

Service Contract Quarterly Performance Report

Fourth Quarter: 1st January to 31st March 2024

1. **Introduction**

This fourth quarter Service Contract Quality Performance Report (SCQPR) covers the period 1 January – 31 March 2024 and provides an overview of St Cuthbert’s Hospice performance against the key local quality requirements (LQRs) and performance indicators (KPI’s) as outlined in our 2023 -2024 NHS Contract.

**Key service issues over the last quarter**

**In Patient Unit,** (IPU). Cumulative deaths totalled since 1 April 2023 is 169 of which 167 achieved their preferred place of death, (PPD). We were able to discuss preferred place of death with 169 patients. 2 people did not achieve their preferred place of death, which was home. IPU bed occupancy in this quarter was 80.88%.

Following the departure of our Medical Director/Consultant (June 2023) and approval of an additional Consultant (June 2022), we have been unable to recruit to either post. Since 2 October Consultant support has been provided virtually by Supportive UK. CDDFT seconded a Specialist Dr for 10 sessions. This Dr works alongside our existing Hospice Drs, (6 sessions) and an Advanced Nurse Practitioner (5 sessions). It is anticipated these arrangements will remain in place while we continue to work with stakeholders on a sustainable medical model for the healthcare local system.

We are using hours freed up by a reduction in hours to number of nursing posts and have recruited a rehabilitation assistant who commenced employment in quarter 4.

**Day Services,** Within the Living Well Centre, services are provided Monday to Friday. We continue to develop our programme and therapy groups including cognitive stimulation therapy, sporting memories activity group, health and wellbeing group, creative writing, physio led strength and balance group and one to one complementary therapy sessions. We continue to offer Day Hospice services for interventions such as blood transfusion. We have recruited to the Nursing Associate (band 4) vacancy in March and await a start date in Q1. Refurbishment of LWC was completed in quarter 4.

We continue to provide Bereavement Support Services, with counselling sessions for adults, children and young people provided Monday - Friday. We are seeing a decrease in our waiting list since the review of staff skill mix and increase to counselling capacity. We have inducted a new CYP counsellor (0.6WTE) and look forward to a second counsellor (0.4WTE) joining us in Q1. Delivery of bereavement support groups has been transferred to our Community Outreach Project.

**Community Services** – The Admiral Nurse provides clinical leadership to the Dementia and Community Outreach Team. Working collaboratively, we are continuing to increase community support for people living with dementia and their carers in County Durham offering one-one clinic appointments, dementia support groups and Namaste care. We are also developing our dementia educational offer and have provided education sessions to carers, facilitators of community Memory Cafes, other nursing professionals and educational establishments.

We have worked with the ICB to agree a way for hospices to collaborate to meet the requirements of the new Patient Safety Incident Reporting Framework (PSIRF). Three workshops were delivered in Q4.

We have completed the VOICES Survey for County Durham on behalf of the Palliative and End of Life Care Steering Group for the County. Over 380 responses were received. Findings will be published in Q1.

The Care Quality Commission (CQC) carried out an unannounced inspection in October 2023. This generated a range of activities including: the purchase of a new air conditioning unit for our cold room; the introduction of new standard operating procedures including management and care of nasogastric tubes, management of anaphylaxis, safeguarding of adults and safeguarding of children, cold room cleaning procedure; Percutaneous Endoscopic Gastrostomy (PEG) tubes policy and procedure; the introduction of a new set of admissions criteria; training for staff on management of NG tubes. Further work to meet the requirements set out following the visit was undertaken in Q4 and will continue in 204/25.

The recommendations from the ICB Quality Assurance visit in August 2023 have been implemented,



1. **Summary of what we have achieved in quarter four**

**Achievements to end of the fourth quarter:**

**Service Activity:**

* **In-Patient Unit:**
  + 58 new admissions into the in-patient unit during this reporting period.
  + 42 deaths
  + 42 patients achieved preferred place of death.
* **Living Well Centre:**
* 978 Face to face appointments.
* **Bereavement Support Services – Adults**
* 170 Face to face appointments attended, 13 well-being calls to 60 people.
* **Admiral Nurse:**
  + 41 patient/carers had 93 contacts, attended 2 memory cafes, 23 community/Hospice groups and 6 training sessions. 30 new referrals received.
* **Namaste team:**
  + 58 patients/carers seen at home/Hospice/outreach, had 536 contacts. 11 new referrals received.

**Protecting people from avoidable harm:**

In Quarter 4 there have been 39 clinical incidents:

* 0 Serious incidents
* 0 Incident of major, permanent harm; severe disruption
* 2 Incident of actual moderate harm/short term harm/disruption
* 14 Incidents of actual minor/minimal harm/low disruption
* 19 Incidents of actual no harm
* 4 Incidents of soft Intelligence
* 0 Near Misses



1. **Service Activity**

In accordance with Integrated Care Board (NENCICB) dataset requirements full data reports are submitted below. For comparison the preceding full year’s performance (2022 - 2023) data is provided and each full quarter’s performance for 2023 - 2024 and this will be updated in subsequent quarterly reports. Specific LQR’s and KPI’s measurements summarising performance can be seen in the Table 1 below:

