St Cuthbert's Hospice

Service Contract Quarterly Performance Report
Fourth Quarter: 1st January to 31st March 2020

1.0 Introduction.

This fourth quarter Service Contract Quality Performance Report (SCQPR) covers the period 1 January – 31 March 2020 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 2019-20 NHS Contract.

Key service issues over the last quarter

The key service issue in the last quarter has been the impact of and our response to Covid-19 virus pandemic. The Clinical Services Manager has met with CCGs Director of Nursing/Gold Commander in order to ensure the hospice contributes fully to the local resilience plan.

The in-patient unit remained been designated as a "clean area" by the local resilience forum and we continue to operate with 10 beds. To ensure we maximise bed occupancy, support the CDDFT with their target of discharging patients within 2 hours of a decision to discharge and mitigate against a reduction in capacity due to staff absence, our clinical team are reviewing and responding to the changing situation daily and working flexibly. In order to facilitate admissions Mon-Sun we have put in place a rota to ensure weekends are covered by a nurse consultant or non-medical prescriber and an on call medic. We continue to complete and submit to the CCG, a comprehensive spreadsheet to monitor reasons for declining referrals/admissions to IPU.

Medical cover: Our PCC and Medical Director, appointed December 2018 is now an established as a member of the Hospice senior management team and attends Board and Clinical Governance sub-committee meetings. Revised arrangements for these including virtual meetings have been in place throughout March. We continue to work in partnership with the Palliative Care Consultant (PCC) and training fellows from CDDFT to conduct pre-admission medical assessments, clerking and prescribing remotely using SystmOne for referrals from CDDFT hospital beds or the community to support improved access to in-patient care at St Cuthbert's Hospice. More recently this collaboration has focussed on supporting our colleagues to deliver the local resilience plan. We continue to build the medical team and a GP registrar joined the medical team on a full time basis in February. In the long term we hope that this will address our difficulty in securing locum cover, to cover leave and in the absence of medical cover have to defer referrals. We are already seeing the extension of speciality grade doctor cover and appointment of the GP registrar improve patient carer, facilitate comprehensive review before the weekend, improve continuity and allow medical cover to continue even in the absence of other members of the team on study, annual leave or having to cover elsewhere in the system in response to Covid-19. We have still not heard from the CCG 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.

Living Well Centre, Community Services and Family Support Services: Due to the vulnerability and general frailty of the people who use or our services and in order to comply with Government/Public Health England Guidance on shielding & social distancing we have had to temporarily suspend operational delivery of our usual services. We are instead offering a wellbeing telephone call at a frequency between daily to monthly to check on physical, social, spiritual and mental wellbeing during the COVID-19 period of social isolation. Any concerns identified regarding wellbeing, advice/support and guidance can be provided by LWC clinical staff and/or signposting to alternative services. The risks of contracting the virus from each other outweigh the benefits of attending. Bereavement support is also being provided in line with PHE guidance with a particular focus on ensuring people unable to be with loved ones feel connected during visiting restrictions.

2.0 Summary of what we have achieved to end of quarter four

Achievements to end of fourth quarter:
Quarter 4 – service activity:

- **In-Patient Unit:**
  - We have seen 62 new admissions into the in-patient unit during this reporting period.
  - Cumulative deaths totalled since 1 April 2019 is 123 of which 101 achieved their preferred place of death. We were unable to discuss preferred place of death with 14 other patients who were too ill on admission. 8 did not achieve preferred place of death.
  - IPU bed occupancy to end of quarter four was 79.6%. It should be noted our average length of stay for the quarter is now 11.2 days.
- **Living Well Centre:**
  - In this quarter we achieved 97% occupancy for our LWC with 130 guests and received 39 new referrals into our service, (despite reduced qualified nurse capacity). In March we conducted a review of capacity and demand within living well services and hope to use this to form the development of a more sustainable operating model in Q1 2020.
- **Family Support Service (FFS):**
  - FSS saw 228 clients over 2018-19 for counselling & bereavement support. In this quarter, we have seen 68 clients and accepted 21 new referrals despite a reduction in capacity due to vacancies, staff having to self-isolate and the Senior Social Worker appointed in Q2 reducing her hours temporarily. In order to comply with Government/Public recommendations. Health England/Professional Guidance we have had to temporarily suspend provision of training to HV/SNs and operational delivery of our usual family support services. We are instead offering a wellbeing telephone call at a frequency between daily to monthly to check on physical, social, spiritual and mental wellbeing during the COVID-19 period of social isolation. We have also completed a review of family support and plan to complete a consultation period with staff in Q1.
- **Dementia care services:**
  - We have had to temporarily suspend delivery of our face to face dementia services, and Namaste on the Ward, and our collaboration with HPJ & Hospice NE. However, some 60 clients (both people living with dementia and their carers) have accessed our service including 28 new referrals to our Admiral Nurse a Dementia Specialist Nurse. Namaste service over the last quarter has worked with 64 clients who received 160 Namaste sessions. We are offering telephone advice and support and wellbeing telephone call at a frequency between daily to monthly to check on physical, social, spiritual and mental wellbeing during the COVID-19 period of social isolation. We have also completed a review of the service which includes a review of caseloads and referral criteria.
- **Patient safety and harm prevention.**
  - We report 2 PU's on admission, 0 acquired PU's, 1 PU's that deteriorated following admission
  - We report 4 medication errors (Controlled drug medication)
  - We report unsafe admissions 0.
  - We report 0 unavoidable falls and 4 avoidable falls during the quarter.
  - We report 0 incidence of catheter associated infection acquired following admission to the Hospice.
  - We achieved 100% compliance with completing VTE assessments for the period of this report.

3.0 Service Activity

In accordance with Clinical Commissioning Group (CCG) dataset requirements full data reports are submitted below. For comparison the preceding full year's performance (2018-19) data is provide and each full quarters performance for 2019 -20 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:

4.0 Local Key Performance Indicators (KPI's)

In-patient unit

During the fourth quarter 25 patients died on IPU. 19 patients achieved their preferred place of death. 1 people did not achieve their preferred place of death which was home. We were unable able to discuss preferred place of care with 5other patients, as they were too ill on admission.

