Beaumond House Community Hospice Quality Account

1st April 2015 - 31st March 2016

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Registered Charity no: 1025442

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INTRODUCTION

Welcome to our quality account report which is written to provide a focus specifically on the quality of care we provide to people who use our services and their families. This is part of our drive to help raise the profile of the significance and importance of the quality and compassionate care that hospices contribute to the overall health and social care provision for their local communities.

The reporting period covered in this report is from the 1st April 2015 to 31st March 2016 and it also summarises the continuous improvements we have planned going forward.

We would like to take this opportunity to acknowledge the achievements of Beaumond House Community Hospice and to thank all the staff and volunteers and local people and businesses that have helped make our work possible.

Julie Humphreys MBA CMgr FCMI RGN Cert.Ed
Chair of the Board

Debbie Abrams OBE MA BSc RN
Interim Senior Manager

1.1 ABOUT US

Beaumond House Community Hospice is a registered charity that provides supportive palliative care to patients with life limiting or terminal illnesses and wider support to their families. We provide services over an approximate radius of 15 miles from Newark. The area it encompasses include: Tuxford, Bilsthorpe, Ollerton, Sutton-on-Trent, Thorpe-on-the-Hill, Leadenham, Caythorpe, Long Bennington, Bottesford, Southwell, Collingham and Bassingham. Each year we provide care for over 500 patients, caring for around 150 patients at any one time.

At Beaumond House, we are really keen to dispel the myth that those we support come to us to die. Yes, we do support people at the end of their life and do so in a way which is truly person centred. We offer personalised, compassionate care and support where patients' wishes are respected and delivered and where family members and friends can be with loved ones in an entirely private setting. We then offer after-care and bereavement support in-house which is extended through our Resource and Information Centre, where expert counselling is available.

However, Beaumond House is also very much about living. Through our doors you will find a lively and vibrant space, filled with life and laughter. Our staff, volunteers and patients alike bring hope and happiness together in a 'home from home' setting. Patients enjoy wholesome home cooked food and days are filled with therapeutic activities and personalised support from our unique nurse led team.

We also recognise that many people wish to stay at home to receive care and support. Our Hospice@Home team take the Beaumond House approach into patients' homes, offering personal care, advice and support.
A key part of Beaumond House are the local GP's who continue to provide medical care to patients; we work alongside them to ensure continuous and high quality care is delivered.

We are proud to have a chaplaincy service across all faiths; chaplains are frequent visitors ensuring that spiritual needs are met when requested.

We're proud of our approach and welcome everyone to come through our doors to visit, take a look at our facilities, talk to our staff and volunteers and feel the warmth and friendliness of Beaumond House.

We are supported magnificently by volunteers working in our day care unit, fundraising department, and our two charity shops located in Newark and Southwell; their contributions are invaluable.

A Board of Directors/Trustees hold the ultimate legal responsibility for the Hospice. They set strategy, make robust policy decisions and ensure that the service maintains financial viability and transparency.

All of our care is provided at no cost to the patient or their family and anyone can make a referral to Beaumond House, our doors are open 365 days a year - 24 hours' a day.

1.2 HOW WE ARE GOVERNED

The Board of Trustees/Directors met regularly to develop and progress the strategic direction of the Hospice.

The membership of the Board is as follows:

NAME	JOINED	ROLE ON BOARD
Julie Humphreys	2015	Chair of the Board of Directors and Trustee
John Marshall	2009	Vice Chair and Trustee
Debbie Abrams OBE	2016	Director and Trustee
Philip Armitage	2009	Director and Trustee
Dr Julie Barker	2008	Director and Trustee
Emma Holden	2012	Director and Trustee
Dr Peter Jones	1987	Director and Trustee
Joanna Parlby	2009	Director and Trustee
Ian Phillips	1995	Director and Trustee
Nic Porter	1995	Director and Trustee
David Tomkinson	2010	Director and Trustee

The Board is committed to ensuring local help for local people.

Our values:

1. We work with INTEGRITY and PASSION to deliver individualised HOLISTIC CARE for patients and their families.

2. Create a HAPPY, SUPPORTIVE atmosphere where all staff and volunteers feel valued.

3. Develop true partnerships, benefitting all parties, inspiring CONFIDENCE and PRIDE.

4. Have OPEN, TRANSPARENT two way communication, drawing REAL VALUE from all relationships.

Through a series of sub-committees we ensured effective governance. The sub-committees are Finance, Fundraising and Marketing, Care Service Development, Governance, Risk and Scrutiny, Property and Estates. Strategy, and Human Resources (HR).