1. **Local Key Performance Indicators (KPI’s)**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Table 1 – Hospice activity against KPIs 2023-2024 | | | | | | | | | |
| Indicators. | **Threshold** | **End of Year. 2022-23** | **Met –**  **Not met** | **2023-2024 quarterly performance.** | | | | **End of year**  **2023-2024** |  |
| **Q1** | **Q2** | **Q3** | **Q4** |  | **Year 2023-2024 Performance** |
| In-Patient Unit (IPU) | | | | | | | | | **COMMENTS.** |
| Total number of in-patient referrals received | N/A for monitoring purposes | **340** | **-** | 90 | 98 | 91 | 86 | 365 | N/A for monitoring purposes. |
| Average waiting time from referral to admission for inpatients (excluding weekends and planned respite). | **≤ 48 hours** | **35.6** | **Met** | 31.6 | 32.7 | 35.7 | 40 | 35 |  |
| Total number of inpatient admissions. | N/A for monitoring purposes | **220** | **-** | 62 | 67 | 60 | 58 | 247 | N/A for monitoring purposes. |
| Percentage bed occupancy. | **≥ 85%** | **86.63** | **Met** | 84.67 | 82.05 | 78.71 | 80.88 | 81.50 | Action Plan in place to improve performance against KPI. |
| Percentage bed availability. | **≥ 95%** | **99.3** | **Met** | 100 | 99.89 | 99.56 | 100 | 99.86 |  |
| Average length of stay for inpatients. | **≤ 15 days** | **14.4** | **Met** | 13.1 | 11.3 | 11.1 | 13.1 | 12.2 |  |
| Number and percentage of inpatients that have been offered an Advance Care Plan. | **90%** | **99.2%** | **Met** | 62  100% | **67**  **100%** | **60**  **100%** | **58**  **100%** | **100%** |  |
| Number and percentage of patients who died at the hospice and have preferred place of death recorded. | N/A for monitoring purposes | **128**  **97.6%** | **-** | **39**  **100%** | **49**  **100%** | **39**  **100%** | **42**  **100%** | **169**  **100%** | N/A for monitoring purposes. |
| Number and percentage of patients who died at the hospice who stated their preferred place of death and achieved this. | N/A for monitoring purposes | **123**  **95.4%** | **-** | 38  97.4% | **48**  **98%** | **39**  **100%** | **42**  **100%** | **167**  **98.9%** | N/A for monitoring purposes |
| Patient’s risk of falls to be assessed within 6 hours of admission. | **100%** | **95.7%** | **Not met** | 87.1 | **94** | **98.3** | **100** | **95** |  |
| Patient’s written care plan tailored to address falls risk completed within 6 hours of admission. | **100%** | **95.7%** | **Not met** | 87.1 | **94** | **98.3** | **100** | **95** |  |
| Pressure ulcer risk assessment to be completed within 6 hours of admission.  (Ref - NHS Improvement 2018 Pressure Ulcers: revised definition and measurement). | **95%** | **95.7%** | **Met** | 87.1 | **94** | **98.3** | **100** | **95** |  |
| Patient’s written care plan tailored to address pressure ulcer risk within 6 hours of admission (Ref - NHS Improvement 2018 Pressure Ulcers: revised definition and measurement). | **95%** | **95.7%** | **Met** | 87.1 | **94** | **98.3** | **100** | **95** |  |
| Venous thromboembolism (VTE) risk to be assessed within 24 hours of admission to determine if prophylaxis required. | **100%** | **98.5%** | **Not met** | 100 | **97** | **95** | **98** | **97.5** | 1 was missed as on admission patient was immediately sent to hospital. |
| Percentage of patients that report a positive experience of care via the Friends and Family Test. | **90%** | **100%** | **Met** | 100 | **100** | **100** | **100** | **100** | Q4 - 13 forms returned since HCA champions identified. |
| Number of complaints and compliments received and actions taken | N/A for monitoring purposes | **-** | **-** | **-** | **-** | **-** | **-** | **-** | N/A for monitoring purposes  Refer to Sect 5.2 in report |
| Number of clinical and non-clinical incidents and actions taken | N/A for monitoring purposes | **-** | **-** | **-** | **-** | **-** | **-** | **-** | N/A for monitoring purposes  Refer to Sect 5.2 in report. |
| Living Well Centre | | | | | | | | | **COMMENTS** |
| Total number of patients attending the Living Well Centre | N/A for monitoring purposes | **249** | **-** | 138 | **135** | **141** | **133** | **302** | N/A for monitoring purposes |
| Number and percentage of Living Well Centre patients receiving a care plan | **100%** | **100%** | **-** | 100 | **100** | **100** | **100** | **100** |  |
| Percentage occupancy | **≥ 80%** | **31.25%** | **Not Met** | 51.2 | **57** | **49** | **53** | **52.55** | Occupancy changes due to reduction in medical procedure offering. |
| Time from referral to Living Well Centre and contact to arrange home visit / assessment. | **90% within 7 days** | **100%** | **Met** | 100 | **100** | **100** | **100** | **100** |  |
| Time from first referral in LWC to Physiotherapy assessment | **100% within 21 days** | **100%** | **Met** | 100 | **100** | **100** | **100** | **100** |  |
| Time from referral in LWC to Occupational therapy assessment | **100% within 21 days** | **100%** | **Met** | 100 | **100** | **100** | **n/a** | **100** | OT left in quarter 4. |
| Percentage of patients that report a positive experience of care via the Friends and Family Test | **90%** | **100%** | **Met** | 100 | **100** | **100** | **100** | **100** | Q4 – 8 forms returned since HCA champions identified. |
| Bereavement Support Services (Adults) | | | | | | | | | **COMMENTS** |
| Total number of clients accessing bereavement support services (adults) | N/A for monitoring purposes | **103** | **-** | 46 | **55** | **54** | **60** | **108** | N/A for monitoring purposes |
| Number and percentage of clients contacted within 15 working days of receipt of referral (adults) | **95%** | **96.3%** | **Met** | 100 | **100** | **100** | **100** | **100%** |  |
| Number and percentage of written assessments of needs and action plans agreed with clients (adults) | **100%** | **100%** | **Met** | 100 | **100** | **100** | **100** | **100%** |  |
| Percentage of clients that report a positive experience of care via the Friends and Family Test | **90%** | **100** | **Met** | 100 | **100** | **100** | **100** | **100%** | Q4 - 15 forms returned. |
| Number of complaints and compliments received and actions taken | N/A for monitoring purposes | **-** | **-** | **-** | **-** | **-** | **-** | **-** | N/A for monitoring purposes.  Complaints are recorded on the Incident Log.  Refer to Sect. 5.2 of report. |
| Number of safeguarding incidents and actions taken | N/A for monitoring purposes | **-** | **-** | **-** | **-** | **-** | **-** | **-** | N/A for monitoring purposes  Refer to Sect. 5.2 in report |
| Dementia services | | | | | | | | | **COMMENTS** |
| Total number of patients attending Dementia Support Service | N/A for monitoring purposes | **95** | **-** | **53** | **76** | **83** | **87** | **153** | N/A for monitoring purposes. |
| Time from referral to Admiral Nurse for first contact and appointment arranged for assessment. | **95% within 15 days** | **99%** | **Met** | 100 | **100** | **100** | **100** | **100%** |  |
| Time from referral to Namaste care for first contact and appointment arranged for assessment. | **95% within 15 days** | **100%** | **Met** | **100** | **100** | **100** | **100** | **100%** |  |
| Percentage of patients who provide feedback and report a positive experience of care | 90% | **100%** | **Met** | **100** | **100** | **100** | **100** | **100%** | Q4 – 12 forms returned. |
| Number of complaints and compliments received and actions taken | N/A for monitoring purposes | **-** | **-** | **-** | **-** | **-** | **-** | **-** | N/A for monitoring purposes  Refer to Sect 5.2 of report |
| Number of clinical and non-clinical incidents and actions taken | N/A for monitoring purposes | **-** | **-** | **-** | **-** | **-** | **-** | **-** | N/A for monitoring purposes  Refer to Sect 5.2 of report |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Table 2 – Hospice activity against LQRs 2023-2024 | | | | | | | | | |
| Indicators. | **Threshold** | **End of Year 2022-23** | **Met –**  **Not met** | **2023-2024 quarterly performance.** | | | | **End of year**  **2023-2024** |  |
| **Q1** | **Q2** | **Q3** | **Q4** |  | **Year 2023-2024 Performance** |
|  | | | | | | | | | **COMMENTS.** |
| % of national safety alerts issued via the Central Alert System (CAS) that are fully implemented within the timescales set out within the alert. | 100% | **-** | **-** | 100% | 100% | 100% | 100% | 100% |  |
| % of patients and carers surveyed who are satisfied with the service. | **75%** | **-** | **-** | 100% | 100% | 100% | 100% | 100% |  |
| % of patients who felt they were treated with dignity and respect, as part of service user experience. | 100% | **-** | **-** | 100% | 100% | 100% | 100% | 100% |  |
| % of eligible staff who have received safeguarding adults supervision in accordance with caseload supervision arrangements and the organisations clinical supervision policy. | **100%** | **-** | **-** | 100% | 100% | 100% | 100% | 100% | Supervision Policy in place. Staff have access to supervision on a 121 basis, (internal and external supervisors), group topic specific / following safeguarding issues. |
| % of staff that have a safeguarding adult training session within 6 weeks of taking up the post.  100% of eligible staff, 95% triggers exception reporting, 90% requires remedial action plan. Excludes maternity and sick leave. | **100%** | **-** | **-** | n/a | 60% | 100% | 100% | 86.7% |  |
| % of staff that have completed safeguarding adults training in accordance with the level, duration and frequency set out in the Adult Safeguarding: Roles and Competencies for Health Care Staff, Intercollegiate Document August 2018.  100% of eligible staff, 95% triggers exception reporting, 90% requires remedial action plan. Excludes maternity and sick leave. | **100%** | **-** | **-** | 92 | 96 | 96 | 100 | 96% | Hospice mandatory training target is 90%. |
| The Provider will ensure that all training around the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DOLS) is provided in accordance with the level, duration and frequency as set out in the Adult Safeguarding: Roles and Competencies for Health Care Staff, Intercollegiate Document August 2018. | **100%** | **-** | **-** | 67.30 | **75** | **77** | **82** | **75.33%** | Hospice mandatory training target is 90%  Decision made to do Face to Face rather than e-learning as adds more value. All staff are booked on the face to face training. |
| % of eligible staff who meet the minimum requirements for “Prevent” mandatory training in accordance with the Prevent Training and Competencies Framework. | **85%** | **-** | **-** | 86 | **92** | **95** | **100** | **93.3%** |  |
| % of eligible staff who have received safeguarding children's supervision in accordance with caseload supervision arrangements and the organisations clinical supervision policy. | **100%** | **-** | **-** | 100% | **100%** | **100%** | **100%** | **100%** |  |
| % of staff that have a safeguarding children training session within 6 weeks of taking up the post.  100% of eligible staff, 95% triggers exception reporting, 90% requires remedial action plan. Excludes maternity and sick leave. | **100%** | **-** | **-** | n/a | **60** | **100** | **100** | **86.7%** |  |
| % of eligible staff that have completed safeguarding children training in accordance with the level, duration and frequency as set out in the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff, Intercollegiate Document January 2019. 100% of eligible staff, 95% triggers exception reporting, 90% requires remedial action plan. | **100%** | **-** | **-** | 88 | **94** | **97** | **99** | **94.5%** | Hospice Target is 90% |
| % of frontline staff to be vaccinated against flu during the flu/winter period. | **75%** | **-** | **-** | n/a | **n/a** | **76.3** | **n/a** | **76.3%** | To monitor uptake during flu season. |
| % of staff that have completed all relevant mandatory training such as infection, prevention, moving and handling, information governance and basic life support. | **100%** | **-** | **-** | 83 | **93** | **95** | **93** | **91%** | Staffing issues/IT constraints have been a barrier to completing mandatory training. Compliance is improving. |
| % of eligible staff that have DBS checks in accordance with statutory requirements. | **100%** | **-** | **-** | 94 | **100** | **100** | **100** | **98.5%** |  |
| % of agency staff used within the reporting period | **<5.00% of staffing structure** | **-** | **-** | 1.84 | **0.49** | **0.54** | **1.3** | **1.04%** | In quarter 4 we had a number of patients who required 1:1 support |
| % of staff sickness within the reporting period | <7.00% of structure days | **-** | **-** | **5.30** | **5.40** | **4.40** | **3.00** | **4.53%** |  |
| % of patients at risk of falls, are assessed within 6 hours of admission. | 98% | **-** | **-** | **87.1** | **94** | **98.3** | **100** | **95%** | Time of recording rather than time of assessment. |
| % of patient's with appropriate Falls Care Plan completed within 24 hours or admission | **98%** | **-** | **-** | 100 | **100** | **100** | **100** | **100%** |  |
| % of pressure ulcers reviewed in line with the organisations Patient Safety Incident Response Plan | **100%** | **-** | **-** | **100** | **100** | **100** | **100** | **100%** |  |
| % of patients with an Advance Care Plan (ACP) or offered ACP discussions. | **98%** | **-** | **-** | 100 | **100** | **100** | **100** | **100%** |  |
| % of patients with an Emergency Healthcare Plan (EHCP) or offered discussions (for hospice inpatients or hospice at home care patients). | **98%** | **-** | **-** | 90.5 | **12.5** | **100** | **100** | **75.8%** |  |
| % of patients with a DNACPR or offered discussions (for hospice inpatients or hospice at home care patients). | **98%** | **-** | **-** | 100 | **100** | **100** | **100** | **100%** |  |
| % of patients who are offered discussions regarding preferred place of death (for hospice inpatients or hospice at home care patients). | **98%** | **-** | **-** | 100 | **100** | **100** | **100** | **100%** |  |
| % of patients who state their preferred place of death and achieve it (for deceased hospice inpatients or hospice at home care patients). | **85%** | **-** | **-** | 97.4 | **98** | **100** | **100** | **98.9%** |  |
| % of discharge summaries to be sent to GP within 24hrs | **95%** | **-** | **-** | 50 | **73.3** | **88.2** | **92.9** | **76.1%** | 1 missed in Q4 |

