Quality Account
2018/19
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1.1 Statement of Assurance from the Joint Chief Executives

It is with real pleasure that we reflect on the last year and our efforts to both assure people of the quality of our services and improve them where we realise that we could do better. The year 2018/19 marks some important developments that we believe will result in tangible benefits for the many stakeholders of care and support provided by St Christopher's.

We want to begin by announcing the appointment of a Director of Quality and Innovation in the organisation – a mark of the priority we place on getting our care and services right. Jan Noble, who took up post at the start of 2019 brings a strong history of clinical leadership in palliative care alongside operational management in the hospice sector. Most recently she has worked as our lead in service development and improvement. She is ideally placed to lead on a formal programme of quality improvement, on which we will focus our efforts in the coming year and report on in the next quality account.

Then, we would like to make mention of the work done by the Quality Governance Committee to review its structure and processes starting in June last year. We held a workshop at which all members considered our strengths and weaknesses, how we build on the former and reduce the latter. We agreed a new focus for each of the committee meetings – allowing a deep dive into the different components of quality – safety, user experience and effectiveness. In addition new sub committees were drawn into the structure – namely a workforce development group and the terms of reference amended for all sub committees. It is early days but the two most recent meetings focused on user experience and safety mark real improvement. Feedback from trustees who attend the group support that claim.

Last year we promised to purchase and adopt a new system to capture and report incidents and other quality related information; we also promised to review our processes related to discharge and to undertake a patient survey as part of our efforts to collect user feedback about our services. We are pleased to report that all have been achieved – as described in more detail later in this report. The patient survey made good reading in the main – overall satisfaction with our services was very high across the Board. Notable areas for improvement focused on our communication with people at home around appointment times, the need for continuity in care and easy access to advice in an emergency. That feedback is shaping our quality improvement initiatives this year. We will repeat the same survey again in the course of 2019 to assess any changes in experience.

Our Personal Care Service was inspected by the Care Quality Commission in early 2019, resulting in an assessment of good for all five key lines of enquiry. Whilst we are delighted with that outcome we realise that we can never be complacent and that we must continue to develop and improve our services wherever we can. In the course of the next year we will learn and embed the theory of quality improvement alongside practical implementation with due focus on a number of areas including timely feedback from users. At the start of the year we reviewed all feedback received in the course of 2018 – drawing on complaints, thank you letters, compliments, suggestion cards, the patient survey, a survey of bereaved carers and more. Whilst the overall message was overwhelmingly positive we were saddened to note a small number of people who had been disappointed in their care but had failed to alert us to that until weeks or months had gone by and our opportunity to change the experience had passed also. We are determined to change that – to encourage feedback in real time so that we have a chance to redress any gaps in care. We look forward to feeding back our progress in this regard in a year’s time and in the mean time we commend to you this report and thank you for your ongoing interest in our work and service.

Heather and Shaun
Heather Richardson and Shaun O’Leary

1.2 Statement of Assurance from the Board

The Board of Trustees of St Christopher’s Hospice commends this Quality Account to the audiences who read it.

We, as two Trustees with delegated responsibilities for quality from the Board are members of the Quality Governance Committee, where we consider a wide range of quality issues and reports presented to the Committee, provide challenge and scrutiny, and feed back to the Board key issues arising, including good practice and any concerns on our part.

As outlined in the Chief Executives’ statement, “This year has seen a number of key developments in quality governance, including the appointment of a new Director of Quality and Innovation, and a fundamental review of the organisation’s Quality governance structures and reporting, in which we have been fully involved.

We welcome these developments and feel that the initiatives have significantly strengthened the organisation’s focus on quality and improved Board oversight. Importantly, the new more strategic and holistic approach, developed in partnership with staff and stakeholders is recognised by staff as enabling a more integrated approach to quality assurance, reporting and improvement.

As Trustees, we are also pleased to see the ever increasing focus on quality improvement alongside effective quality assurance, which you will see described in this report.

