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and relates to good governance. We found omissions and incomplete entries in people's care records. We also found no record in place to confirm audits had taken place in connection with medicines and care plans. At this inspection we found that the provider had taken sufficient action to address this.

At the time of our inspection there was not a registered manager in place, as the previous registered manager had left the service in June 2016. The current manager was present and assisted with the inspection and was in the process of having their application to register with the Commission processed. They had worked at the service since 2015 and had previously worked in a health related principal lecturing capacity at one of the local universities. They had also previously been a registered nurse, but was no longer registered with the NMC and could not practise as a nurse.

We spoke with a number of staff, including nursing and care staff. It was not made clear to us who had particular individual responsibilities, with regard to the cover arrangements for the vacant post of clinical lead. This meant that staff were not clear in their roles and responsibilities.

Communication was raised as an issue by half of the staff we spoke with. This mainly included communication around changes within the organisation and the feeling that staff were not always fully involved or consulted. We brought this to the attention of the hospice director as a representative of the provider. They told us that this was an area in which they wanted to further improve and would discuss ways of doing this with the trustees and whole staff team. They also told us, "We are a very different organisation now"; "We share a lot of information across organisations" and "There is much more positivity".

We recommend that the provider ensures that communication is monitored and included improvements at all levels.

A small number of notifications had not been sent in to the Commission as legally required under the provider's registration. We spoke to the hospice director about the monitoring of this process. They told us that they would update the reporting process to ensure that all future notifiable incidents were reported in a timely manner and in line with their legal responsibilities. We have dealt with this outside of the inspection process.

People and their relatives thought the service was well led, although they directed their comments about being well led, to interactions with senior nursing staff. Comments from people included, "Overall the service is brilliant I could not fault it"; "Overall they are excellent I would give them 10 out of 10 and [nurse name] has even given me their home phone number if I have any problems"; "They go through everything, telling me what they are doing and what they are writing down" and "I am not frightened to ask [nurse] any question, they has the right approach and is excellent I am very happy with the service".

Comments from relatives included, "We are utterly satisfied, marvellous how they do it as a charity - I don't know, but they are excellent all of them"; "The managers [nurses] ring or visit about every two months to see how we are doing and they are always helpful and I appreciate the personal contact" and "As you can see [person] is very happy with the service as we all are as a family"

We witnessed willingness by everyone connected with the hospice to improve and develop, including directors, trustees and management.

The provider had a 'service user' charter in place which listed what the staff at the service would do in support of each person who used the service. This included for example, in relation to the service as a whole:

- Value each person as an individual
- Respect your dignity, privacy and freedom of choice
- Provide and equitable service to all, without discrimination

The provider's mission was "Easing the end of life journey for people in our community". From what people and their relatives told us and from what we heard while talking with staff, the charter and the mission statement were in practice across the organisation.

Although staff, including nurses told us they had been trained and the training matrix we had been given included details to confirm this, we could not find the training certificates for all of the staff and nurses in the records we checked. We found that quality assurance checks had not ensured that training details were kept up to date. This meant that the provider did not always have a robust system in place to monitor staff training. We brought this to the attention of the manager and hospice director who later emailed us to confirm that actions were being taken to rectify this and ensure that copies of certificates were in all staff files and would be fully monitored in future. They told us that work was already underway to combine mandatory and other training onto one document and ensure training was aligned with policies, for example, medicines.

Audits and checks were carried out, including those in connection with care records and medicines. We also saw the report on the findings of the latest medicines care plan audit from August 2016. This showed that areas had improved and where further issues had been identified, recommendations had been put in place, for example, to remind staff to use black ink and ensure that times of administration of medicines were always completed.

We recommend that the provider implements more regular audits in line with best practice and reviews checks in relation to administration tasks, including the monitoring of staff training.

Care plans provided us with evidence that people received skilled, compassionate care. Daily updates on care and support provided was called into the office base by the staff member on duty. We noted, however, that no copy of care records were kept at the provider's office base and only the initial assessment details were stored. This meant that if particular records went missing there was no copy kept as back up. We spoke with one of the trustees and the hospice director about this and they told us they would address this.

Regular meetings were held for all staff and volunteers throughout the year, although one staff member told us it was difficult to get all staff and volunteers to attend, as many of them worked and "sometimes the timings did not suit everyone." When meetings had taken place, a range of topics were discussed, including for example, staffing, care records, referrals, equipment, fundraising and dementia.

Surveys were in place for people and their relatives to complete. However, the manager and the hospice director told us that they were reviewing the process as they did not receive many surveys back. They understood that after a person passes away, the last thing a relative might think of doing was to complete a survey. We asked people and their relatives if they had ever completed a survey on their thoughts of the service they received. One relative who had used the service for a number of months told us, "I don't think I have been asked to fill in anything, but I would if I was. It's such a valuable service." We were also told that they were looking at utilising surveys with other health and social care professionals in order to gain their feedback too.

Newsletters were produced every quarter which were distributed to people's homes and other venues across the Tynedale and Northumberland area. They included information on activities that the hospice was participating in to fundraise, stories about people and families who had used the service, information about the people who volunteer for the service and explanations on how to get involved. This meant that the provider shared its success and promoted people, relatives, staff, volunteers and others to be involved with the organisation.

A 'service user' guide was produced for people using the service. The guide contained, for example, information about how each element of the service operated, how people could complain, information on how to feedback people's views of the service provided and other information about services available in the area for people with life limiting illnesses. This guide gave people and their relatives additional information and offered them the opportunity of increased choice on how their care was provided.

The Hospice at Home service worked in partnership with other providers. The hospice director told us that one member of staff had been seconded from another local hospice provider to support them in fundraising activities. Senior staff confirmed they attended the north regions 'hospice' management meetings, which is a forum to share good practice. We saw details of meetings which included conversations on, for example, collaboration, income workshops and sustainability plans. The service also worked with a local organisation which provided alternative therapies to people, including aromatherapy. Staff also attended a range of meetings including, local cancer support groups, and palliative care partnership meetings. This meant that the service did not work in isolation and shared information, practice and utilised specialist services to further support people and the service as a whole.

The provider had employed a consulting firm dedicated to helping individuals, organisations, and governments to create positive change in society. We saw that from a list of challenges that the organisation faced, including for example, having limited office space and room for confidential meetings that this had already been addressed and the provider was moving the service into new premises at the end of the year. The service had a strategic plan for the years 2016 to 2019; this was in the final stages of being approved with the trustees at an up and coming board meeting. The plan included many of the recommendations made by the consulting firm, including for example, further ways to generate income and maintain robust financial planning to sustain and grow the services that the organisation provided to people in the local community.