1. **Protecting people from avoidable harm through prevention falls, suspected deep tissue injuries, pressure ulcers and thromboembolism.** 
   1. **Patient Safety**
   2. The review and updating of policies has continued over 2023 - 2024 to ensure our suite of care related policies and procedures reflect local and national guidelines. Within this quarter we updated key policies such as Control of Infection caused by Ectoparasite and Threadworms Policy & Procedure

To fulfil our ‘*Duty of Candour*’ we report all serious incidents to statutory and regularity bodies, our commissioners and internally in our own clinical governance forums. See tables 2 and 3 below. Furthermore, our Clinical Practice Development Nurse also provides in house Duty of Candour training sessions for clinical staff.

**Summary of clinical and other untoward incidents**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Table 2 – Clinical and untoward incidents 2023-2024 | | | | | | | | |
|  | **Code** | **2022-23**  **Totals** | **Q1.** | **Q2.** | **Q3.** | **Q4.** | **Year end** | **Comments** |
| Service Falls | 1 | **21** | **3** | **10** | **9** | 4 | 26 | 4 Unavoidable |
| Pressure Ulcers/SDTI | 3 | **31** | **6** | **5** | **11** | **6** | **28** | 2 PU (2 patients on admission) and 4 SDTI following admission (3 patients) |
| Medication Errors | 4 | **18** | **7** | **7** | **5** | **4** | **23** | 3 external and 1 internal to Hospice |
| Other clinical incidences | 6 | **38** | **18** | **26** | **20** | **16** | **80** |  |
| Infection Prevention and Control - Health acquired infections | 7 | **12** | **1** | **3** | **3** | **1** | **8** | 1 COVID |
| Other non-clinical incidences | 8 | **4** | **0** | **0** | **0** | **0** | **0** |  |
| Information Governance | 9 | **16** | **6** | **3** | **3** | **2** | **14** |  |
| Subject Access Requests | 10 | **0** | **1** | **1** | **0** | **1** | **3** |  |
| Safeguarding | 11 | **1** | **1** | **4** | **1** | **1** | **7** |  |
| MCA/DoLS | - | **22** | **8** | **4** | **3** | **8** | **23** | SIRMS completed for all MCA/DoLS |