In conclusion, we are satisfied that the organisation takes its responsibilities for ensuring and improving the quality of its services seriously and is committed to continuous quality improvement.’

Jane Walters
Ian Judson

Trustees
1.3 The Strategic Priorities of the organisation

Set by the Trustees and Executive Team, the strategic priorities give strategic direction to all we do, so we can understand what success looks like and work as a team to achieve shared goals.
1.4 Our Values

The way that we work towards our strategic priorities is guided by our organisational values.
Part 2 - Priorities for improvement and statements of assurance

2.1 Priorities for improvement 2018/19 - what we achieved last year

2.1.1 Purchase and implement a new system to capture and report incidents and accidents

Why was this a priority?
Although we considered that hospice staff had a positive attitude to the reporting of incidents, the reporting software was out of date, not user-friendly and unpopular with staff. A new system to make reporting quicker and analysis more thorough would allow us to better identify areas of improvement in safety and patient care.

How did we achieve this?
We purchased software that will allow data on multiple quality topics to be cross-referenced and reported on within a wider quality context. Managers and team leaders will have the ability to produce their own team-specific reports, on multiple quality indicators, over a time period of their choosing. Incident reporting is the first module; future modules will include risk management, complaints and compliments.

What was the outcome?
We are continuing to build the incident reporting module which will be launched on 1st July 2019. The software has been demonstrated to more than 120 staff, giving us valuable usability feedback.

2.1.2 Improve the quality of patient transfer from care/ discharge

Why was this a priority?
Transferring or discharging patients from care can be challenging for patients, their carers, and for staff. It is an aspect of patient care that affects all clinical teams.

How did we achieve this?
We established a programme that, over 12-24 months, will develop auditable standards at both organisational and team level on multiple aspects of patient transfer. Six quality improvement projects were identified; each resulting in a clinical audit.

What was the outcome?
The results from these audits will help us to develop standards across a range of teams that input to patient transfer. The methodology used in this project will also be rolled out to other quality improvement projects throughout the hospice.

2.1.3 Undertake a hospice-wide patient survey

Why was this a priority?
Building on work from last year, we identified that service users had a number of mechanisms for giving us feedback, including compliments and complaints, “What would you like to tell us?” feedback forms, and questionnaires aimed at specific groups of service users such as the recently bereaved. While extremely useful, there were limitations to this feedback. Specifically, it only represented a small number of service users and was not necessarily ‘real time’ feedback. We wanted to garner the views of current patients across all our clinical services in order to understand in which areas of our care we were doing well and where we could improve. We used the Oxford University “Experience of Care” survey, which gave us the opportunity to benchmark our results against other hospices.
**How did we achieve this?**

We undertook a survey of all patients registered with us within a specific time period of a couple of weeks in early summer. Although we had hoped to use both paper and electronic versions of the questionnaire, ultimately it was only practical to use paper surveys.

**What was the outcome?**

Feedback was extremely positive overall, with satisfaction levels above 90%. Some respondents took the opportunity to provide feedback on occasions when the levels of care could have been better. It was interesting to note that complaints and negative feedback were most likely to occur when we failed to meet the expectations of patients in the areas they would most expect us to support them, such as timely home visits, or adequate pain control.

The survey will now be repeated annually and integrated with results of other feedback such as complaints and compliments in order to give us a wider understanding of all aspects of hospice care.

### 2.2 Priorities for improvement 2019/20 - what we will achieve next year

#### 2.2.1 Expand the use of software in order to capture data on a wider range of quality-related indicators

**Why is this a priority?**

Once our new accident and incident reporting module is embedded throughout the organisation we will focus on developing further modules. These will include modules to capture information on risk management, compliments, complaints and clinical audit.

**How will we achieve this?**

Individual module development will be assigned to key committees in order to oversee their development.

**How will we monitor and report progress?**

Project development will be overseen by the Head of Quality, reporting to the Quality Governance Committee.