Table 1 – Hospice activity 2019-20									
Indicators.	**Threshold**	**End of Year. 2018-19**	**Met – Not met**	**2019-20 quarterly performance.**				**End of year 2019-20**	
				Q 1.	**Q 2.**	**Q 3.**	**Q 4.**		**Year 2019-20 Performance**
In-Patient Unit (IPU)									**COMMENTS.**
Total number of in-patient referrals received	N/A for monitoring purposes	**New KPI**	**-**	**78**	**89**	**93**	**86**	**346**	N/A for monitoring purposes
Average waiting time from referral to admission for inpatients (excluding weekends and planned respite).	**≤ 48 hours**	**New KPI**	**-**	**11.7**	**51.3**	**41.8**	**50.4**	**38.8**	MET In Q2 there was a change to the way we calculate hours.
Total number of inpatient admissions.	N/A for monitoring purposes	**171**		**49**	**55**	**57**	**62**	**223**	N/A for monitoring purposes
Percentage bed occupancy.	**≥ 85%**	**83.5**	**Not met**	**79.6**	**75.7**	**85**	**79.6**	**80**	NOT MET Reasons for refusing/delaying admissions are captured and reviewed via a monthly spreadsheet.
Percentage bed availability.	**≥ 95%**	**99.2**	**Met**	**99.5**	**98.5**	**100**	**100**	**99.5**	MET
Average length of stay for inpatients.	**≤ 15 days**	**New KPI**	**-**	**16**	**12**	**13.7**	**11.2**	**12.9**	MET Improved average LOS could be a consequence of additional management capacity & increased awareness of KPIs amongst staff

Number and percentage of inpatients that have been offered an Advance Care Plan.	**90%**	**94.2**	**Met**	**49 96%**	**52 92.9 %**	**53 96.4 %**	**60 92.3 %**	**214 94.4 %**	MET Potentially an indication of what has been recorded as offered rather than what has actually been offered
Number and percentage of patients who died at the hospice and have preferred place of death recorded.	N/A for monitoring purposes	**92.6**	**-**	**29 93.5 %**	**34 87.2 %**	**26 92.9 %**	**20 80%**	**109 88.4%**	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	**94**	**-**	**25 86.2 %**	**33 84.6 %**	**24 92.3 %**	**19 95%**	**101 89.5**	N/A for monitoring purposes
Patient's risk of falls to be assessed within 4 hours of admission.	**100%**	**New KPI**	**-**	**34.7**	**52.7**	**69.2**	**74.6**	**57.8**	NOT MET - Staff have been advised to record time of assessment rather than time of entry on to SystmOne.
Patient's written care plan tailored to address falls risk completed within 8 hours of admission.	**100%**	**New KPI**	**-**	**83.7**	**92.7**	**98**	**88.1**	**90.6**	NOT MET - Staff have been advised to record time of assessment rather than time of entry on to SystmOne.
Pressure ulcer risk assessment to be completed within 6 hours of admission. (Ref - NHS Improvement 2018 Pressure Ulcers: revised definition and measurement).	**95%**	**New KPI**	**-**	**57.1**	**61.8**	**82.7**	**83**	**71.1**	NOT MET - Staff have been advised to record time of assessment rather than time of entry on to SystmOne.
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%**	**New KPI**	**-**	**57.1**	**61.8**	**82.7**	**83**	**71.1**	NOT MET - Staff have been advised to record time of assessment rather than time of entry on to SystmOne.
Venous thromboembolism (VTE) risk to be assessed within 24 hours of admission to determine if prophylaxis required.	**100%**	**99**		**100**	**100**	**98.2**	**100**	**99.6**	NOT MET
Percentage of patients that report a positive experience of care via the Friends and Family Test.	**90%**	**New KPI**		**100**	**100**	**67**	**100**	**91.6**	MET Q3 - Only 3 responses received this quarter, 2 rated extremely likely, 1 rated don't know
Number of complaints and compliments received and actions taken	N/A for monitoring purposes	**New KPI**		**0**	**37 compliments**	**18 compliments**	**10 compliments**		N/A for monitoring purposes Refer to Sect 5.2 in rep[ort
Number of clinical and non-clinical incidents and actions taken	N/A for monitoring purposes	**New KPI**		**-**					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	-		141	144	145	130	257	N/A for monitoring purposes
Number and percentage of Living Well Centre patients receiving a care plan	**100%**	**100**		**100**	**100**	**100**	**100**	**100**	MET
Percentage occupancy	**≥ 80%**	**93.1**		**96.6**	**101.7**	**103.7**	**97**	**100**	MET Level of over booking has been better informed by data overtime
Time from referral to Living Well Centre and contact to arrange home visit / assessment	**90% within 7 days**	**91.9**	**Met**	**93.8**	**95.7**	**94.6**	**94.1**	**94.6**	MET
Time from first referral in LWC to Physiotherapy assessment	**100% within 21 days**	**New KPI**	**-**	**92.9**	**90.9**	**100**	**100**	**96**	NOT MET - 1 service user. Reduced capacity within OT/Physiotherapy due to staff absence
Time from referral in LWC to Occupational therapy assessment	**100% within 21 days**	**New KPI**	**-**	**100**	**100**	**100**	**100**	**100**	MET
Percentage of patients that report a positive experience of care via the Friends and Family Test	**90%**	**New KPI**	**-**	**88**	**82**	**100**	**100**	**92.5**	MET Q1 - 8 forms – 1 did not return Q2 – 17 forms, 2 not completed
Dementia services									**COMMENTS**
Total number of patients attending Dementia Support Service	N/A for monitoring purposes	**169**	**-**	**112**	**114**	**97**	**124**	**140**	N/A for monitoring purposes
Time from referral to Admiral Nurse for first contact and appointment arranged for assessment.	**95% within 15 days**	**94.9**	**Not met**	**88.5**	**100**	**100**	**100**	**97.1**	MET
Time from referral to Namaste care for first contact and appointment arranged for assessment.	**95% within 15 days**	**New KPI**	**-**	**100**	**98**	**95.5**	**100**	**98.4**	MET
Percentage of patients who provide feedback and report a positive experience of care	90%	**New KPI**	**-**	**100**	**83**	**100**	**100**	**95.8**	MET Q2 – Only 6 forms returned
Number of complaints and compliments received and actions taken	N/A for monitoring purposes	**New KPI**	**-**	**1**	**0**	**0**	**3**	**4**	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	**New KPI**	**-**						N/A for monitoring purposes Refer to Sect 5.2 of report
Family Support Services									**COMMENTS**
Total number of clients accessing Family Support Services	N/A for monitoring purposes	**343**	**-**	**78**	**58**	**64**	**68**	**147**	N/A for monitoring purposes Refer to Sect 5.2 of report Pull for psychological support on IPU in Q4
Number and percentage of clients contacted within 15 working days of receipt of referral	**95%**	**100**		**100**	**100**	**100**	**100**	**100**	MET All referrals to counselling services contacted within 7 days
Number and percentage of written assessments of needs and action plans agreed with clients	**100%**	**100**		**100**	**100**	**100**	**100**	**100**	MET
Percentage of clients that report a positive experience of care via the Friends and Family Test	**90%**	**New KPI**		**100**	**100**	**90**	**0 responses**	**96.7**	MET No responses received in last quarter
Number of complaints and compliments received and actions taken	N/A for monitoring purposes	**New KPI**		**11 compliments**	**8 compliments**	**3 compliments**	**8 compliments**		N/A for monitoring purposes Service leads are now dating & saving complement cards/letters. 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

Living Well Centre

Our transformed day care services have resulted in a significant increase in attendance to the Living Well Centre and an increase in new referrals. We are now offering patients a range of interventions based upon a 12-week rehabilitative programme of care. The introduction of a rehabilitative model of care has resulted in more people accessing our services from previously underrepresented groups such as younger adults with neurological disease. See table 2.