* 1. **Serious Incidents and complaints**

**Quarter Four**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Incident Number | Incident Date | Cause Group | Cause 1 | Cause 2 | Details Of Incident | Initial impact | Actual Impact | Outcome Description |
| 114018 | 02/01/2024 | Safeguarding Adults | Deprivation Of Liberty |  | Patient admitted to hospice, who lacks capacity to consent to care and treatment following capacity assessment. | 5 - Catastrophic//Death/Service Or Sytem Failure | 1 - No Harm | MCA 1 & 2 completed Urgent Dols request sent SIRMS completed  CQC notification sent Verbal duty of candour |
| 114029 | 02/01/2024 | Medication | Administering Medication | Medication Other | Medication given (prednisolone) when had been stopped on Kardex day before | 2 - Low Harm / Minor / Low Disruption | 2 - Low Harm / Minor / Low Disruption | Reflective practice with nursing staff and medical staff involved. Patient advised of error and apology made and accepted. No harm to patient. |
| 114325 | 09/01/2024 | Tissue Viability | Pressure Ulcer - Grade 2 |  | Patient admitted with healing grade 2 pressure sore. | 1 - No Harm | 1 - No Harm | Patient admitted with what appears to be healing grade 2 pressure sore. Appropriate care plan put in place. |
| 114335 | 09/01/2024 | Clinical Documentation | Mislabelled / Misfiled Documentation | Controlled Drug | Patient required pain relief, Oxynorm oral solution.   Myself and other staff nurse on duty went to administer the drug. Oxynorm 5mgs /5mls had been received and documented in the controlled drug book as a full bottle of 250mls.  On inspection appeared to be an open bottle, measured 225mls. | 1 - No Harm | 1 - No Harm |  |
| 114462 | 15/01/2024 | Tissue Viability | Skin Tear | Moving And Handling | Small skin tear when left hand rubbed against bath chair. | 2 - Low Harm / Minor / Low Disruption | 2 - Low Harm / Minor / Low Disruption | Care plan initiated. |
| 114463 | 16/01/2024 | Tissue Viability | Skin Tear |  | Patient incurred accidental skin tear 4cm by 5cm to form on right forearm. | 2 - Low Harm / Minor / Low Disruption | 2 - Low Harm / Minor / Low Disruption | Care plan and dressing regime initiated. |
| 114598 | 19/01/2024 | Safeguarding Adults | Deprivation Of Liberty |  | Patient admitted to IPU lacks capacity to consent to care and treatment following capacity assessment. | 6 - Soft Intelligence | 1 - No Harm | MCA 1 & 2 completed Urgent Dols request sent SIRMS completed  CQC notification sent Verbal duty of candour |
| 114673 | 22/01/2024 | Infection, Prevention And Control | Other IPC Incident | COVID-19 Related | Patient admitted to IPU from hospital, admission LFT test positive for Covid | 6 - Soft Intelligence | 1 - No Harm | IPC guidance followed. |
| 114724 | 23/01/2024 | Health & Safety | Other Health And Safety | Lack Of Clinical Or Risk Assessment | Volunteer gave patient a custard cream biscuit when on pureed diet. | 1 - No Harm | 1 - No Harm | Correct procedure in place at time of incident re: Volunteer handover sheet Verbal duty of candour. No harm to patient. Reflective practice/supervision with volunteer given to support. |
| 114756 | 24/01/2024 | Health & Safety | Slip/Trip/Fall | Patient Fall From Chair/Wheelchair | Slip from recliner chair at | 2 - Low Harm / Minor / Low Disruption | 2 - Low Harm / Minor / Low Disruption | Unwitnessed unavoidable slip from chair, mitigating actions in place at time of slip. |
| 114844 | 27/01/2024 | Implementation Of Care | Inadequate Staffing Levels |  | Staff sickness left ward with only 1 x RN for 12hr day shift (3 X HCA staff on morning and 2 on afternoon). | 3 - Moderate Harm / Short Term Disruption | 3 - Moderate Harm, Short Term Disruption | Due to staff sickness IPU staffed with correct establishment to manage 7 patients but skill mix compromised only 1 x RN on duty. Unable to obtain bank/agency RN.  IPU service manager made telephone contact throughout the day. SSMT made aware HCA staff on duty able to second check CD medication and night staff replenished syringe drivers. |
| 114889 | 30/01/2024 | Patient Accident | Patient Fall From Chair/Wheelchair |  | Patient had an unwitnessed slip from his recliner chair to the floor. He was found sat on the floor by his chair. After being checked - no injuries noted - he was safely hoisted back in to bed. | 1 - No Harm | 1 - No Harm | Unavoidable unwitnessed slide from chair, mitigating actions in place at the time of slide from chair. |
| 114918 | 29/01/2024 | Medical Device, Equipment | Medical Device/Equipment Failure |  | Macerator showing F7 error code | 2 - Low Harm / Minor / Low Disruption | 2 - Low Harm / Minor / Low Disruption | Servicing providers called out, unblocked and sensor changed on unit. working fine again. |
| 114925 | 31/01/2024 | Safeguarding Adults | Financial / Material Abuse |  | Concerns reported by family member relating to safeguarding nature, financial/emotional abuse. Also concerns around a vulnerable adult having contact with a man who has an alleged criminal offence. | 2 - Low Harm / Minor / Low Disruption | 2 - Low Harm / Minor / Low Disruption | Policy and procedure followed once concerns raised. Safeguarding referral made 31/1/24 Verbale duty of candour Safeguarding CQC notification sent 1/2/24 Hospice in contact with police and public protection officers. |
| 114971 | 30/01/2024 | Safeguarding Adults | Deprivation Of Liberty |  | Patient admitted to hospice lacks capacity to consent to care and treatment | 6 - Soft Intelligence | 6 - Soft Intelligence | MCA 1&2 completed DoLs application made Verbal duty of candour  CQC notification SIRMS |
| 115026 | 02/02/2024 | Medication | Medication Supply Issue - Hospital Discharge | Lost/Misplaced Medication | Patient admitted from UHND hospital from Ward 16.  On his discharge medication bag, we received one medicine which was not belonging to the patient. It was labelled with different name. Patient has not received any of this medicine. | 1 - No Harm | 1 - No Harm | SIRMS sent to transferring ward to report on. |
| 115047 | 04/02/2024 | Patient Accident | Patient Found On Floor - Not Witnessed |  | Patient found on floor outside his room, he said he was trying to | 1 - No Harm | 1 - No Harm | Unwitnessed unavoidable fall, all mitigation actions in place at time of fall in line with patients wants and wishes. New appropriate mitigating actions put in place post fall following discussion with patients. Reviewed post fall as per policy by Dr and Physio within 24hrs. |
| 115181 | 07/02/2024 | Discharge Issue | Discharge - Planning Failure | Discharge Summary Not Received / Missing | Patient admitted to IPU (St Cuthberts Hospice) without discharge letter or meds list. | 6 - Soft Intelligence | 1 - No Harm | SIRMs sent to transferring ward for feedback. |
| 115234 | 07/02/2024 | Health & Safety | Slip/Trip/Fall | Patient Found On Floor - Not Witnessed | Bed sensor alarmed. staff found patient on floor. | 2 - Low Harm / Minor / Low Disruption | 2 - Low Harm / Minor / Low Disruption | With information received from hospital and presentation of patient on admission fall unwitnessed unavoidable fall as mitigating actions that were available at the time in place. |
| 115265 | 08/02/2024 | Tissue Viability | Deep Tissue Injury (DTI) |  | New SDTI developed – patient at EOL. | 3 - Moderate Harm / Short Term Disruption | 2 - Low Harm / Minor / Low Disruption | New SDTI during admission to hospice. SDTI developed approx 26 hours before death. care plan adjusted as changes to skin and overall condition noted. Verbal duty of candour SIRMS Safeguarding referral made - no neglect noted CQC notification sent. |
| 115320 | 11/02/2024 | Tissue Viability | Deep Tissue Injury (DTI) |  | Patient noted to have SDTI | 2 - Low Harm / Minor / Low Disruption | 2 - Low Harm / Minor / Low Disruption | SDTI. Documentation issues Verbal duty of candour. Leaflet given to family SIRMS completed Safeguarding informed - no neglect noted, skin deteriorating due to overall deterioration Training - IPU service manager continues to find ongoing training as some staff have had TV training, but this was one off and not repeated for hospice staff. |