#### 2.2.2 Review of the Bereavement ‘follow up’ process

**Why is this a priority?**

Learning from two complaints in the past 6 months has highlighted the need to review this process. The VOICES questionnaire is sent out to the next of kin 3 months after a death, sometimes these are returned with a relative expressing concerns about their experience of our service. By reviewing the bereavement process we hope to enable people to connect in a more timely way with the hospice, in the event of outstanding concerns or additional requirements for support.

**How will we achieve this?**

A Quality Improvement project will start in July 2019, bringing together a multi-professional project team to map the current process and identify areas of improvement.

**How will we monitor and report progress?**

The project will be led by the Director of Quality and Innovation, reporting to the Quality Governance Committee.
2.2.3 Feedback from users in ‘real’ time

Why is this a priority?
We are committed to increase the engagement we have with users as they are receiving care, rather than after care is ended. Care may end because the patient has been discharged from our service or because the patient has died, in which case the feedback we receive is from a next of kin or carer. We would prefer to receive feedback as concerns arise so we can do our best to resolve them and improve the patient/ carer experience.

How will we achieve this?
Create a short questionnaire for patients/ carers to complete on an iPad when on our in-patient unit, or attending appointments at our 2 sites. Volunteers will be trained in engaging with patients and carers and assisting with the completion of the questionnaire when necessary.

Changes will also be made to some of our literature, inviting feedback if users are unhappy with the support they are receiving.

How will we monitor and report progress?
Feedback will be reviewed as it is received by the Head of Quality, who is responsible for making contact with the relevant team if there are any issues that need resolving immediately.

A report will be reviewed at each Service User Experience Committee.

2.2.4 Timely and appropriate support to care home staff

Why is this a priority?
Our model of supporting care home staff has changed over the past year. We know there will be a significant increase in the numbers of people who will be dying in care homes in the coming years. We are committed to ensuring our staff are available and responsive to calls for help from care home staff, particularly out of hours.

How will we achieve this?
We have secured funding for a dedicated Clinical Nurse Specialist who will be a member of our Single Point of Contact team, her focus will be on triaging all new referrals from care homes and responding to calls from care home staff. A telephone assessment will be completed for new referrals, identifying the patients’ needs and the level of support the care home staff require.

A database of all the care homes in our area will be created which will help staff identify (particularly out of hours) the level of support the care home may need. We will also explore the use of technology in supporting this.

How will we monitor and report progress?
The project team will meet regularly to review progress and report to the Quality Governance Committee and the Commissioners who have funded this project and supported the Quality Improvement initiative.
3.1 Internal Assurance

In 2018/19 we re-designed how we monitor and support quality governance within the hospice. Moving to quarterly meetings instead of bi-monthly, the Quality Governance Committee now focuses on one aspect of quality at each meeting rather than trying to review all facets at every meeting. This enables us to engage with a wider range of teams and services, and supports them to understand their role within each of the quality domains covering Safety, Experience, and Effectiveness. The fourth meeting of the year allows for a general review.

3.1.1 Safety

We consider ‘Safety’ to apply to all groups associated with the hospice: patients, their families and carers; our staff and volunteers; everyone involved in fundraising events; people visiting our buildings and shops; our neighbours, and the broader general public who have a relationship with us.

The Board agreed a new approach to risk, one that allows us to acknowledge the balance between risk avoidance and being responsive to new opportunities and challenges in a rapidly changing healthcare environment.