Table 2 –Living Well Centre available places and occupancy							
Year 2019-20Performance				**Year 2019-20 Performance**			
	Number of places	**Average % Occupancy**	**Quarter**	**Number of places (15)**	**% Occupancy**	**Average % Occupancy**	**Comments**

Quarter 1 April-June	**900**	**87.7%**	**Quarter 1:**				**MET**
			April	**300**	**102.7**	**96.6**	Had everyone booked attended occupancy would have been 147%
			May	**315**	**92**		
			June	**300**	**95.3**		
Quarter 2 July-Sept	**945**	**85.9%**	**Quarter 2:**				
			July	**345**	**94.8**	**101.7**	Had everyone booked attended occupancy would have been 139%
			August	**300**	**101.3**		
			September	**315**	**109.5**		
Quarter 3 Oct-Dec	**915**	**101%**	**Quarter 3:**				
			October	**345**	**107.5**	**103.7**	Had everyone booked attended occupancy would have been 149%
			November	**315**	**107.6**		
			December	**270**	**94**		
Quarter 4 Jan-Mar	**915**	**97.8%**	**Quarter 4**				
			January	**330**	**92.4**	**97%**	Had everyone booked attendance would have been 136%
			February	285	101.8		
			March	75	98.1		

5.0 Safety Thermometer Data - Incident, Trends and Lessons Learned

5.1 Patient Safety

To support best practice and enhance patient safety within St Cuthbert's Hospice care settings a continuing review and update of care policies and procedures was carried out during 2015-18 and a number of key polices were updated including the Safeguarding Policy and those related to patient safety and incident reporting. The review and updating of policies will continue over 2019-20 to ensure our suite of care related policies and procedures reflect local and national guidelines. 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 forum. See table 3 below.

Summary of clinical and other untoward incidents

Table 9 – Clinical and untoward incidents 2019-20								
	Code	**2018-19 Totals**	**Q1.**	**Q2.**	**Q3.**	**Q4.**	**Year end**	**Comments**
Service Falls	1	**38**	**5**	**17**	**6**	**4**	**32**	4 avoidable 0 unavoidable
As above – staff &clinical volunteers	2	**3**	**1**	**0**	**1**	**2**	**4**	1 moving and handling and staff member 1 filing cabinet injury
Pressure Ulcers	3	**23**	**6**	**7**	**11**	**3**	**27**	2 on admission 1 acquired or deteriorated post admission

Medication Errors	4	**5**	**4**	**5**	**7**	**8**	**24**	4 non CD's – No patient harm 4 CD's – No patient harm 2/8 Dispensing errors
Other clinical incidences	6	**8**	**4**	**6**	**4**	**3**	**17**	Albumin incorrectly labelled District Nurse records Patient with respiratory distress – no harm
Health acquired infections	7	**0**	**0**	**0**	**0**	**0**	**0**	
Other non-clinical incidences	8	**0**	**3**	**0**	**1**	**3**	**7**	1 x fire 1 x unauthorised people entering building 1 x break in green house
Information Governance	9	**3**	**2**	**1**	**2**	**5**	**10**	EHCP on printer Nurses purse stolen and then found at home Letter found on printer Blood results found on printer Lost badge
Subject Access Requests	10	**3**	**0**	**0**	**0**	**0**	**0**	
Safeguarding	11	**1**	**1**	**3**	**8**	**3**	**15**	3 x DOLs applications

5.2 Serious Incidents and complaints

Quarter One

Table 3: Summary of serious / potentially serious incidents and complaints.

Incident log number	**Brief details of incident / complaint**	Reported to	Yes / No		Date	STEIS Number	Outcome
2019/0271	Patient admitted from hospital with a suspected deep tissue injury	CQC					
		NECS					
		Safeguarding					
		CGC / SMT					
Incident log number	**Brief details of incident / complaint**	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0276	Patient admitted from hospital with category 3/4 pressure damage	CQC					
		NECS*					
		Safeguarding		X			
		CGC / SMT					
Incident log number	**Brief details of incident / complaint**	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0277	Patient admitted from hospital with category 3 pressure damage	CQC					
		NECS					
		Safeguarding					

		CGC / SMT					

Quarter Two

Table 3: Summary of serious / potentially serious incidents and complaints.							
Incident log number	**Brief details of incident**	Reported to	Yes / No		Date	STEIS Number	Outcome
2019/0323	Patient disclosed husband had hit her	CQC	x				Patient reviewed by duty social worker prior to going home. Duty social worker will follow up in community
		NECS					
		Safeguarding	x		26/07/19		
		CGC / SMT	x		Q2		
Incident log number	**Brief details of incident**	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/00324	Controlled drug error – Ketamine prescribing	CQC		x			Ketamine Shared Care Protocol Developed
		NECS*					
		Safeguarding		x			
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0326	Controlled drug error – Ketamine supply	CQC		**x**			Pharmacist with licence to stock Ketamine sourced
		NECS					
		Safeguarding		**x**			
		CGC / SMT	**x**		**Q2**		

Incident log number	Brief details of incident	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0330	Client unhappy about way in which information was communicated to her.	CQC					Apology given. Treated as informal complaint
		NECS					
		Safeguarding					
		CGC / SMT	x		Q2		
Incident log number	**Brief details of incident**	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0331	Client asked informally for change of key worker	CQC		x			LWC met with client and issue resolved to the clients satisfaction
		NECS*					
		Safeguarding		x			
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0334	Verbal abuse towards staff	CQC					Deprivation of liberty put in place

		NECS					
		Safeguarding					
		CGC / SMT	**x**		**Q2**		
Incident log number	**Brief details of incident**	Reported to	Yes / No		Date	STEIS Number	Outcome
2019/0344	Controlled drug error – dispensing of Pregabalin (not administered)	CQC					Second incident of this nature, pharmacist informed (UHND Pharmacy)
		NECS					
		Safeguarding					
		CGC / SMT	x		Q2		
Incident log number	**Brief details of incident**	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0347	Safeguarding – potential financial abuse	CQC	X				CQC notified
		NECS*					
		Safeguarding	**X**				
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0352	**Controlled drug error – administration error (Tramadol from another patients box of medication**	CQC		**x**			No harm to patient
		NECS					
		Safeguarding					
		CGC / SMT	**X**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	
2019 / 0358	**Controlled drug error – supply Ketamine**	CQC					CCG notified
		NECS					
		Safeguarding					
		CGC / SMT	**X**				

Quarter Three

Table 3: Summary of serious / potentially serious incidents and complaints.							
Incident log number	**Brief details of incident**	Reported to	Yes / No		Date	STEIS Number	Outcome
2019/0364	Pressure ulcer on admission – Grade 3	CQC	X				CQC informed. Spoke with safeguarding, questions answered regarding pressure damage, not thought to be neglect, case closed.
		NECS					
		Safeguarding	x				
		CGC / SMT	x		Q3		
Incident log number	**Brief details of incident**	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/00375		CQC					
		NECS*					