2 QUALITY OVERVIEW

2.1 Review of quality performance

During the last twelve months we have had both internal and external reviews of our work. These include a mock CQC inspection, an infection control audit, and unannounced inspections by members of the Board. Learning from all audits and inspections is monitored through the development and implementation of plans of action and progress is overseen by the Care Services Development Sub Committee .

An action plan was developed to ensure areas identified on our mock CQC style inspections were being addressed. Some examples of results were, improvements to safeguarding processes and further development of policies and staff training, improvements to documentation to reduce risk of transfers between care settings, and a more robust audit schedule

The introduction of the Safety Thermometer to enable monitoring of ways we keep people safe has been particularly welcomed as has the End of Life Care Co-ordination work we have progressed.

We have refreshed our referral criteria and confirmed that we will continue to have a policy of an open referrals system for people with life limiting conditions such as a progressive disease where they will benefit from palliative care. Further details about our referral criteria are available on our website www.beaumondhouse.co.uk

The Care Services Development Sub Committee has also led work on some important new policies such as the Duty of Candour which encourages us to be open about if things do not go as well as they should have done and how we learn from such events. Whilst all the sub-committees contribute significantly to the successful delivery of our services, for this quality report, the work of the governance sub committee and the care services committee are particularly relevant.

3 CLINICAL INDICATORS

Clinical Activity	
Indicator	**2015 - 2016**
Total number of new referrals	377 new referrals
Total number of admissions to the In Patient Unit (IPU) – some patients accessing respite will have a number of admissions in the year	101 admissions
Average length of stay	Our beds were occupied for 75% of the total bed days available Our CCG target for this is 98%
Average length of stay	13 nights
Total number of Day Care attendances	2462 day care sessions were delivered which equates to 85% of total sessions available. Our CCG target is 99.3%
Total number of Complementary Therapy sessions: For carers , patients and people who are bereaved	442 complementary therapy sessions
Total number of Hospice at Home hours delivered	3,203.5 which is only 79% of CCG target and we need to do more
Total number of people supported in bereavement: Group session – 12 monthly sessions One to one support – data not being fully captured Telephone support – data not being fully captured	167 people
Total number of people advised by welfare rights officer	187 people

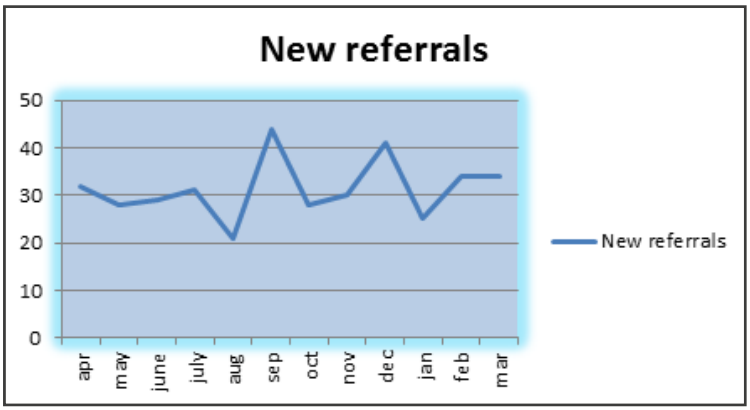
We want to do more for people to whom we provide services and are looking to increase our workforce so that this can be achieved. In particular we would like to offer our inpatient services to more people and are looking at how this could be provided.