We have undertaken a range of safety-related activities within our governance sub-committees:

Within the Organisational Safety Committee we have:

- Increased awareness and compliance around Health and Safety in our shops
- Undertaken new risk assessments that are supported by action plans to increase control measures
- Conducted a security review and improved security levels
- Implemented fire safety improvements
- Designed and implemented a new Health and Safety induction for new starters; this now includes providing all staff with Fire Extinguisher training
- Reviewed the Organisational Safety Committee’s Terms of Reference and membership, which now includes staff-elected H&S representatives from across the workforce

Within our Patient and Service User Safety Committee we have:

- Instigated a Duty of Candour Register
- Introduced new risk assessment tools to support tissue viability
- Purchased new oxygen equipment and fire breaks for portable oxygen, and introduced new e-Learning on the management of oxygen therapy

Within our Workforce Development Committee we have:

- Introduced a simplified appraisal process that has supported an increase in the appraisal completion rate
- Overhauled the mandatory and compulsory training requirements to reduce the burden associated with compulsory requirements without compromising on the accessibility of relevant training available
- Strengthened the Freedom to Speak Out policy and procedure
- Trained members of the Equality and Diversity Group, which has been given responsibility for carrying out EQUIAs for all new and reviewed policies
- Implemented a range of safety related ad-hoc training (e.g.) Right to Work, Safer Recruitment, GDPR
• Become an Age Positive Employer
• Ran the first (10 month) In-house Leadership Development Programme and introduced Action Learning Sets as a mechanism of embedding the learning.
• Evaluated the In-house Leadership Development programme through questionnaires, interviews and focus groups to improve the programme for the second cohort group
• Established a sub-group to work on transforming the hospice into a Learning Organisation

Within our Safeguarding Committee we have:
• Reviewed and developed safeguarding training, made significant improvements in both the quality of training and the number of staff attending
• Improved the robustness of the Safeguarding Sub Committee to ensure it also included work relating to the Mental Capacity Act, and the Deprivation of Liberty Safeguards
• Utilised our electronic patient record software – SystmOne – to fully capture the full range of safeguarding activity across the organisation
• Introduced Making Safeguarding Personal throughout the organisation to ensure that social work interventions are linked to specific outcomes determined by the patient or carer
• Undertaken a Safeguarding Adult at Risk Audit Tool (SARAT) assessment – see Section 3.7

We recognise that we have further work to do within a Safety domain, including:
• Continue to encourage staff to report incidents and accidents (particularly near misses)
• Train key staff to undertake and review risk assessments
• Instigate ‘Prevent’ training
• Have better involvement in safety-related committees from all teams and areas within the hospice
• Raise the completion rate of mandatory training, including safeguarding training
• Develop and introduce a new risk management database, drawing together incidents, risk registers and assessments.

Experience
Over the years the hospice had developed a variety of methods to encourage service user feedback. This led to so many feedback mechanisms (more than twenty) that we were struggling to use this important information in a meaningful and consistent way. We therefore decided to limit feedback to a narrower range of mechanisms such as compliments (including thank you cards and letters), complaints, an annual patient survey, and the VOICES survey of bereaved relatives. At the same time we broadened our perspective from whom we receive feedback to include all service users including patients, their family and carers; those who visit our shops; all healthcare organisations with whom we work; and those who live and work within or geographical area. We have undertaken a range of Experience-related activities within our governance sub-committees:

Within our Information Governance Committee we have:
• Undertaken a gap analysis as part of a GDPR action plan
• Rolled out GDPR Basic Awareness Training to staff
• Successfully transferred active patient records to SystmOne, our new electronic patient record

Within our Service User Experience Committee we have:
• Reduced the number of ways we gather user feedback, as the wide range of options made it difficult to maintain a cohesive understanding of users’ experience with us.
• Undertook a patient survey of all patients under our care.
• Continued to use VOICES to receive retrospective information about patient care
• Ensured that service user compliments are considered as part of feedback, not just complaints.
Patient Experience of Care Survey
This was the first time we have undertaken a ‘real-time’ patient survey of all teams and services throughout the hospice. Undertaken during July 2018, this was a snapshot survey of all patients registered with St Christopher’s over a two week period, using postal questionnaires to all patients at home, and handing out questionnaires on the wards to those able to participate. Satisfaction levels were very high with an average of 9 out of 10. The survey also elicited a range of very positive comments with numerous superlatives used to describe the care provided: “excellent”, “fantastic”, “first class”.