	Controlled drug error –patient given s/c Oxycodone 15mg instead of oral Oxycodone 15mg	Safeguarding					No harm to patient. Duty of candour fulfilled. Clinical Supervision with staff. Improvement to medicines management ongoing. MAR chart being revised to reduce the likelihood of human factors. Medicines management training, competency assessment & drug calculation tests on going.
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
		CQC					

2019/0378	Controlled drug error – s/c dose of Alfentanil administered sublingually rather than s/c	NECS	**X**				No harm to patient. Duty of candour fulfilled. Clinical Supervision with staff. Improvement to medicines management ongoing. MAR chart being revised to reduce the likelihood of human factors. Medicines management raining, competency assessment & drug calculation tests ongoing.
		Safeguarding					
		CGC / SMT	**X**				
Incident log number	**Brief details of incident**	**Reported to**	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0379	Avoidable patient fall – left proximal humerus fracture	CQC	**X**				The care of plan written in the care record did not reflect the care being carried out. E.g. Falls assessment completed within agreed timeframe but time not recorded accurately. Lessons learned shared by email, during 121s, at team meeting 13 Nov. Staff advised that, falls risk assessment must be done within 4hrs of admission and recorded accurately in the care record, falls risk assessment must be reviewed in a timely manner post fall, all high risk patients must have falls mats (not withstanding consent) Quote obtained for under mattress falls sensors (patients step round mat sensors) Duty of Candour training being sourced for service managers.
		NECS				**2019/26402**	
		Safeguarding	**X**				
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0394	Assault - Brother and Sister of patient in lounge having a discussion staff heard raised voices and what sounded to be a slap. Brother spoke with FST and stated had been hit by sister. Brother had hand print to face no other injury.	CQC					FST spoke to sister about what is/is not acceptable within IPU and to offer support.
		NECS					
		Safeguarding					
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0399	Suspected pressure ulcer on admission Patient admitted to IPU 20th Nov 2019. . Patient noted to have a suspected deep	CQC	**X**				Risk assessment & plan of care put in place pressure ulcers. CQC notification form completed. Referred to safeguarding
		NECS				**2019/26412**	
		Safeguarding	**X**				

	tissue injury to her left heel with small darkened area ? SDTI Pin Point size to centre, skin remains intact – red area approx 4cm x 4cm. The right heel has a suspected deep tissue injury approx - 1cm x 1cm necrotic area surround skin red in total approx. 5cm x5cm.	CGC / SMT	**X**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0405	Suspected deep tissue injury Patient has red heels and has continued to have red heels during her time at the hospice, staff attended to patient on 6/12/19 am to bed bath patient noted and documented the heels were discoloured, more so to the left but remained intact. PM patient transferred on a stretcher to UHND for a CT scan, she was at the appointment approximately an hour and on her return staff nurse noticed the left heel had changed to blue in colour and ? if this was a suspected deep tissue injury.	CQC	**X**				Patient assessed on return from hospital, husband informed in change of skin, already nursed on air flow mattress, Waterlow and care plan updated. Photographs taken with patients consent. Patient hemi paretic & reluctant for positional change does not spend time on sides as uncomfortable. Referred to TVN. Referred to safeguarding team who decided neglect had not paid a part in deterioration in skin. No further action taken. Skin went on to deteriorated over weekend area now dark almost black in colour unable to see wound bed, no breaks noted area 5cm x 2cm. CQC notification completed.
		NECS					
		Safeguarding	**X**				
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0409	Pressure Ulcer Skin changes to sacrum noted on 10/12/19 small 1cm x 0.5cm maroon area identified suspected to be SDTI small broken area 0.5cm x0.5cm noted ? Grade 2 at this point.	CQC	**X**				Skin reviewed by staff at least 2-3 times a day depending if patient will allow. Proshield applied. Patient unable to tolerate lying on sides for long periods of times so when in bed predominately nurse on back, bed tilt altered. Family and patient informed of further skin breakdown. Referred to safeguarding & CQC notified. 13/12/19.
		NECS					
		Safeguarding	**X**				
		CGC / SMT	**X**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0410	Patient admitted to St Cuthbert's hospice from home on 11/12/19. On admission skin assessed and though to have a Grade 4	CQC	**X**				11/12/19IR1 completed. Wound dressed with flaminal and dressing applied. Referred to TVN team who visited 13/12/19.
		NECS					
		Safeguarding	**X**				

	pressure ulcer to L outer aspect of ankle. Risk assessment completed & care plan put in place. Nursed on air flow matters. Patient independently mobile and able to change own position without prompt, has capacity and in self caring. Patient stated pressure damage noted on discharge from Darlington hospital ?in June 2019. Patient under the care of district nurse team and have been visiting to provide pressure area care.	CGC / SMT	**X**				13/12/19 Assessed by TVN – Noted to be grade 3 pressure damage not grade 4. New dressing regime in place. Dressings ordered. Care plan updated. Referred to safeguarding who had no concerns about neglect. Note made on file. No further action required. CQC Notification completed. Patient and family informed of referrals to TVN, Safeguarding and CQC, happy with actions and they have no concerns.
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0412	Patient developed SDTI to L heel 2cm x 2cm	CQC	**X**				Patient aware. Nursed on airflow mattress, bed board removed from bed previous days. Position of foot to be altered as patient can tolerate currently floating off bed as bed board removed. Proshield being applied to area Photograph taken, care plan, water low, 18/12/19 Referral sent to TVN, CQC notification completed and emailed to C.S.M.
		NECS					
		Safeguarding	**X**				
		CGC / SMT	**X**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0416	18/12/19 Admitted to hospice from Wd 1 UHND. On admission and transfer from ambulance stretcher staff unable to assess skin integrity as patient in too much pain. 19:15pm Following analgesia staff able to roll patient and reposition but not able to full assess skin integrity as planned as patient could not tolerate being on sides for any length of time. From what could be seen was red area across (1) sacrum which appeared broken on both buttocks (butterfly effect), (2) dark area to upper leg/lower buttock. Unable to obtain photographs due to discomfort and pain.	CQC	**X**				TVN referral made, husband aware of deteriorating skin condition, reported to safeguarding 30/12/19 - no concerns from them. CQC notification completed and emailed to clinical services manager to email forward. See attached sheets to incident for.
		NECS					
		Safeguarding	**X**				
		CGC / SMT	**X**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0417	Overall skin condition noted to be deteriorating. 1) Sacral dressing intact no	CQC	**X**				Referral to tissue viability nurse made. Husband aware of deteriorating skin condition.
		NECS					