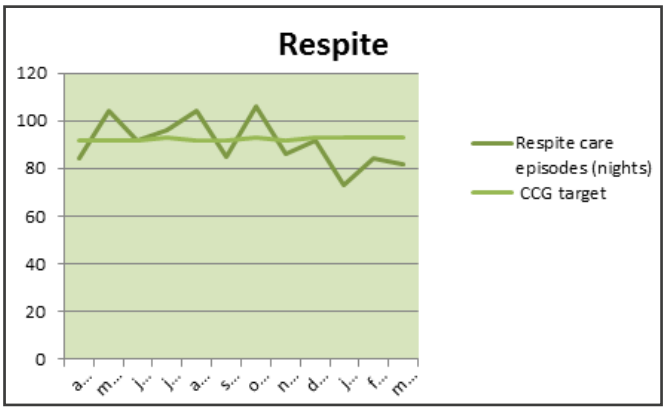
3.1 OUR REFERRALS & ACTIVITY

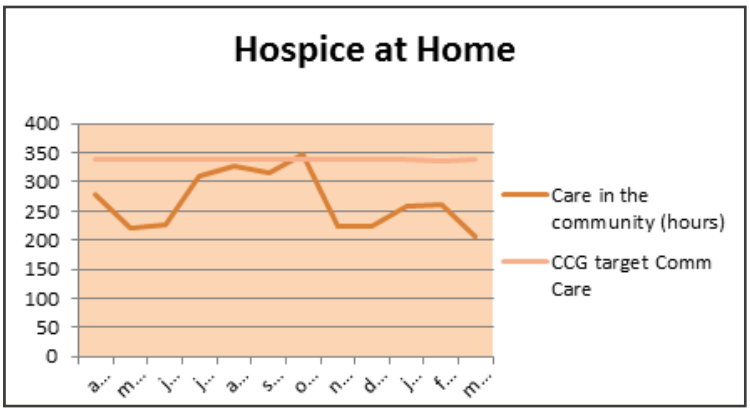
The graphs below illustrate our new referrals average around 30 per month with a range of between 20 to 40 some months. Respite care averages around 90 episodes (nights) per month.

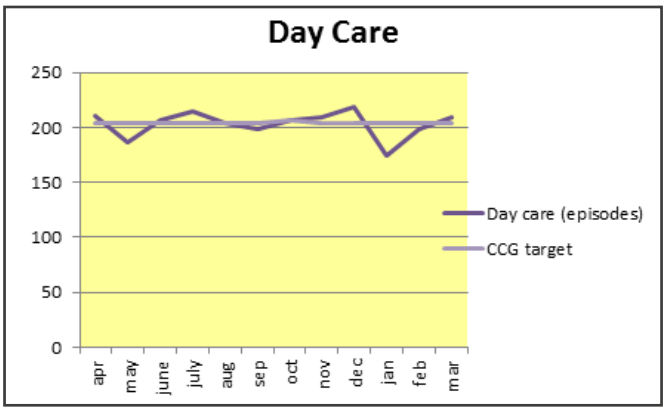
Our hospice at home hours average around 275 per month, which is less than the target of 345 hours per month required by the Newark and Sherwood Clinical Commissioning Group. We are working to improve this and in particular have reviewed ours ways of working and our activity for hospice at home hours has increased during April and May 2016.

Our day care episodes average around 200 episodes which is significantly above the Clinical Commissioning Group target.









3.2 Safety Thermometer

In October 2015 we started recording a 'Safety Thermometer'. The Safety Thermometer allows us to measure harm and the proportion of patients that are 'harm free' during their working day.

We recorded four main areas of potential harm to patients:

- Catheter acquired infections
- Pressure damage
- Falls (with and without harm)
- Venous thrombo-embolism (VTE)

Patients diagnosted with specific infections during admission												
	Apr 15	May 15	Jun 15	July 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
MRSA							0	0	0	0	0	0
C. Diff							0	0	0	1	0	0
CA UTI							0	0	1	0	0	0

Definitions:
MRSA – Methicillin-resistant Staphylococcus aureus.
C. Diff – Clostridium difficile.
CA UTI – Catheter acquired urinary tract infection

Pressure ulcer incidence - in-patient care												
	Apr 15	May 15	Jun 15	July 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Aquired							0	0	0	0	0	1
Inherited							3	3	2	0	0	1
							1	0	1	0	0	0