VOICES
We continue to receive regular and consistently positive feedback via the VOICES survey of the recently bereaved, with 95% saying they are ‘extremely likely’ or ‘likely’ to recommend St Christopher’s to a family member if our services were required. 89% of respondents considered that their relative died in the right place, and that 97% received a good welcome from staff in our day centres.

Complaints
During 2018/19 we held six Learning Panels to review complaints and help us to identify areas for improvement. In total 33 members of staff have attended the learning panels. The learning gained from the panels included offering more timely and appropriate support for care homes with complex patients, the need to review the support we give families immediately after a death and in bereavement. Another Learning Panel identified the need for better support for hospice staff working outside of normal working hours in being able to recognise potentially difficult clinical situations and when to escalate to more senior colleagues. For more data on complaints received in this period, see Section 3.2

Compliments
Compliments received from patients and their families can easily be taken for granted. In 2018/19 we began to review compliments with an equal weight to any complaints we received. As a result we are now beginning to gain an understanding not just of how many written thank you cards and emails we receive, but also exactly what it is that people are thanking us for. People regularly recognised us as a compassionate organisation, where care was individualised and highly personalised. People felt safe in our care, particularly on the inpatient unit, and there was strong consistency in how patients, carers and families experience our services. See below for further details on compliments received.

Combining all forms of feedback
We reviewed all forms of feedback (positive and negative) and matched them to our organisational Values in order to identify emerging themes. This has enabled us to address key questions about our care, such as:

- How satisfied are people with our services?
- What do people most value?
- What were people disappointed about?
- How does this relate to people’s wider experiences and challenges?
- Does the satisfaction of people vary between contexts and services?
- What strengths do we have that we can build upon in the future?
- Where are our areas for improvement?
- Any other learning?

Analysis shows that there is a strong correlation between when people are most grateful for our support, and what leads to a complaint. When the things that we do most well, most often, are perceived as not being to a sufficiently high standard, clinically-related complaints tend to occur. Patients and families will
have a sense of frustration and disappointment, with people most likely to be distressed by events that occurred to the patient or carer close to death.

<table>
<thead>
<tr>
<th>Area or Team</th>
<th>Average Score out of 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bromley Community</td>
<td>9.48</td>
</tr>
<tr>
<td>Bromley Care Coordination</td>
<td>9.33</td>
</tr>
<tr>
<td>Anniversary Centre</td>
<td>9.52</td>
</tr>
<tr>
<td>Caritas House</td>
<td>9.24</td>
</tr>
<tr>
<td>Croydon Community</td>
<td>9.00</td>
</tr>
<tr>
<td>LSL Community</td>
<td>9.36</td>
</tr>
<tr>
<td>Bereavement Service</td>
<td>10.00</td>
</tr>
<tr>
<td>In-Patient Unit</td>
<td>9.25</td>
</tr>
<tr>
<td>Overall</td>
<td>9.36</td>
</tr>
</tbody>
</table>

A selection of feedback comments

The staff were always there for us, but gave us plenty of space just to be a family. I wouldn't have wanted my husband to have been anywhere else (IPU)

Cannot praise team highly enough. Dr … and the nursing team were compassionate and caring. We never felt rushed during visits and felt listened to at all times (Community)

My husband could not have had better care, he was comfortable, relaxed and pain free. The care to him and my family was exceptional. Thank you (IPU)

With heartfelt thanks to all the skilled doctors, nurses, staff and volunteers at St Christopher’s hospice during xxx’s recent illness. You never failed us in your love and support. You moved mountains to grant (his) last wish that he spend his last weeks in his home (Thank You Card)

Can’t speak highly enough of all community staff involved in my wife's care (Community)

Policies

A review of in-house clinical and non-clinical policies identified a need to reduce them to a number that better supported staff to keep up to date with them. Better differentiation between policies, procedures and guidelines meant that the number of approved policies almost halved to around 60.