	strike through so left in place and changed on nightshift, surrounding skin pink – proshield applied for protection. 2) Upper leg/lower buttock – Dark red area remains ?SDTI, skin broken- proshield and foam dressing applied 3) R calf – Red area remains, not broken may deteriorate and develop into ? SDTI – Proshield applied 4) L calf ? SDTI approx. 2 cm x 1cm – proshield applied. 5) Elbows pink but intact – proshield applied 6) L ear – dark area noted ? SDTI, head favours L side, proshield applied and positioned as much as possible so ear not touching pillow but this is difficult due to patients head favouring L side.	Safeguarding	**X**				Reported to reported to safeguarding 30/12/19 - no concerns about neglect. CQC notification completed and emailed to clinical services manager to email forward. See attached sheets to incident form.
		CGC / SMT	**X**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2019/0420	Patient prescribed 400mg gabapentin nocte. Dose omitted by staff. Staff where working way through drug kardex when came to CD where going to go back to it when all other non CDs had been dispensed for the patient and forgot to go back to Gabapentin.	CQC					Reflective practice undertaken with both nurses. 31/12/19 Nurse new to unit and previously had used computer system which would not allow you to move past medication without signing to say had been dispensed so staff member getting used to using paper kardex's. Discussed checking the kardex's once a patient's medications have been dispensed to ensure all medications for that medication round have been dispensed. No other issues noted with staff members capabilities re the dispensing and administration of medication. 3/1/20. Reflected on omission and discussed learning re: not going back to CD's at end of that individuals drug dispensing but doing it at the time of getting to the CD drug, recommended this for ongoing practice. Support given.
		NECS					
		Safeguarding					
		CGC / SMT	**X**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
		CQC					

2019/0421	Patient prescribed 5mg oxycodone at night which had been omitted by staff.	NECS					Staff where working way through drug kardex when came to CD where going to go back to it when all other non CDs had been dispensed for the patient and forgot to go back to oxycodone. Nurse A – 30/12/19 - Senior Nurse informed nurse about incident and they spoke and reflected on the incident, Nurse new to unit and previously had used computer system which would not allow you to move past medication without signing to say had been dispensed so staff member getting used to using paper kardex's. Discussed checking the kardex's once a patient's medications have been dispensed to ensure all medications for that medication round have been dispensed. No other issues noted with staff members capabilities re the dispensing and administration of medications. Ward sister spoke with staff member 31/12/19 re assured and supported member – no further action needed. Ward sister will speak with Nurse B on return to shift 3/1/20. 3/1/20 Spoke with Nurse B re omission, reflected on omission and discussed learning re: not going back to CD's at end of that individuals drug dispensing but doing it at the time of getting to the CD drug, recommended this for ongoing practice. Support given. No further action required.
		Safeguarding					
		CGC / SMT	**X**				

Quarter Four

Table 3: Summary of serious / potentially serious incidents and complaints.							
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0430	Patient prescribed co amoxiclav 625mg QDS instead of 625mg TDS.	CQC					Prescriber has reflected and learned from incident. No harm occurred. Human error. Policy followed re: being open and honest with patients and relatives
		NECS					
		Safeguarding					
		CGC / SMT	**X**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0431	Miscount of patient's drug - oxycodone 50mg/1ml injection	CQC					Count in book corrected. IR1 completed. Copy of CD register taken and attached to IR1. C.S.M and hospice pharmacist aware. Plan to reflect with staff involved and learn from admin error. Wider team to be informed verbally and by email of the importance of thoroughly checking medications when they arrive from pharmacy and when counting CD drugs when dispensing drugs for patient.
		NECS					
		Safeguarding					
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0437	Patient admitted to IPU from home with medications dispensed from own pharmacy. Bottle of morphine sulphate in correct box 10mg/5mls but patient label marked as morphine sulphate 20mg/ml give 2-3 mls which is a under dosage of required medicine. Bottle unopened on admission and not given during admission.	CQC					Wards Sister spoke with Pharmacist at Wells chemist informed of dispensing error, he apologised and I accepted this. He will investigate incident from his end. He does not have anyone to collect bottle of medicine from us so had requested we return oramorph to our pharmacy to dispose of. Note made on bottle informing Whitfields pharmacy of the labelling error to bottle so they are aware we are aware.
		NECS					
		Safeguarding					
		CGC / SMT	**x**				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0451	24 sevredol 20mg tablets signed into patients own stock in CD register and signed back out to	CQC					
		NECS					
		Safeguarding					

	return to Whitfields pharmacy for return at the same time as signed in as patient discharged and sent home with oramorph not sevredol. On collection of medications from W Whitfields pharmacy staff unable to locate 24 x sevredol tablets	CGC / SMT	x				CSM sought advice from CDLIN. Concluded most likely to have been sent back to pharmacist or accidently disposed off rather than stolen. No further action required other than monitoring for similar issues in future.
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0459	Staff came to administer medication and noticed measure not correct with what was reordered in CD register. Should have been total of 214mls corrected measure showed 198.5mls	CQC					To find out % of acceptable shortfall, I have read policy and am unable to obtain this information To start using medicine bottle bungs to stop leakage and waste – Ward sister to look into.
		NECS					
		Safeguarding					
		CGC / SMT	x				
Incident log number	**Brief details of incident**	Reported to	**Yes / No**		**Date**	**STEIS Number**	**Outcome**
2020/0479	Strong smell of smoke noted on IPU. Consultant went to smoking area and noted a lot of smoke coming out of cigarette bin, fire distinguished with water by Consultant.	CQC					Sign in place warning users of the shelter that bin is only to be used for cigarette ends and nothing else. Ward Sister d/c with guest services manager provision for emptying the bin as from walk around maintenance team were taking over the emptying of the bin. I expressed concerns that the bin is often full and there was nothing in place to inform when the bin had been emptied I have requested a daily emptying of the bin. I have also requested? a safer bin as people are still putting plastic wrappers into the bin. Guest services manager to order sand bin and maintenance manager will check and empty this daily mon-fri. Domestic staff who works a weekend happy to check new bin when it arrives on a Weekend. Ward Sister to r/v risk assessment if available if not to do a risk assessment.
		NECS					
		Safeguarding					
		CGC / SMT	X				

5.3 Falls

Although ambitious our aim for the period 1 April 2018 to 31 March 2019 was to reduce the incidence of '***unavoidable***' patient falls to zero, based upon number of falls recorded (11) during 2017-18. 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. • Falls risk assessments(FRAT) – designed into SystmOne record • Bed rail assessment – designed into SystmOne record • Regular patient checks and encouragement to ask for help • Assessment and plan of care for toileting needs • Moving & handling assessment and physiotherapy input • Assessment and plan of care for postural hypotension • Assessment of cognition and/or mental capacity and plan of care to address this • Review of medications	• Bed rails assessment and mobility care plans. • Weekly MDT formal review of falls risk and record action plan. • Moving and handling equipment including ***ultra hi/low bed in 2016-17*** • Bed, chair and floor falls and movement sensor alarms and soft landing crash mats. • One to one nursing / monitoring with **r**ooms 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 • 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. • Liaison with the CDDFT Falls Co-ordinator to review best practice such as 'swarm' reviews and close observation charts for those at high risk – these are being implemented.

Not all of 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 classifying falls as either avoidable or unavoidable dependent upon the measures put in place to help reduce / minimise the risk of falls. See Table 5.