| 115527 | 12/02/2024 | Information Governance | InformationLeftUnattended(Printer,EmptyOffice |  | RGN found an HCA appraisal document left in nurses office. | 1 - No Harm | 1 - No Harm | Confidential information left in nurses’ station unintentionally. Not a recurrent issue. Apology made to staff member. Discussed with staff member who had left paperwork. |
| 115644 | 17/02/2024 | Tissue Viability | Deep Tissue Injury (DTI) |  | Patient is approaching end of life. SDTI found to left ear 0.5cm-1cm in size. | 2 - Low Harm / Minor / Low Disruption | 2 - Low Harm / Minor / Low Disruption | SDTI most likely due to deteriorating condition.  Patient's wife is aware, verbal duty of candour. Care plans adjusted.  Safeguarding informed - no neglect noted, SDTI due to deteriorating condition CQC notification completed SIRMs completed |
| 115647 | 15/02/2024 | Safeguarding Adults | Deprivation Of Liberty |  | Patient admitted to hospice lacks capacity to consent to care and treatment following MCA | 6 - Soft Intelligence | 6 - Soft Intelligence | MCA 1&2 completed DoLs application made Verbal duty of candour  CQC notification SIRMS. |
| 115714 | 19/02/2024 | Safeguarding Adults | Deprivation Of Liberty |  | Patient does not have capacity to consent to care and treatment at hospice. | 6 - Soft Intelligence | 6 - Soft Intelligence | MCA 1&2 completed DoLs application made Verbal duty of candour  CQC notification SIRMS |
| 115815 | 20/02/2024 | Implementation Of Care | Correct Care / Treatment Not Provided | Pressure Ulcer - Grade 2 | Patient admitted to IPU with grade 2 pressure damage to coccyx. | 2 - Low Harm / Minor / Low Disruption | 2 - Low Harm / Minor / Low Disruption | SIRMs sent to transferring place of care for feedback. |
| 115938 | 23/02/2024 | Clinical Documentation | DNAR/EHCP Record Issue | Controlled Drug | Patient on admission to St Cuthbert's Hospice issues noted on red Kardex with regards to Oxycodone and dose not given within recommended limits. | 1 - No Harm | 1 - No Harm | SIRMs sent to Community Nurse team for review and feedback. |
| 115960 | 23/02/2024 | Self Harm | Accidental Self Harm |  | Patient scratched own face. | 2 - Low Harm / Minor / Low Disruption | 2 - Low Harm / Minor / Low Disruption | Patient with Huntington's disease and known to have rapid dyskinetic movements patient accidentally scratched face. Wife made aware no concerns raised |
| 115958 | 26/02/2024 | Safeguarding Adults | Deprivation Of Liberty |  | Patient admitted to hospice lacks capacity to consent to care and treatment following MCA | 6 - Soft Intelligence | 1 - No Harm | MCA 1&2 completed DoLs application made Verbal duty of candour  CQC notification SIRMS |
| 116014 | 27/02/2024 | Safeguarding Adults | Deprivation Of Liberty |  | Patient lacks capacity for care and treatment | 6 - Soft Intelligence | 1 - No Harm | MCA 1&2 completed DoLs application made Verbal duty of candour  CQC notification SIRMS |
| 116089 | 27/02/2024 | Health & Safety | Struck Against Something Fixed/Stationary |  | Driver reports during minibus transport, wheelchair tipped momentarily, and patient knocked their head against grab bar in minibus. Driver reports patient remained secure in wheelchair and wheelchair returned to floor immediately. No injuries reported. Seen by RN. | 2 - Low Harm / Minor / Low Disruption | 1 - No Harm | 27.02.24 - Reviewed by RN - no concerns reported.  Checked out minibus - wheelchair locking system in situ, no apparent concerns. Vehicle maintenance is up to date. Driver training is up to date.  29.02.24 - Minibus reviewed by garage- wheelchair locking system checked over by mechanic, no concerns reported. Additional advice provided to driver on position of tie downs to minibus base. |
| 116405 | 01/03/2024 | Discharge Issue | Discharge Summary Incorrect/Unclear | Controlled Drug | Discrepancy between discharge letter/red kardex and contents of CSCI Alfentanil 2000mcg/ midazolam.  CSCI partially confirmed after hospice staff spoke with ward staff- verbally.   Finally confirmed via copy of email on referral form - CSCI had been adjusted to Alfentanil 2500mcg (increase) Midazolam 15mg (decrease) Levomepromazine 25mg (addition) in part to enable patient to be less sedated but symptoms managed. | 0- Near Miss | 1 - No Harm | Awaiting feedback from hospital |
| 116674 | 06/03/2024 | Health & Safety | Moving And Handling |  | Staff injury following appropriate moving and handling of a patient. | 2 - Low Harm / Minor / Low Disruption | 2 - Low Harm / Minor / Low Disruption | -Staff member sustained incidental injury to R shoulder following appropriate transfer of a patient. Patient care plan reviewed and updated, reviewed by OT. Risk assessment created for staff member. No long term damage. |
| 116736 | 13/03/2024 | Information Governance | Misdirected Email/Hard Copy Received Containing Confidential Info | Breach Of Patient Confidentiality | Referral e-mail sent to general Hospice e-mail address. | 1 - No Harm | 1 - No Harm | Email to referrer to advise they have used the wrong email address. Guidance reiterated to use Hospice's NHS.net email account for referrals in future, as per referral from instructions, to avoid this issue.  Response from referrer - apologies, human error and aware to use correct email address in future. |
| 116929 | 07/03/2024 | Health & Safety | Moving And Handling (Patient) |  | Injury sustained to staff members back during appropriate moving and handling episode of care. | 3 - Moderate Harm / Short Term Disruption | 3 - Moderate Harm, Short Term Disruption | Staff member sustained injury to back following an appropriate/recommended transfer of patient from bed to commode.  As staff member was unable to work for more than 7 days HSE injury report completed. Documentation issue - email sent to staff. Handover lessons - email sent to staff. Patients falls bundle and assessments up to date and correct at the time of incident. patient was being 121 nursed to prevent falls as mobility and cognition variable  Patient reviewed next day post incident by OT and physio on day off. Risk assessment for staff member implemented with return to work information |
| 116982 | 25/03/2024 | IT | Telecommunications Failure | Access To Service Failure (Other) | A nurse was calling the hospital for a handover and the nurse stated that they had been trying to get through to us but were unable to do so.   I called the hospice line from my mobile and once it connected, the line was dead. | 1 - No Harm | 2 - Low Harm / Minor / Low Disruption | Estates and Facilities Manager tested calling the line with the same result. Notified Select who responded to say on testing they had no Issues.   Estates & Facilities Manager asked select to look into any faults showing. Select are also monitoring the line.   The Main Line and Automated attendant now working as expected. |
| 117011 | 25/03/2024 | Estates And Facilities | Facilities Management |  | 02 CD cylinder in sluice noted to be only half full. | 0- Near Miss | 1 - No Harm | Policy and procedure was followed. |
| 117021 | 26/02/2024 | Medical Device, Equipment | User Error | Medication Incorrectly Stored/Sealed | Medicine fridge temperature not recorded by nightshift HCA. | 1 - No Harm | 1 - No Harm | Reflective practice with staff member re: checking fridges each night and ensuring we write the temperatures down. No harm |
| 117044 | 25/03/2024 | Safeguarding Adults | Deprivation Of Liberty |  | Patient admitted to hospice does not have capacity to consent to care and treatment at hospice. | 6 - Soft Intelligence | 6 - Soft Intelligence | MCA 1&2 completed DoLs application made Verbal duty of candour - family aware CQC notification SIRMS |