3.1.2 Quality Markers

Staff reported 488 incidents or accidents for the period 2018-19, the majority of which were slips/trips/falls. Three quarters of all incidents were rated Green, while 25% were rated Amber. There was one Red incident resulting from a patient choking and being conveyed to hospital following a respiratory arrest.

Two incidents were notified to the CQC, one involving a patient suffering a minor injury resulting in an A&E assessment, the other involving police being called to the hospice to calm an upset patient. Two other Amber incidents were reported under RIDDOR, both relating to staff injuries.

3.1.3 Hospice UK Benchmarking

St Christopher’s participates in the Hospice UK benchmarking programme, which enables hospices to compare data per 1000 occupied bed days (OBDs) on the Inpatient Unit for specific types of incidents. St Christopher’s is categorised as a Large Hospice.
Patient Slips, Trips and Falls
On our inpatient unit there were 12.2 patient falls per 1000 OBDs. This is a reduction of 2.7 compared to the previous year, and slightly above the average (10) for other hospices in our category. 84% of our patients who fell experienced no harm, which is significantly higher than other hospices in our category (where 58% experienced no harm). 16% of our patients who fell experienced low harm, compared to 40% of other hospices in our category.

Medication Incidents
On our inpatient unit there were 5.3 medication incidents per 1000 OBDs, a fall from 7.9 last year. This compares to 10.5% for similar hospices. 97% of our patients experience no or low harm, compared to 89% in our category.

Pressure Ulcers
The Hospice UK benchmarking programme in 2018/19 required the team to record individual pressure ulcers that had developed on patients before they were admitted to the unit, and then to record any that develop while an inpatient. This included any red marks caused by pressure, or bruising to the skin caused by previous falls. Over the year the hospice had 32.1 ulcers per 1000 occupied bed days compared to the national average of 18.4 per 1000 occupied bed days. Between April 2018 and March 2019 there were 8 pressures ulcers that developed into a category 3 ulcer. These arose out of a combination of patients wishing to remain in certain positions for comfort, the patient's poor nutritional intake and rapid deterioration prior to death. All developed pressure ulcers of category 3 or above are subject to root cause analysis. Issues identified included ensuring that nursing staff understand how to use the new electronic patient record to complete the wound care assessment on patient admission, and the need for ongoing education in clinical update sessions and one-to-one reflection with staff.

3.1.4 Infection Prevention and Control
In 2018/19 there were no cases of patients with a new diagnosis of Clostridium Difficile infection or a blood stream MRSA infection. No vomiting and diarrhoea outbreaks took place at the hospice over this year.

3.2 Quality markers: summary of clinical governance data (all teams, clinical and non-clinical)

<table>
<thead>
<tr>
<th>Area</th>
<th>No.</th>
<th>Action/comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slips, trips and falls</td>
<td>155</td>
<td>As would be expected, 90% of falls were on the wards.</td>
</tr>
<tr>
<td>Pressure Ulcers</td>
<td>26</td>
<td>Eight developed in to Grade 3+, RCA undertaken on all; 18 inherited</td>
</tr>
<tr>
<td>Medication Incidents</td>
<td>73</td>
<td>We continue to see fewer serious medication incidents than comparable hospices.</td>
</tr>
<tr>
<td>RIDDOR reports</td>
<td>2</td>
<td>Both reports rated as Amber</td>
</tr>
<tr>
<td>Notifications to CQC</td>
<td>2</td>
<td>1 x incident reported to the police; 1 x injury to a person who uses the service</td>
</tr>
<tr>
<td>MRSA</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>C Diff</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>MHRA Alerts</td>
<td>6</td>
<td>1 x updating battery compartment in syringe pumps; 1 x ensuring correct battery usage in syringe pumps; 1 x risk assessment undertaken on portable fans; 3 x information shared with relevant staff</td>
</tr>
<tr>
<td>Formal complaints</td>
<td>54</td>
<td>Clinical: 30 complaints, 13 fully or partially substantiated.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-clinical: 24 complaints, 12 fully or partially substantiated.</td>
</tr>
</tbody>
</table>
3.3 Our response to the Commissioning for Quality and Innovation (CQUIN) Payment Framework