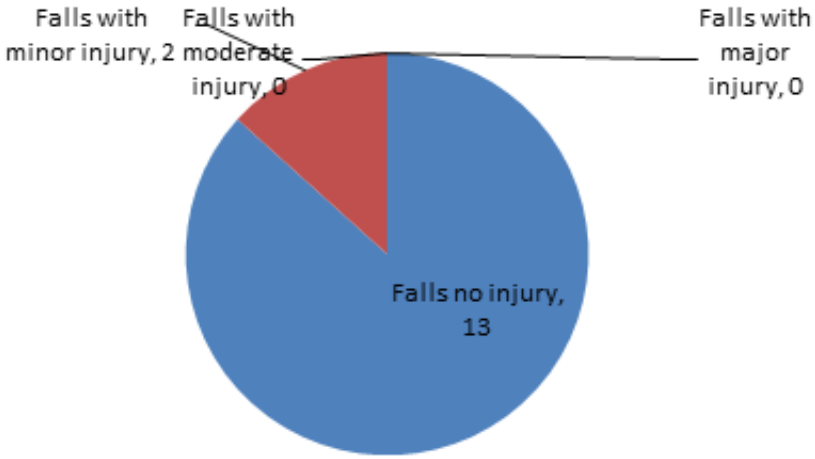
Definitions:
Acquired – pressure damage developed during in-patient stay
Inherited – pressure damage on admission to in-patient care
Deteriorated – Pressure damage deteriorated during in patient stay

Each incidence of pressure damage was examined to see if anything more could be done to promote healing and prevent deterioration.

3.3 Falls 2015-2016

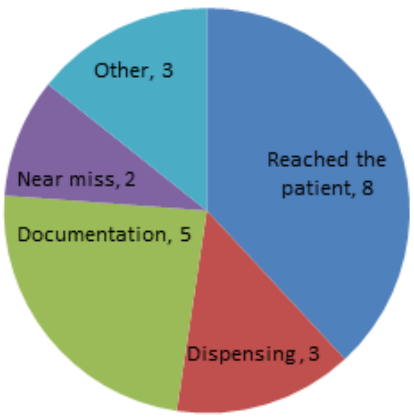
We had a total of 15 falls during the last year with 13 of them being falls where people sustained no injury and 2 of them where people sustained a minor injury.

Widening the therapeutic activities available to patients attending is important to us
and movement and relaxation workshops were very well received. This has many clinical benefits including reducing the risk of falls.



3.4 Medication Incidents

We have a zero tolerance approach to medication errors recording all medication related incidents including near misses, documentation errors and dispensing supply discrepancies. A robust but fair process is followed for all incidents and we feel this has resulted in good reporting of medication incidents at all levels. Of the medication errors that reached the patient no significant harm resulted.



All incidents are accidents are reported and examined to see where remedial action needs to be put in place.

4 PROMOTING SAFETY & REDUCING RISK WITH GOOD GOVERNANCE ACTION

Our sub-committees help us scrutinise and appropriately challenge where required the need to change and to continuously improve our services. The Governance sub-committee appropriately identified the requirement to have an effective process for identifying and managing all risks and determined that a risk register be put in place that identified the risk, assessed the level of risk and ensure that mitigating actions be put in place. This process is now up and running and owned by sub-committees with all high level risks being reported on quarterly to the Board.

We recognised that our policies needed a system of regular review and have updated and improved some of them with more work to do still as this is an ongoing process. Also where required new policies are introduced such as the Duty of Candour policy mentioned earlier in this report.

Through our learning and development sessions with the care team we have delivered training on harm free care, how we record incidents on the safety thermometer and the steps we take to reduce risk factors.

An awareness campaign has been commenced to inform patients and carers on how we can work together to prevent these potential harms through displays and the provision of information leaflets

In 2016 we purchased two mattresses to provide a high specification of pressure relief. The model promotes patient comfort and reduces friction to high risk areas such as heels.

We have also purchased recliner chairs for all the bedrooms. Two of these have inserts to provide alternating pressure relief for patients who are at high risk from pressure.

A nationally approved audit tool was used to assess the environment of Beaumond House to see what steps could be taken to improve the environment. Some simple steps were taken to address some of the issues identified, for example brighter light bulbs, reducing the clutter of notices and having a pack of visual signs for use if needed. Staff also attended training to become Dementia Champions.

For next year we hope to increase the audits and surveys we do to inform our continuous learning and also identify a way to participate in research through our specialist palliative care networks.

4.1 Advance care planning and Gold Standard Framework

The GSF is a systematic evidence based approach to optimising care for all patient approaching the end of life. Our goal was to attend all the GSF meetings at GP practices within our catchment area to improve partnership working, improve awareness of services and increase referrals from GP's.

Compassionate care is part of our culture at the Hospice. It includes empathy, active listening and sensitivity and is about valuing patients, carers and families at a potentially difficult time. It embraces human kindness, dignity and respect. Striving to care for patients in the environment they would choose and actively encouraging patient, family and carer involvement in care decisions because social and personal factors can be as important as medical ones for patients at the end of life. Talking to people about how they want to live while they are dying.