* 1. Prevention of Falls 2023 - 2024

Although ambitious our aim for the period 1 April 2023 – March 2024 is to reduce the incidence of ‘***unavoidable***’ patient falls to zero, based upon number of falls recorded (23) during 2021 - 2022. We recognise that despite assessing each patients’ ‘falls risk’ against a wide range of factors we can identify those patients with an increased risk or likelihood of falls but even after implementing measures to reduce the incidence of falls it is not always possible to avoid some falls see Table 4:

|  |  |
| --- | --- |
| Table 4 Falls assessment and prevention. | |
| Assessments | **Falls prevention measures** |
| * Follow best practice as outlined in ‘Falls in older people’. Quality standard [QS86] Published March 2015. Last updated January 2017. * Regular patient checks and encouragement to ask for help. * Falls risk assessments (FRAT) – redesigned within SystmOne templates – rolled out 2022/23 Q2. * Bed rail assessment – redesigned within SystmOne templates rolled out in 2022/23. * Assessment and plan of care for toileting and continence needs. * Moving & handling assessment and physiotherapy/OT input. * Assessment and plan of care for postural hypotension * Assessment of cognition and/or mental capacity and plan of care to support. * Review of medications – Doctors and Pharmacists. | * Weekly MDT formal review of falls risk and record action plan. * Moving and handling equipment including*ultra* hi/low bed * Bed, chair and floor falls and movement sensor alarms and soft-landing crash mats. * Bed rails assessment and mobility care plans. * One to one nursing / monitoring withrooms 5, 9 and 14 near to the nurses’ station designated close observation rooms. * Orientation to the environment and appropriate lighting and flooring * Comfortable and safe positioning of the patient * Timely answering of nurse call to attend to patient. * Appropriate footwear provision if needed. * Access to the nurse call bell ‘*Make the call avoid the fall’* signs in patient rooms. * Educating the patient and carers on safe moving techniques. * Falls Prevention Link Practitioner Group – meets quarterly to review measures in place and updates in line with best practice. * Annual staff training and falls prevention refresher sessions. * Annual ‘train the trainer’ updates from an external moving/handling provider. * External audit completed in May 2023 by independent Ergonomic Advisor (Cloud 9 Health & Wellbeing, Middlesbrough.) No concerns identified. |

Not all these measures are routinely used for example, not every patient is nursed one to one, but these are care plan options if required for the patient’s safety. In trying to maintain the patient’s safety we recognise the need for patients to make choices and take risks and we continue to promote their independence if they have capacity and ability to do so. We will continue to classify falls as either avoidable or unavoidable dependent upon the measures put in place to help reduce / minimise the risk of falls.

**5.4 Prevention of Pressure Ulcers and Suspected Deep Tissue Injuries**

The findings from several independent studies highlight that preventing pressure ulcer occurrence may be difficult to achieve in patients who are dying and explains why we continue to report unavoidable PU’s. St Cuthbert’s Hospice in-patient unit (IPU) has set an ambitious target to achieve a 0% incidence rate of avoidable pressure ulcer (PU) development or deterioration following admission during 2022 - 2023. The charts below include pressure ulcers on admission and new following admission.

**5.5 Prevention of Thromboembolism**

VTE assessments are carried out on all in patients within 24 hours of admission and are recorded in patient SystmOne care plans / medical notes to evidence decisions made with regard anticoagulation therapy. Table 8 below outlines VTE assessments. Incident reports are completed for patients who do not achieve the required standard.

In 2022 – 2023 98.5% of VTE assessments were completed within 24 hours of admission. In 2023 – 2024 Q4 98% of assessment were completed within 24 hours, 1 patient who was a readmission, but was sent too hospital during clerking in was missed.

**6. Service Development Activity**

Pressure Ulcer (Recording and Management).

Catheter Acquired Urine Tract Infection (UTI).

**6.1 Strategic Goal 1: To enable people at the very end of life to achieve a good death in the place of their choosing.**

We continue to exploit opportunities for the Hospice to share our specialist knowledge with the wider community, (Aim 3) and work collaboratively in teaching, audit, and research.

We continue to collaborate with further and higher education institutions and currently host students from:

* Local further education colleges level completing level 2 - 4 qualifications in health and social care/nursing.
* Trainee Nursing Associate Students from Teesside/Northumbria Universities
* Pre-registration nursing students from Northumbria University

Unfortunately, in Quarter 4, due to uncertainty about Consultant cover, we have been unable to support GP registrars (GPRs) on the GP training scheme, full time for 6 months or Specialist Registrars from Training Programme in Palliative Medicine within the North East. However we hope to reinstate GPRs from summer 2024.

Planned developments include hosting student physiotherapist and occupational therapists.

**6.2 Strategic Goal 2: To enable people with life limiting illness who use the Hospice services to live well and make every day count.**

**6.2.1 Paracentesis Service**

Following the departure of our specialist palliative care consultant and the outcome of our business case we are no longer accepting referrals to Day Hospice for paracentesis. We have continued to support three existing patients and have been working with CDDFT to clarify medical responsibility for these patients. In Quarter 4

* 0 paracentesis were carried out in IPU.
* 12 ascitic drainages were carried out in LWC on 1 patient (non-cancer).

**6.2.2 Blood Transfusions**

In Quarter 4

* 0 blood transfusions were carried out in LWC.
* 2 were carried out in IPU.

**6.3 Strategic Goal 3: To provide the information and support that carers of people with life limiting illness need to provide the care they want to provide.**

**6.3.1 Admiral Nurse**

The Admiral Nurse works with families and people affected by dementia, particularly during complex periods of transition. This is achieved through casework, coordination, groups and clinics to:

·    Promote physical, social, and psychological health of family carers and people with dementia.

·    Improve well-being and quality of life for people with dementia and their family carers.

·    Enhance adjustment and coping strategies for people affected by dementia and their families.

**6.3.2 Namaste**

In addition to improving the quality of life for people living with dementia evaluation of Namaste care has identified direct benefits to carers themselves. Carers have reported that having regular contact with a volunteer through Namaste home visits and the link this provides to additional support from the Dementia Team if required makes them feel well supported and more confident in their caring roles.

Carer attendees to our Namaste groups have reported that they enjoy spending quality time with their loved ones in an environment where they feel safe and supported. Carers have commented on the feelings of connection this time together can provide and the pleasure they have experienced seeing their loved ones engaged in therapeutic activity that is specifically tailored to meet their needs. Carers also highlight greatly appreciating the opportunity to access both peer and professional support when attending the groups.

**6.3.3 Carers Support Needs Assessment Tool (CSNAT)**

In this Quarter we have undertaken a review of the use of the CSNAT and following an options appraisal have decided to continue to use the CSNAT in Dementia Services and now use the carers conversation wheel in IPU/LWC. Consensus is that the CSNAT tool works well for longer term support within Dementia Services. Whereas the carers conversation wheel works well for short episodes of support within IPU/LWC.

We continue to forge good working partnerships with other carers’ services and develop our partnership with Durham County Carers Support (DCCS) and The Bridge Young Carers Service, (BYCS). Initiatives include:

* Working with DCCS to:
* Deliver the Everything in Place Project to carers.
* Achieve the Carer Friendly Employer Award, to become a more supportive employer to unpaid carers.
* Working with BYCS to embed a Young Persons Charter. The Child & Young Persons’ counsellors act as the link workers with BYCS.

We understand that a short break from caring can make a significant difference and recognise that offering a short course of complementary therapies will help reduce carer stress, help improve carer wellbeing and give emotional support. We have therefore strengthened our offering of complementary therapies to carers.