Table 5 - Patient falls monitoring 2019-20

	Total falls recorded for 2019-20								
	Number of falls	1st falls risk assessment	Falls risk assessment			Fall reduction / prevention	Mobility care plan in place	Extent of harm 1 – None	Avoidable / unavoidable

		completed within 4hrs. of admission	updated after any/all falls	Moving and handling assessment	Falls risk reviewed at weekly MDT (Include from 2018-19)	measures in place		2 – Minor Inj. 3 – Moderate Inj. 4 – Serious Inj.	
2018-19 totals	**38**							**X 27 No harm X 10 Minor injury X 1Serious Injury**	**1 avoidable falls reported for year.**
1st Quarter									
April	**1**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	1 x minor injury	
May	**3**	Yes	**Yes**	**Yes**	Yes	**Yes**	**Yes**	2 x no harm 1 x minor injury	
June	**-**	-	-	-	-	-	-	-	-
2nd Quarter									
July	**3**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	2 x no harm 1 x minor injury	
August	**2**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	1 x no harm 1 x minor injury	
September	**5**	Yes	Yes	Yes	Yes	Yes	Yes	4 x no harm 1 x minor injury	
3rd Quarter									
October	**2**	Yes	Yes	Yes	Yes	Yes	Yes	1 x minor injury 1 x serious injury	2 avoidable
November	**1**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	1 x minor injury	1 avoidable
December	**3**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	1 x no harm 2 x minor injury	2 avoidable 1 unavoidable
4th Quarter									
January	**2**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	2 x no harm	2 avoidable
February	**2**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	2 x no harm	2 avoidable
March	**-**	**-**	**-**	**-**	**-**	**-**	**-**	-	-
Year totals	**24**							X 15 no harm X 8 minor injury X 1 serious injury	

4.4 Pressure Ulcer recording and management 2019-20

St Cuthbert's Hospice in-patient unit (IPU) set an ambitious target to achieve a 0% incidence rate of avoidable pressure ulcer (PU) development or deterioration following admission during 2018-19. Despite implementing evidence based and best practice guidelines we did not meet this target, we reported18 PU's on admission and 7 PU's occurring or deteriorating after admissions during 2018-19.

The findings from a number of 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. We know complete prevention is difficult to achieve due to the nature

of palliative care. We recognise that when patients are dying their bodies become more vulnerable and that the measures normally implemented to reduce the risk of PU development are not as effective. To support monitoring, management and ensuring we meet the standards of practice in PU prevention and management, we have implemented a number of measures embedded these measures in SystmOne* including:

- Risk assessment with pressure area mapping charts and validated tools such as the Waterlow Risk Assessment tool*
- Incident reporting of all pressure ulcers graded at 2 or above
- Positional change charts to record regular turnings and the use of pressure relieving aids and equipment.
- The use of sector leading pressure area skin barrier solutions and dressings

Following the publication of '*Pressure ulcers: revised definition and measurement. Summary and recommendations*' by NHS Improvement. in 2018 we will for 2019-20 redesign our data capture; see Table 6 to standardise PU incidence reporting in line with the. NHS We will no longer report Kennedy Ulcers and instead use the term suspected deep tissue injury (SDTI) and also other the new criteria Inherited PU, PU Deteriorated post admission, PU acquired as result of medical device and moisture lesions the distinguish between PU type and possible causality.

Table 6 - Pressure Ulcer (PU) Monitoring 2019-20

	No of Inherited PU	**No of PUs acquired following admission**	**No of PUs deteriorated following admission**	**No of PUs acquired due to medical device**	**No of SDTI**	**No of moisture lesions**	**PU Category** Category 1 Category 2 Category 3 Category 4	**Pressure area care plan implemented on admission including:**				
								Waterlow assessment completed on admission	**Pressure area mapping and grading**	**Pressure relieving aids or equipment offered and in place**	**Positional change plan and rounding chart in place**	**Pt with capacity aware of risk and declines positional changes**
1st Quarter												
April												
Patient 1	**1**	**0**	**0**	**0**	**1**	**0**	**-**	**Yes**	***Yes***	**Yes**	**Yes**	**No**
May												
Patient 1	**1**	**0**	**0**	**0**	**0**	**0**	**3**	**Yes**	***Yes***	**Yes**	**Yes**	**No**
Patient 2	**1**	**0**	**0**	**0**	**0**	**0**	**3**	**Yes**	***Yes***	**Yes**	**Yes**	**No**
Patient 3	**1**	**0**	**0**	**0**	**0**	**0**	**2**	**Yes**	***Yes***	**Yes**	**Yes**	**No**
Patient 4	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**Yes**	***Yes***	**Yes**	**Yes**	**Yes**
June												
Patient 1	**1**	**0**	**0**	**0**	**0**	**0**	**2**	**Yes**	***Yes***	**Yes**	**Yes**	**No**
2nd Quarter												
July												
Patient 1	**1**	**0**	**1**	**0**	**0**	**0**	**2**	**Yes**	***Yes***	**Yes**	**Yes**	**No**
Patient 2	**0**	**1**	**1**	**0**	**0**	**0**	**2**	**Yes**	***Yes***	**Yes**	**Yes**	**No**
Patient 3	**0**	**1**	**0**	**0**	**0**	**0**	**2**	**Yes**	***Yes***	**Yes**	**Yes**	**No**
August												
Patient 1	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**Yes**	***Yes***	**Yes**	**Yes**	**No**
Patient 2	**1**	**0**	**0**	**0**	**0**	**0**	**2**	**Yes**	***Yes***	**Yes**	**Yes**	**No**
September												
	0 reported											
3rd Quarter												
October												
Patient 1	**1**	**0**	**0**	**0**	**0**	**0**	**3**	**Yes**	***Yes***	**Yes**	**Yes**	**No**
Patient 2	**1**	**0**	**0**	**0**	**0**	**0**	**4**	**Yes**	***Yes***	**Yes**	**Yes**	**No**
November												

Patient 1	**0**	**2**	**0**	**0**	**0**	**0**	**1/2**	**Yes**	***Yes***	**Yes**	**Yes**	**No**
Patient 2	**2**	**0**	**0**	**0**	**1**	**0**	**4**	**Yes**	***Yes***	**Yes**	**Yes**	**No**
December												
Patient 1	**0**	**2**	**0**	**0**	**0**	**1**	**3**	**Yes**	***Yes***	**Yes**	**Yes**	**No**
Patient 2	**1**	**0**	**0**	**0**	**0**	**0**	**3**	**Yes**	***Yes***	**Yes**	**Yes**	**No**
Patient 3	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**Yes**	***Yes***	**Yes**	**Yes**	**No**
Patient 4	**2**	**0**	**0**	**0**	**0**	**1**	**2**	**Yes**	***Yes***	**Yes**	**Yes**	**No**
Patient 5	**3**	**3**	**2**	**0**	**3**	**0**	**2**	**Yes**	***Yes***	**Yes**	**Yes**	**No**
4th Quarter												
January												
Patient 1	**1**	**0**	**1**	**0**	**0**	**1**	**2**	**Yes**	***Yes***	**Yes**	**Yes**	**Yes**
February												
Patient 1	**1**	**0**	**0**	**0**	**0**	**0**	**2**	**Yes**	***Yes***	**Yes**	**Yes**	**No**
March	**0 reported**											
Total	**21**	**10**	**5**	**0**	**6**	**3**						