This is about treating everyone as an individual – an extension of being person-centred. It includes everyone with different needs and wants. Accepting and recognising the unique circumstances of each patient, carer and family - beliefs, community, home, support, relationships and age. Assessing and managing pain and other symptoms in a way that is appropriate to each patient, their carers and families. Giving information at the patient's own pace and in a way that they can easily understand.

We have promoted the use of electronic palliative care co-ordination systems within the hospice to record palliative care information. Nurses within the hospice have attended communication training to improve effectiveness in holding conversations with patients about preferences. Although we hoped to apply for accreditation with GSF, a small audit of patient notes and our electronic patient record system showed that these measures were not fully embedded. A full audit has been carried out of recording of 'do not resuscitate cardiopulmonary resuscitation orders'.

Following publication of the National Institute for Health and Care Excellence (NICE) guidelines on Care in the Last Days of Life a Care plan has been developed and piloted .

5 WHAT PATIENTS & THEIR FAMILIES SAY ABOUT US

Patient satisfaction surveys have been carried out for in-patients, day care, Hospice at Home, and Complementary Therapy. A feedback exercise was carried out and below are a selection of comments:

"We love to see the carers smile. They are always encouraging us."
"Good services, staff and volunteers great, excellent food and excellent care."
"Marvellous staff and volunteers involved here. Excellent care from everyone and fabulous food. Don't know what I would have done without you."
"You showed wonderful compassion and care for which we will be forever grateful"

A day care specific questionnaire was sent out and nine people responded, 8 of whom had been attending 6 months or less. The overall response was how satisfied people were. When asked about their privacy and dignity 8 said their needs were met all the time and 1 said their needs were met some of the time. When asked about their involvement in care the following answers were submitted.

The following reflects you and your Care	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Unsure**
I was involved in planning my care	2 (22%)	5 (56%)			
I have had a conversation to discuss my wishes for my future care	1 (11%)	5 (56%)	1 (11%)		1 (11%)
There is never an opportunity to ask the questions I would like to ask			5 (56%)	3 (33%)	
Answers to my questions were always given in a way I could understand	2 (22%)	6 (67%)			
I would be comfortable asking to talk about my religious or spiritual needs	1 (11%)	6 (67%)			

When asked what we could improve, the day care attendees said:

- "The steps at the front of the house are difficult". We advised them to use the back entrance which has a ramp for ease of access.
- "I would like to see more tolerance and understanding by day care patients towards new patients". Staff have been encouraged to be proactive in introducing new patients and using relationship building skills to help everyone be included.
- "A weekly raffle would be nice, and Bingo too. People could help by bringing in prizes for the winners to receive". Staff ensure a regular review of activities and adapt the programme based on people's preferences and needs.

We are pleased to say that our first hospice involvement group meeting has been held and although attendance was low an action plan has been developed to establish this group as a forum for patient and carer participation. We are also setting up a volunteers involvement group during 2016.