**6.3.4 Carer Satisfaction Outcomes: Q4**

|  |  |
| --- | --- |
| **Most commonly occurring needs in quarter:** | |
| * Emotional support – Listening Ear Service remains in demand. * Info and Guidance on community funding options * Referrals for home-based community adaptations (Care Connect) * Benefit applications | |
| **Intervention provided:** | |
| * Provided advice on CHC funding. * Supported with completion of CHC checklist request. * Provided listening ear and one to one session with carers. * Escalated emotional support needs with a referral to counselling. * Referral completed to Social Care Direct to result in increased support for their relative * Supported with completion of PIP and Attendance Allowance forms. * Provided advice on level of support required for their relatives. * Provided information on care homes that were suitable for their relative * Provided bereavement support to relatives to ensure appropriate ongoing level of support. * Provided information on community support options including care home agencies. * Referral to Admiral nurse for specialist input | |
| **Outcomes met:** | **Outcomes not met and why:** |
| * Emotional wellbeing * Information/advice/guidance | * None |
| **Thank You and Compliments:** | |
| * Friends and Family Test Feedback. | |
| **Feedback and Improvements:** | |
| * Carer support wheel to be used. * Carer support wheel used on 4 occasions during Q4 | |

**6.4 Strategic Goal 4: To support those who have been bereaved as a consequent of a life limiting illness to adjust to life without their loved one.**

We have worked with the Commissioning Support Project Officer, to review our service to children and young people. We have successfully implemented an action plan agreed in response to risks to business continuity and intended to reduce our waiting list for CYP counselling. We continue to embed our Bereavement Pathway and new ways of working, for example development of a Listening Ear Service, a bereavement service offered to those experiencing a need for anticipatory grief and post bereavement support, means our Family Support Team have been able to provide more emotional support to Living Well Centre guests and Inpatients and their families.

* 1. **Strategic Goal 5: To break down the taboos associated with dying, death, loss and grief.**

**6.5.1 Community Outreach Project**

Our community outreach project is ongoing within Chester le Street. The three years funding secured from Big Lotteries Community Fund has enabled us to recruitment to four posts: Community Outreach Manager, Community Outreach Co-Ordinator, Namaste Co-Ordinator, Namaste Support Worker. These posts are enabling us to deliver a project aimed at increasing our engagement and outreach into the community to support more people affected by life limiting illnesses through a range of volunteer led projects i.e. Everything in Place, Namaste, Carer Support Groups and Bereavement Support Groups.

In this quarter we have completed an evaluation and have subsequently decided to focus our energy and resources, in year two, on the areas that are working well, Hospice Hub, Bereavement Support and Dementia Care. This will free up capacity to undertake more community engagement and strengthen the Hospice Hub, Everything in Place, Bereavement Support and Dementia Care.

**6.5.2 Everything in Place (EiP)**

Everything in Place promotes a Public Health approach to encouraging family conversations around death, dying and bereavement. The course is delivered over eight, weekly sessions, covering topics such as Wills, Power of Attorney, Advance Care Planning, funeral planning, making memories etc. The overall aim of the programme is to encourage what can be difficult conversations, support informed decision making and the drafting of legal/informal documents preparing individuals and families for later life/end of life.

Prior to the Pandemic the Hospice delivered ‘Everything in Place’, in local community venues. During the pandemic the course was re-written to enable virtual delivery which has proven to be successful. Following an end to the non-recurring funding the departure of the Everything in Place Project Manager and the availability of volunteers the EIP stalled. However, through the Community Outreach Project face to face delivery of the course recommenced in March 2023.In this quarter we have seen demand for Everything in Place increase and we hope to respond to this in Q1.

**7. Clinical Governance, Quality Assurance and Quality Improvement**

* 1. **Clinical Audit**

St Cuthbert’s Hospice was last inspected by the Care Quality Commission (CQC) in 2023 and was rated ‘requires improvement’. An action plan is in place to meet the requirements as identified in the report. St Cuthbert’s Hospice is committed to continuous improvement and to support this, we have a well-developed programme of Clinical Audit, adopting wherever possible, recognised or validated audit tools for example those provided by Hospice UK national hospice audit tools group. Data collected, collated and analysed from our audit programme will be subject to internal scrutiny and review by Clinical Governance Group and Sub Committee before being shared in future service quarterly performance reports. Attached is the annual audit schedule of key clinical audits the findings of which are captured and monitored on an Audit Summary Tracker, also attached. Findings and any areas of concerns highlighted by a specific audit will be subject to a quality improvement plan owned by the relevant Link Practitioner Group.

 

An internal audit tool is being used to support a Caldicott Guardian ‘*spot check audit’* of all areas that hold personal identifiable data (PID) this can include patients and services users. The aim of the audit will be to identify where we reflect best practice in managing and securing PID and where we might be at risk and what steps will be needed to protect sensitive data. This will be completed at least annually.

* 1. **Link Practitioner Programme (LPP)**

The Link Practitioner Programme is an initiative proposed after the formulation of the North East Hospice Collaboration (NEHC 2017). Prior to the pandemic there were nine hospices who came together to share and develop both clinical and non-clinical areas for practice development. Within this community the initiative was viewed as a cost effective and creative approach to learning, which also enables bench marking, innovative thinking and the sharing and dissemination of best practice findings. In 2023 – 2024 the Hospice hopes to reinvigorate this community of practice potentially under the Patient Safety Incident Report Framework (PSIRF).

Within St Cuthbert’s Hospice senior leaders see the Link Practitioner Programme as key to embedding a quality improvement ethos within the Hospice, and subsequently avoiding complacency, retaining our outstanding rating and realising our vision of becoming a centre of excellence. The board and senior management team recognise that the LPP programme helps overcome barriers to staff involvement and engagement with quality improvement and quality assurance. It strengthens clinical leadership and engagement at all levels of the organisation and helps managers and front-line staff to work together to deliver a shared and aligned mission and vision. The Head of Clinical Services acts as sponsor for the LPP demonstrating visible leadership commitment from the board and senior management team.

Within the Hospice we have the following Link Practitioner Groups:

* Safeguarding
* Falls Prevention
* Tissue Viability
* Infection Prevention
* Blood Transfusions
* Nutrition & Hydration
* Medical Devices
* Complementary Therapies
* Information Governance
* Intravenous Lines
* Clinical Competency
* Student Nurses

Achievements in this quarter, deliverables for the following quarter and risks and issues for each Link Practitioner Group are captured in the following attachments:

       

* 1. **Evaluating Practice - Palliative Outcome Measures**

In 2015-16 St Cuthbert’s Hospice implemented the suite of validated Palliative Care Outcomes Measures Toolkit (OACC) outlined below in Figure 1 below.

**Figure 1 – Palliative Care Outcome Measures**

In 2022/23 we aimed to place a greater emphasis on reporting outcomes. We aimed to embed reports as PDF files and make data subject to internal scrutiny and review by our Clinical Governance Sub-Committee before publication in our Hospice Contract and Quality Monitoring quarterly reports and our Quality Account. This has however been hampered by a lack of capacity and capability in data analysis, something we hope to resolve with a joint post across Hospice Northeast & North Cumbria.

Despite the constraints, we have managed to record and analyse, pre and post outcome measures for guests attending LWC, our first attempt since the pandemic. Within the LWC, the Integrated Performance Outcome Score (IPOS) is the preferred outcome measure. The IPOS covers a range of performance domains related to peoples’ quality of life status and include both physical and emotional domains. Our Day Services Referrals and Admission Standard Operating Procedure (SOP) states the IPOS should be completed pre input from the LWC team, at the initial assessment and post input from the LWC team, at the final review.

Analysis of outcomes has demonstrated that frequently occurring problems were addressed through LWC interventions and that these: -

23 guests completed IPOS at both the beginning and the end of their care and 5 patients died.