The aim of 2018/19 CQUIN was to increase routine utilisation of validated tools that assess the needs of family or personal carers supporting someone at the end of life. It is well recognised that family or personal carers can be hard to identify. Their wellbeing, however, is critical to enabling people to remain at home. The original timescale was as follows:

<table>
<thead>
<tr>
<th>Qtr</th>
<th>Aim</th>
<th>Achievement level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>Establish a carer’s strategy</td>
<td></td>
</tr>
</tbody>
</table>
| Q2  | Sign up to the Carer Support Needs Assessment Tool (CSNAT)  
Train staff from a range of services in the use of the validated tool and how to identify and engage with carers to introduce the assessment so that they can train others | Train 10 staff who will become trainers of others |
| Q3  | Identify how an assessment tool is integrated into SystmOne to inform plans for care, and enable collection of data. Identify, assess and make a plan to engage a proportion of carers to use the assessment tool | CSNAT integrated into SystmOne.  
15 carers receive an assessment of their needs, followed by clear identification of plans to respond to their needs |
| Q4  | Continue to implement the assessment tool, using it to identify people who could benefit from coaching from an ex carer | A further 15 carers receive an assessment of their needs, followed by a clear plan to respond to their needs. Where they could benefit from the involvement of an ex-carer to help them navigate the system on behalf of themselves or the person for which they are caring, at least 50% of those who could benefit will be referred to Coach4Care |

Due to a delayed start in agreeing the CQUIN, work did not start on this project until well into Q2. Two senior members of staff undertook CSNAT training in September, if a CSNAT has been offered or completed this is recorded on SystmOne (our electronic patient record).

A CSNAT training programme was developed and rolled out to relevant staff within the hospice.

About 100 CSNAT assessments have been completed overall. From those assessments a further three carers were referred to the Coach4Care project, which providers a previous carer (having completed a training programme) to ‘buddy up’ and support a current carer.

3.4 Clinical Audit

The following Infection Prevention and Control audits were undertaken:
- Hand hygiene
- Cleanliness of clinical/non-clinical areas
- Waste/sharps management/pool care audits
- Aseptic technique
- Isolation precautions
- Equipment store
- Mattresses
- Annual infection control audit

Actions as a result of the infection prevention and control audits:
- To continue with regular audit programme for infection prevention and control
- To support Intravenous competent nurses to have updated and training regarding the care of Central Venous Access Devices
- To continue annual infection prevention updates using e-learning for staff that have patient contact
- Continue laundry practice education

In addition, a re-audit of community pool cars (to ensure equipment is not left in cars) will be undertaken in 2019/20

### 3.5 Medicines Management Audit

In October 2018 we invited an external expert to undertake an audit of our medicines management processes. The audit encompassed a range of pharmacy-related aspects including:
- Medicines reconciliation
- Pharmacy services arrangements
- Stock control
- Prescription control
- Controlled drugs
- Governance
- Waste medicines/return (non-Controlled Drugs)
- Medical gases
- Staff training
- Self-administration of medicine
- Discharging patients from the In-patient unit

The report noted a high level of compliance against many elements of the audit, with only relatively minor suggestions for improvement. One priority for improvement centred on medicines reconciliation when a patient is admitted to the inpatient unit – an action plan has been developed for this.

### 3.6 Transfer of Care/ discharge - quality improvement project

In 2018 we embarked on a programme that would both encourage quality improvement projects on a key area of patient care, and support staff to undertake clinical audit in a structured, educational way. Transfer of patient care (ToC) was chosen as the topic, and more than twenty staff from a range of professional backgrounds took part.