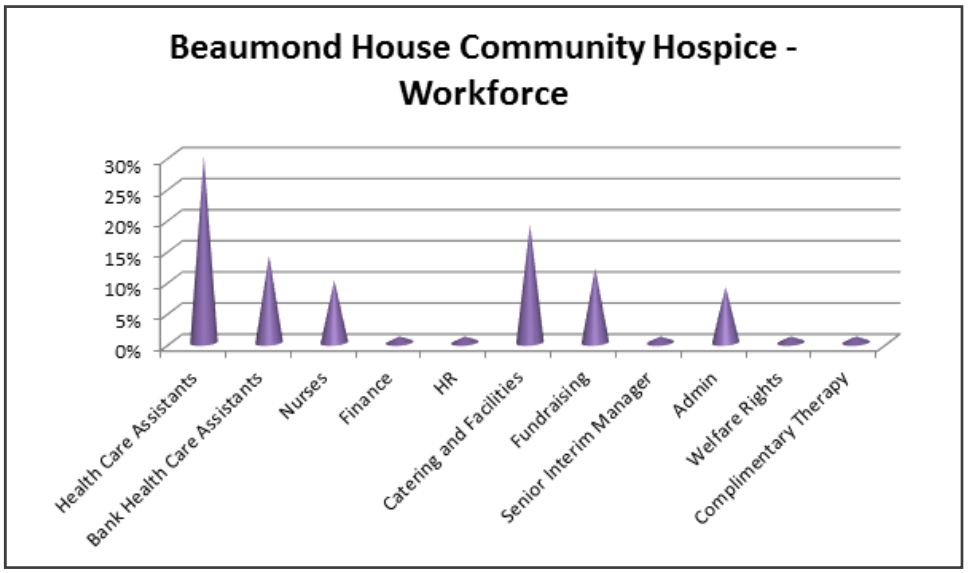
5.1 Complaints and Compliments

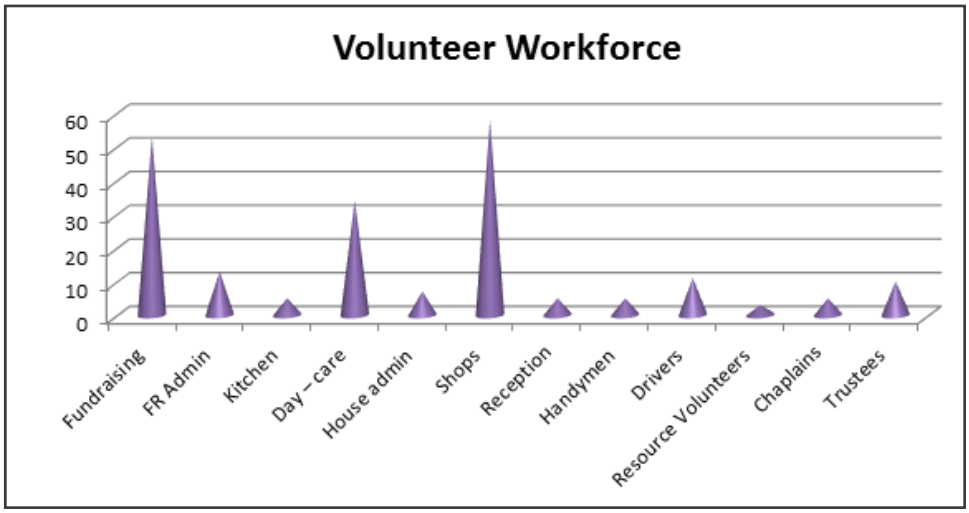
We have put in place this year a system of recording complaints and suggestions for improvement and well as capturing compliments that we receive. During the year covered by this report we received one formal complaint which was thoroughly investigated as required by our processes. The details of the complaint are not listed here in order to preserve anonymity of the complainant. In the future if a number of complaints are received we are revising our complaints policy so that we can also examine if there are any trends that need remedial action.

6 OUR WORKFORCE

At Beaumond House we have a rigorous recruitment process for staff and volunteers. We believe that training, supervision, clinical supervision, one to ones, appraisals and reflective practice are an essential aspect of how we support our staff.

The recruitment process at Beaumond House ensures the right number of people; with the right skills are employed to deliver the service. We have a core of bank staff that allows us to increase staff ratios when the need arises.