* 1. **Evidenced Based Practice**

We have met or made substantial progress in meeting all our key aspirations for quality improvement as outlined in our 2022 - 23 Quality Account. However, we recognise that to maintain and continually improve our care services, we must ensure that the knowledge, skills, and competence of our staff and volunteers and the evidence that underpins our practice is updated in line with current best practice and research. To reflect best practise we have adopted the NICE Guidance or Standards listed in Appendix 1 to inform both policy and enhance our practice. In addition, the Hospice Clinical Practice Development Nurse supports clinical practice and individual development & training needs. We are also very pleased to be adding to the evidence base with our Clinical Practice Development Nurse becoming one of the Principal Investigators for CHELsea II which is a Randomised Controlled Clinical Trial, badged by the National Institute for Health Research. This is on hold until Medical Director is in post.

1. **Patient Experience and Friends and Family Test**
   1. **Welcome Pack- Patient, Client and Guest Survey Feedback**

We have updated our in-patient service user information pack to reflect changes to the unit. We routinely seek the views of all those who use our services such as in-patients Living Well Centre guests, Family Support service clients and Dementia service clients. We have redesigned the carer’s questionnaire to include the ‘Friends and Family Test’. There are a range of questions that seek views about our services such as the hospice environment, the staff caring for patients and the services delivered. The questionnaire is distributed to all service users or the families of those who have accessed the range of Hospice services, whether their relative has died or been discharged, it also includes those who attended for respite care. See table 13 for summary feedback for each Hospice service.

**Service user feedback questionnaire charts and comments**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

**8.2 Suggestion box feedback**

There are suggestion boxes situated at communal areas around the hospice, giving everyone the opportunity to make suggestions in a confidential/ anonymous manner. During Q4 there have been 3 suggestions from people using our service.

|  |  |
| --- | --- |
| **Suggestion** | **Response** |
| Employee Recognition Scheme Anyone can nominate a team or individual for good work.  Reviewed on a quarterly basis and shared by quarterly blog. Quarterly winners to be put forward for a yearly award. |  |
| Bring back Midnight Walk – bereaved family feel everyone can participate in this. |  |
| Is there any way to limit the sound in the coffee shop – perhaps pads for the bottom of the chairs |  |

1. **Workforce Assurance**

**9.1 Absence**

We are carrying several vacancies:

* Family Support Worker 1.0 WTE
* HCA (24 hours) 0.7 WTE

As part of our on-going review of teams and workforce transformation, we use exit questionnaires as an opportunity to learn and improve and vacancies as an opportunity to review models of care and workforce development needs.

**9.2 Recruitment**

We have successfully recruited to several posts: -

* Nursing Associate 0.6 WTE
* Rehabilitation Assistant 0.8 WTE
* Children’s Counsellor 0.4 WTE
* Ward Clerk 0.5 WTE
* Band 6 Senior Staff Nurse 1.0 WTE
* 2 Band 5 Nurses (1 x FT, 1 x 30 hours) 1.8 WTE

We continue to actively review and increase the number of RN and HCA bank staff, for the most part from a pool of staff who have previously worked at the Hospice this will assist with staff induction prior to commencing work on the unit. On rare occasions when they are not available at short notice or are already covering bank for another health care provider, we make use of a local agency for bank cover. Staff absence has resulted in increased use of agency staff in this quarter.

**9.3 Staffing Levels**

**In Patient Unit**

To better match our workforce skill mix and numbers of staff to demand; as measured by patient numbers, dependency and acuity we introduced as of Monday 13 July 2016 a new In-Patient Unit (IPU) dependency tool for based upon NHS England (Shelford Group) safer care. This helps us to establish benchmark acuity data to better model and predict our IPU care workforce needs against fluctuating bed occupancy and changes in patient acuity. Our nurse-to-patient ratio on the In-Patient Unit under usual circumstances is:-

* 8am to 2pm: 3 RNs to 10 patients, 2 HCAs to 10 patients
* 2pm to 8.30pm: 2 RNs to 10 patients, 2 HCAs to 10 patients
* 8pm to 8.30am: 2 RN to 10 patients, 1 HCAs to 10 patients

We have still not heard from the ICB or CDDFT regarding whether the funded PA session vacated following the retirement of Dr le Dune will be transferred to the Hospice, however we aim to continue pursuing the transfer of this funding to the Hospice.

**9.4 Training & Development**

We continue to support training and development. Staff can access a range of modules under the HENE CPD Tier one funding and we continue to support staff attendance at relevant conferences and workshops. All staff receive mandatory training and compliance against our mandatory training target of 90% is currently:

* Bereavement              96%
* Community                             100%
* Dementia                                93%
* Family Support Services        100%
* Guest Services                      79%
* LWC                                       100%
* IPU                                         97%
* Medical                                   97%

We currently have 5 independent prescribers (1 pharmacists and 4 nurses). In this quarter 4, a pharmacist secured a place on Independent Prescribing for Pharmacists.

We continue to roll out competency assessments. Examples include:

* Medicines Management
* Blood transfusion
* Syringe drivers
* Midlines
* Verification of Expected Adult Death
* Catheterisation

Training and Development sessions are also provided by our Clinical Practice Development Nurse and cover topics such as CQC, Duty of Care, Continence Care, Physical Observations, Intentional Rounding, Hypercalcaemia, Delirium, Metastatic Spinal Cord Compression, Seizures, Haemorrhage, Bowel Obstruction, Neutropenic Sepsis, Sepsis, Record Keeping, Communication in Handover, Nutrition and Verification of Expected Adult Death. All permanent clinical staff have completed care and management of the expected and unexpected deteriorating patient. In August/September we have tissue viability training which will include pressure ulcer, moisture associated skin damage and fungating wound education. Hickman Line and PICC training/competency assessment will take place in Quarter 2. We support clinical staff to undertake the Foundations and Advances in Palliative Care Course.

**Appendix 1**

**NICE Guidance or Standards used to inform both policy and enhance our practice.**

*Improving supportive and palliative care for adults with cancer. NICE Cancer service guideline (CSG4) March 2004.*

*Palliative care for adults: strong opioids for pain relief. NICE Clinical Guideline (CG140) May 2012. Last updated: Aug 2016.*

*Nutritional support in adults: oral nutritional support, enteral tube feeding and parenteral nutritional. (NICE) Clinical Guidance 32 (2006).* [*www.nice.org.uk/Guidance/CG32*](http://www.nice.org.uk/Guidance/CG32)*. (Updated 4 Aug 2017).*

*Pressure ulcers: prevention and management. NICE Clinical Guideline (CG179) April 2014.*

*End of life care for adults. NICE Clinical Guideline (QS13) 7 March 2017.*

*Care of dying adults in the last days of life. NICE Clinical Guideline (QS144) 2 March 2017.*

*Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NICE guideline (NG5) March 2015.*

*Medicines optimisation NICE Clinical Guideline (QS120) 24 March 2016.*

*Controlled drugs: safe use and management. NICE Clinical Guideline (NG46) Published date: April 2016.*

*Palliative care for adults: strong opioids for pain relief. NICE Clinical Guideline (CG140) May 2012. Last updated: Aug 2016.*

*Falls in older people. NICE Quality Standard (QS86) Published March 2015. Updated January 2017.*

*Head injury: assessment and early management. NICE Clinical Guideline (QS176). Updated 2017.*

*Mental Health Act 1983 Code of Practice TSO, 2015.*

*Pressure ulcers: revised definition and measurement. Summary and recommendations. NHS Improvement (NHSI) June 2018.*

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