4.5 Catheter acquired urine infection

Within the Hospice setting patients are catheterised to maintain dignity and comfort at the end of their lives. Verbal explanations are given to patient, their relatives about the benefits and risks associated with catheterisation, and permission for the insertion of catheter is sought from all patients, or if they are unable to consent their relatives/carers. The benefits of the catheterisation to patient dignity and comfort often outweigh the risk of acquiring an infection at this phase in their life. Although catheter acquired infection can occur it is relatively uncommon within the end of life care setting. Any signs of infection and discomfort from the catheter are closely monitored and any adverse effects of catheter-associated infection are dealt with on an individual patient basis. Catheter care follows best practice guidelines and is documented in patient care plan / notes on SystmOne. We have recently reviewed our infection control policies with support and guidance from the Department of Health Guidelines for Care Homes. We continue to regularly carry out infection control audits to ensure that we are complying with standards and improvements are made where required and provide mandatory training to all hospice staff with regards infection control. The incidence of catheter acquired urine infections during 2019 -20 we aim to record a zero return.

To the end of quarter four, we have again had no incidence of catheter-associated infection acquired following admission to the Hospice.

4.6 Paracentesis Service Activity

NB: Following the recent appointment of Dr Tim Morgan as palliative care consultant who is expert at performing this procedure we have now offered paracentesis as a component of symptom management. We aim extend access to paracentesis drainage on IPU/LWC and in Q4 met with commissioners to explore this.

4.7 VTE Assessment

VTE assessments are carried out on all patient 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. It is clear that during 2015-16 we did not achieve 100% compliance in completing these assessments and this has been addressed with the clinical team to ensure all assessments are completed within 24 hours of admission.

Table 8 - VTE Assessments number of VTE assessments completed during 2019-20			
Number of patients admitted to IPU	**% of VTE assessments completed within 24hrs of admission**	**% of VTE assessment completed within 24hrs of admission but not recorded in medical records**	**% that received anti-coagulant therapy**
2018-19 totals	**169 (99%)**	**0**	**33 (20%)**
2019-20			
Quarter 1	**47 (100%)**	**0**	**14 (29.8%)**
Quarter 2	**55 (100%)**	0	**17 (30.9%)**
Quarter 3	**56 (98.2) -1 missed as patient admitted from a & e and had to return 5 hours later with sepsis**	**0**	**13 (23.2%)**
Quarter 4	59 (100%)	0	15 (25.4)
Total	**217 (99.6)**	**0**	59 (27.3)

5.0 Clinical Governance and Quality Assurance

5.1 Clinical Audit

St Cuthbert's Hospice has not been re-inspected by the Care Quality Commission (CQC) and retains its rating as '*Outstanding*' status for the quality of our service and the care we deliver. St Cuthbert's Hospice is committed implementing any strategies that will help us to maintain this rating and our reputation for excellence. It is vital that we continue to secure and promote our position as a sector-leading hospice with key partners, stakeholders and at local, regional and national events, conferences and forums. Central to achieving this are the *'golden threads'* of robust clinical governance and quality assurance processes that will provide the evidence needed to continually assure and enhance the quality of our palliative and end of life care services. 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 Committee before being shared in future service quarterly performance reports. Table 10 outlines an annual schedule of key clinical audits the finding of which will be retained in an audit file. Any areas of concerns highlighted by a specific audit will be subject to a quality improvement plan.

20190820 Audit Schedule NEW V0.0

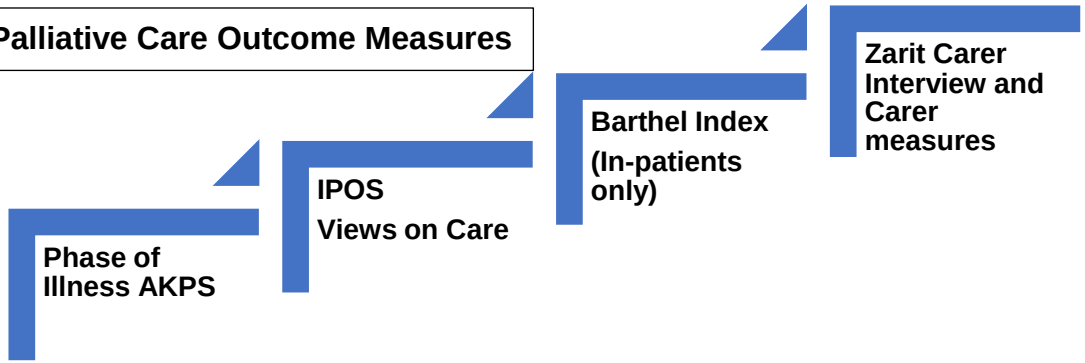
An internal audit tool is being used to support a Caldicott Guardian '*spot check audit'* of all areas that hold personal identifiable data (PID) this can include patients and services users. The aim of the audit will be to identify where we reflect best practice in managing and securing PID and where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

Table 11 - Caldicott Guardian Audit Schedule													
Service to be audited	1st Quarter: April - June			2nd Quarter: July - Sept			3rd Quarter: Oct - Dec			4th Quarter: Jan - Mar			
In-patient Unit									✓				
Day Hospice													
Family Support Service													
Admiral Nurse													

5.2 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



We are now able to report the findings from data collected, collated and analysed so far. We will provide embedded reports as PDF files in quarter two and end of year quarter four report. The data is 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. We will continue to embed OACC reports at 6 months and end of year.

5.3 NICE Guidance

To reflect best and leading practice St Cuthbert's Hospice adopt National Institute for Health and Clinical Excellence (NICE) Guidance or Standards to inform both policy development and procedures informing clinical practice for example:

- ***Improving supportive and palliative care for adults with cancer***. NICE Cancer service guideline [CSG4] March 2004.
- ***Nutritional support in adults: oral nutritional support, enteral tube feeding and parenteral nutritiona***l. (NICE)Clinical Guidance 32 (2006): www.nice.org.uk/Guidance/CG32.
- ***Pressure ulcers: prevention and management.*** NICE Clinical guideline [CG179] April 2014.
- ***Care of dying adults in the last days of life.*** NICE guideline [NG31] December 2015.
- ***Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes***. NICE guideline [NG5] March 2015.
- ***Controlled drugs: safe use and management.*** NICE 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. Last updated January 2017.
- ***Dementia: assessment, management and support for people living with dementia and their carers.*** NICE guideline. Published: 20 June 2018. nice.org.uk/guidance/ng97
- **Urinary Tract Infection (lower): antimicrobial prescribing.** NICE Guideline (NG109) Published October 2018
- **Urinary Tract Infection (recurrent): antimicrobial prescribing.** NICE Guideline (NG112) Published October 2018
- **Urinary Tract Infection (catheter-associated): antimicrobial prescribing.** NICE Guideline (NG113) Published November 2018

NHS Improvement

- ***Pressure ulcers: revised definition and measurement. Summary and recommendations***. NHS Improvement. June 2018

6.0 Patient Experience and Friends and Family Test.

6.1 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.