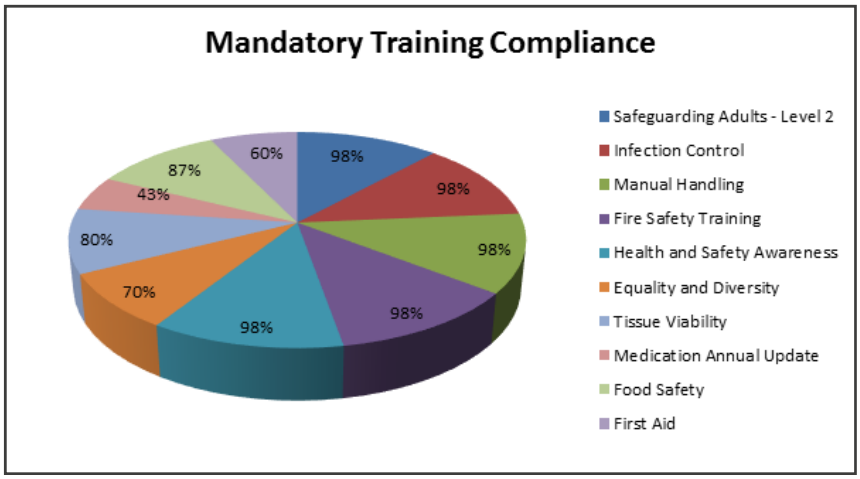




6.1 Staff training

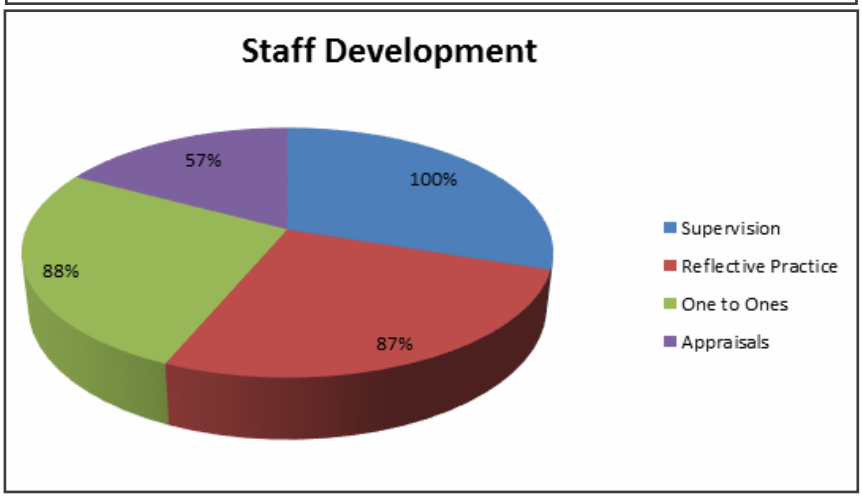
We have delivered 12 mandatory training and information training sessions throughout 2015/16. These are delivered monthly for all new starters and existing staff. These sessions are planned to minimise disruption to the services we offer.

We use internal and external trainers and electronic learning packages. We also use a training impact form for all training before, during and after at staggered intervals to capture responses from all trainees. We use this information to evaluate the value it adds in job roles and on the care we deliver. In addition we have monthly learning and development sessions for all staff.



37% of our care staff have NVQ 2 and they are working towards achieving their NVQ 3.
43% of our care staff have an NVQ 3 qualification.

Over the last year we have had information training sessions on Parkinson's disease and a number of staff have become Dementia friends. Supervision, clinical supervision, individual meetings, appraisals and reflective practice are an essential aspect of how we support our staff at Beaumond House.



6.2 Volunteer training

Our Volunteer Coordinator undertook a five week 'Skills Development' course for Volunteers to get an insight into the types of subjects that might be useful for a new volunteer who is being inducted.
The training was delivered in five separate two hour modules which were:

- Good practice standards for volunteers
- Communication, Customer Care and Confidentiality
- Health & Safety and Personal Safety
- Safeguarding
- Equality, Discrimination and Diversity

6.3 Staffing Levels

We pride ourselves on ensuring the correct numbers of staff are on duty to meet the needs of the service and deliver the care to ensure the best patient experience. We tailor our staffing levels on patient dependency and a model of professional judgement is used to determine this.

This was then condensed into a training session appropriate for our volunteers and cascaded to a number of people. 98% of volunteers are up to date with their mandatory training most of which is delivered at induction.

7 OUR PRIORITIES FOR 2016 - 2017

Our reputation for high quality care is essential to our existence and we want to improve ways we demonstrate this to our local community and commissioners. We anticipate we will shortly have a CQC inspection and will robustly implement learning from that inspection. We will implement a quarterly performance dashboard to accompany other performance information for the Board.

Last year we published our vision and values and will be working to translate those into a five year strategy for the future. There will be opportunities for patients, relatives, staff and the community to contribute to this. We also anticipate an opportunity to further secure the future of the Hospice services later this year when commissioners will set out their requirements for 2017 and ongoing.

The Board objectives are and will continue to be:

- Quality - to deliver high quality, safe, responsive, effective, well-led care which meets both individual and community needs
- Innovation and collaboration - to deliver innovative and integrated care which supports and improves palliative care and last day's care
- Sustainability - to deliver value for money and be financially viable and successful
- People - to be a highly effective Hospice with empowered, highly skilled competent staff and volunteers

2017 will also see our 30th Anniversary. This will be an opportunity to look back on past achievements as well as to look forward as to what the next 30 years might bring. Thank you for reading this quality account.

If there are any questions or you would like to discuss any parts of this further please do contact:

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