**Methodology**

The project took place over four months. Staff from a variety of backgrounds (including nurses, physiotherapists, administrators and doctors) volunteered to take part in six training sessions. Each session focused on a particular aspect of clinical audit, ranging from choosing a topic to presenting audit results. Six multi-professional groups formed, each undertaking a clinical audit on a specific aspect of RoC:
- effectiveness of communication during handover from community to In Patient Unit (IPU)
- effectiveness of communication for Community Palliative Care Team patients transferred into and out of hospital
• preparation of patients/relatives/carers for ToC
• admission planning
• signposting of patients to external organisations after ToC
• the “step down” process

The format for each training session was broadly similar. A short presentation and training session allowed participants to gain an understanding of the next step in the audit cycle and to be able to relate it to their project. There was then a set period of a number of weeks for staff to undertake the next audit step, before moving on to the next phase. By the end of the programme each group was required to produce an audit report and to present it to a relevant staff group/committee. Action plans will be implemented throughout 2019.

3.7 audit
The Safeguarding Adult at Risk Audit Tool (SARAT) is an organisational-wide audit of safeguarding across seven key standard domains, each of which is RAG rated.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership</td>
<td>Green</td>
</tr>
<tr>
<td>Organisational responsibilities</td>
<td>Green</td>
</tr>
<tr>
<td>Workforce and training</td>
<td>Green/Amber</td>
</tr>
<tr>
<td>Inter-agency work</td>
<td>Green</td>
</tr>
<tr>
<td>Diversity</td>
<td>Green</td>
</tr>
<tr>
<td>Communication</td>
<td>Green</td>
</tr>
<tr>
<td>Learning from Safeguarding Adult Reviews</td>
<td>Amber</td>
</tr>
</tbody>
</table>

As a result of the audit, the following actions have been identified for 2019:

• Further develop and embed training and development plan
• Capture what outcomes patients, carers and families want in relation to safeguarding
• Target self-neglect and financial abuse concerns
• Under ‘Making Safeguarding Personal’, developing support and resources for people who lack decision specific capacity at the end of life

3.8 Other audits

<table>
<thead>
<tr>
<th>Name of audit</th>
<th>Review of referrals to Speech and Language Therapy on the Inpatient Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit driver(s)</td>
<td>Changes in the International Dysphagia Diet Standardisation Initiative; an NHS Patient Safety Alert (2018); changes in referral practice following introduction of new hospice Electronic Patient Record (EPR)</td>
</tr>
<tr>
<td>Outcome</td>
<td>New EPR does not give sufficient SALT assessment guidance</td>
</tr>
<tr>
<td>Actions</td>
<td>Improve the SALT assessment on the EPR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of audit</th>
<th>Hospice UK Management of inpatient pressure ulcers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit driver(s)</td>
<td>To audit the management of pressure ulcers within the inpatient unit using the national hospice audit tool which is uses NICE quality standards and standards recommended by the European Pressure Ulcer Advisory Panel (EPUAP).</td>
</tr>
<tr>
<td>Outcome</td>
<td>100% compliance</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Actions</th>
<th>To ensure continued high level of compliance, have a version of the Purpose T Risk Assessment Tool on the EPR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of audit</td>
<td>Documentation of allergies and intolerances to medicines and other substances of patients on the IPU</td>
</tr>
<tr>
<td>Audit driver(s)</td>
<td>Internal clinical concern</td>
</tr>
<tr>
<td>Outcome</td>
<td>Allergy wrist bands are not routinely being given to patients</td>
</tr>
<tr>
<td>Actions</td>
<td>Further reminders/uploads to staff; regular auditing to ensure compliance.</td>
</tr>
</tbody>
</table>

3.9 National Clinical Audit
St Christopher’s was not eligible to participate in any of the national clinical audits or national confidential enquiries, as none of the 2017/18 audits related to specialist palliative care.