6.2 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. The table 12 below highlights what was suggested and what was done over the past quarter:

Table 12: Summary of suggestion box comments.

2019-20	Source	Individual	Idea	Benefits	Additional comments	Action
Quarter 1						
April	IPU	Service User	I strongly believe and strongly recommend a known volunteer should become part of the St Cuthbert's team. She would be a great asset for everyone.	This volunteer totally relaxes you, she gave me a head, neck and shoulder massage and it helps in so many ways mentally and physically.	This volunteer is such a lovely lady, she really cares about those who she sees – she also has a good talk with you and gives very good and honest advice. I just really feel having her as a member of your staff would be another great asset to the team.	We appreciate the contribution of all of our volunteers and the added value they bring. There are currently no vacancies for a paid complementary therapist. A number of staff within IPU and the Living Well Centre are trained to deliver this service.
May	None received					
June	Reception	Volunteer	Possibly have more recycling facilities located in the café area/corridor to the art room/art rooms themselves? Could be a bin for non-recyclables beside a bin for recyclables (clearly marked)	Less plastic sent to landfill. Greater recycling rates.		To liaise with the Guest Services Manager.

June	Reception	Staff member	E-cards on our website	Fundraising opportunity (and better for environment!)	Marie Curie offer e-cards on their website for £1 - could we do something similar? If unable to set this up ourselves there are companies that may host this for us e.g. dontsendmeacard.com and we can add our own designs	E - Cards are being looked at as a possibility by the retail team alongside the Hospice selection of actual Christmas cards that we sell.
Quarter 2						
July	IPU	Supporter	Could domestic workers have brighter uniforms than black - quite depressing!	Uplift patients morale being brighter	Fantastic staff + nothing is too much trouble - from sisters + all staff including cleaners	Before the current uniforms were implemented, staff were consulted and it was determined that the uniforms needed to be Airtex, super cool, non-iron, and ventilated as well as able to be washed at a suitable temperature for infection control. We discovered that uniforms of this quality were only available in black or dark navy and staff agreed black would be the most practical.
August			None received in August			
September	Reception		Better seating in training room	Comfort for full days of training		
September	Reception		My family has been in more than once. I only think you should treat all staff the same not just ones who are high up. I don't think housekeepers are. Just because they are cleaners. They are very important.			

Quarter 3						
October	IPU	Staff member	Ice making machine for IPU	Would have regular ice supply for patients as we are always running out	Over time would save Hospice money as regularly purchase bags of ice.	This was investigated and we identified there were a couple of occasions when our supplier was unable to supply us with ice, usually this is available. However, we also looked into purchasing an ice machine but have been advised that we would encounter installation problems but more importantly that they may be a risk. We don't intend to progress this.
October	Reception	Volunteer	Provide transport e.g. a small coach for people to go to Strictly Come Dancing	People who are unable to get there by car can still go to the show	More people - more funds for the Hospice!!	The Community and Events Team are currently looking into the feasibility of this ahead of tickets going on sale early next year.
October	Reception	Volunteer	Provide transport for people who don't drive to go to Strictly Come Dancing	People who can't drive can go to Strictly meaning an increase in takings		The Community and Events Team are currently looking into the feasibility of this ahead of tickets going on sale early next year.
October	Reception	Volunteer	People leaving the building to let Reception know if they will be back or how long they will be			Staff have been advised to let reception staff know when they leave the building and when they are expected to be back.
November	IPU	Service User	Dog waste bin	Every visiting dog owner can dispose of their dog waste.	My husband brought my dog to visit and after picking up the waste found there was nowhere to dispose of it and had to carry it in his pocket for rest of visit until he went home and disposed of it.	We have contacted the local council and they are going to erect a dog waste bin just outside the Hospice, near to the Park entrance

November	Reception	Volunteer	Could someone be designated to replace the bottles on the water coolers regularly? I volunteer on a Thursday in IPU and they are always empty. I have replaced them myself but am not willing to put my back in jeopardy.	Visitors will have access to water		Please don't attempt to replace the bottles for the water cooler. They can only be replaced once fully empty. We have a designated person who makes regular checks and replaces these when needed. However, if you do notice a bottle that needs replacing please inform a member of staff who will then contact our Grounds & Maintenance Co-ordinator or the Central Support Services Office to action.
December			NO SUGGESTIONS RECEIVED			

CQUIN 1 2019 – 21

Improvement plan 2: Improve the carer and practical support of carers by implementing aims outlined in the Hospice Carer Strategy.

Year 1: Establish a strategy implementation team to establish baseline intelligence of "carer burden" by co-ordination the collection and interpretation of data about the extent of carer burden for those informal carers supporting patients who access our in-patient care or living well centre services.

Year 2: Based upon intelligence gathered adopt a recognised too such as the Carer Support Needs tool (CSNAT) to assess prioritise decisions for the implementation of a range of interventions and measure outlined in the strategy to enhance carer support and reduce carer burden.

Rationale – Improve identification of known factors that contribute to carer burden and strengthen carer resilience buy implementing measures that reduce carer burden and improve patient care at home of in the community.

Progress

The absence of the FST Manager and impact of Covid-19 has meant a delay in implementing the Carers' Strategy but this was beyond our control.

7.0 Workforce Assurance.

Absence due to long term sickness, annual leave and staff turnover are slightly above expected levels but to date staff absence has not affected adversely on ensuring safe staffing level in our clinical services. We maintain a pool of registered nurses (RN's) and health care assistants (HCA's) on our bank, 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 although this has been rarely utilised by the staff on IPU.

As part of our on-going review of teams and workforce transformation, we have dis-established the Patient Services Manager post and have used vacancies as an opportunity to introduced skill mix. We have recruited to the following posts, Band 3 HCA, Band 6 Senior Staff Nurse, Band 7 Ward Sister and Nurse Consultant. We currently carry 2 vacancies in FST. Since the appointment of our palliative care consultant in November 2018, we have continued to build the medical team.

Following discussion with Dementia UK our experienced specialist dementia nurse who leads our dementia care and Namaste services is badged as an Admiral Nurse. Following a successful Reaching Communities Big Lottery bid we secured a contract extension for our Namaste Care project lead and recruited a part-time band three project worker to join the team.

Up until Q4/Covid-19 any staff vacancies that have occurred in 2019 have been recruited to with internal promotions or external appointments. We continue to actively increase the number of RN and HCA bank staff 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.

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 will help 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.

We continue to support training another two members of our senior staff nurses are due to commence the independent prescriber course other staff are accessing 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, which covers recognising and reporting safeguarding issues, this is being modified to fit with current legislation and to include training on the mental capacity act, deprivation of liberty and duty of candour.

Table 13 - Service user feedback questionnaire charts and comments.

IPU Carer Questionairre Analy:	Friends and Family Test LWC - 2019 202(	Friends and Family Test Admiral Nurse N	Friends and Family Test FST - 2019 2020.

Allison Welsh