Policy:	**East Cheshire Palliative Care in Partnership [PCiP] Hospice @Home Standard Operating Procedure**		
Executive Summary and associated documents	**THIS POLICY WILL PROVIDE GUIDANCE TO ENSURE EAST CHESHIRE PALLIATIVE CARE IN PARTNERSHIP, H@H SERVICE WILL OFFER PATIENTS WITHIN THE LOCALITY OF EAST CHESHIRE "TIMELY AND EQUITABLE ACCESS TO A HIGH-QUALITY SERVICE ACROSS ALL SETTINGS, DELIVERED BY APPROPRIATELY TRAINED PROFESSIONALS".**		
Description of Amendment(s)	Adapted in November 2021 to meet the requirements for the PCiP Project Business Case Reviewed and adapted in March 2022 to meet the requirements for CHC and Marie Curie collaborative working		
Associated Hospice Policies and Procedures	**RELATED HOSPICE POLICIES/PROCEDURES:** • Complaints • Governance • Gift acceptance • All ECH Health and Safety Policies • All ECH HR Policies • All ECH Insurance Policies • All ECH IT policies • All ECH Clinical Policies • Lone Worker Policies • Driving at Work policies • Weather Conditions Policy • Personal Safety Policy • Discharge and Transfer Policy • H@H Service Specification		
Associated CQC Regulations	Regulation 9 – Person Centred Care Regulation 10 – Dignity and Respect Regulation 11 – Need for Consent Regulation 12 – Safe Care and Treatment Regulation 13 - Safeguarding service users from abuse and improper treatment		
Associated CARE Principle	**C**ompassion – we ensure we put our patients, their families and carers at the centre of everything we do, and we always act with care and compassion and demonstrate this in our daily activities.		
Policy Area	Hospice @Home – Community Care		
Effective Date:	April 2020	Review Date:	April 2023
Responsible person for updating policy	Tess Cleaver Hospice @Home Manager		
Approval Record			
			Date
Ratified by:	PCCG Board		
Chief Executive Officer:	Karyn Johnston		

East Cheshire Hospice

Palliative Care in Partnership [PCiP]

East Cheshire Hospice @Home (H@H)

inc. Palliative Community Care, Carer Breaks and Rapid Response Night Support

1.0 Introduction

This Standard Operating Procedure will provide a framework that captures key information regarding service delivery and arrangements. It will outline the context of the service, explain the philosophy of the H@H service, and give clear guidance on referral and assessment procedures and the service's role, function, and objectives.

There is an increasing acknowledgment that a sizeable proportion of terminally ill patients in the UK would wish to die at home. Population studies of preferred places of death [PPD] indicate that over 60% of people including those who are not facing a life limiting illness wish to die at home, although unfortunately following a population study of just under 10,000 adults across England, only 34% have been able to achieve their PPD.

The NICE Quality Standard for end-of-life care for adults (2019) set 16 quality statements providing a picture of what high quality end of life care should look like and putting more emphasis on timely holistic, personalised care, appropriate to patient need.

The Choice in End-of-Life Care Programme Board (2015) carried out an extensive patient survey that provided the government with advice on improving the experience and quality of care for patients at end of life, generally the evidence suggests that although in many cases PPD was the patient's own home, many patients were not achieving their preferred place of death.

2.0 Aim

East Cheshire Hospice together with the End-of-Life Partnership, CCICP (Central Cheshire Integrated Care Partnership) and Cheshire and Wirral Partnership NHS Foundation Trust will provide a rapid, planned, and unplanned care response which will be supported by a single point of access step up and step-down care model across all Cheshire localities. This will enable a coordinated and seamless approach to care provision that will ensure physical, psychological, and emotional wellbeing, improved communication provided by highly skilled specialist teams to support patients and carers who are in final 12 weeks of life. This process will reduce the amount of time spent referring into several services, reduce variation in care

provided, allow care to be implemented within a timely manner and instil confidence to the patient and carer at a stressful and anxious time

The purpose of the hub within East Cheshire, will be to build on the enhanced existing service, Hospice @Home (H@H), and offer additional support to that which is provided by the statutory services already established. H@H aims to be a single point of access and will support palliative and end of life patients in East Cheshire who have been recognised as having a rapidly deteriorating condition that may be entering a terminal phase and have identified their usual place of residence as their preferred place of care and death.

The service will be equitable to all people identified as having a rapidly deteriorating condition that may be entering a terminal phase. The service will support the following: -

- Holistic care, support, and advice
- Crisis and planned responses

The service will promote continuity of care, patient dignity and offer patients, and those who are important to them appropriate advice concerning their care.

Holistic care planning completed for each patient utilising approved patient documentation, which will be continually monitored by Care Community Teams

The aims and objectives of the re-designed service will align to support best practice and guidance, such as the delivery of The NHS Long Term Plan, Gold Standards Framework (GSF), National Institute for Clinical Excellence (NICE), Ambitions for Palliative and End of Life Care. These aims and objectives include: -

- Enables patients, families, carers, and health professionals to better plan and prepare for EOL (End of Life)
- Improved single point of access to domiciliary support for End-of-Life care and single point of contact for health and social care professionals, patients, and carers
- Increased opportunity for access and improved continuity of care packages provided by a fully integrated model.
- A responsive joined up and place-based service that can meet end of life needs in crisis every day of the week with 24/7 cover including access to integrated overnight care.
- Access to a consistent pre and post bereavement/Holistic support Cheshire wide.
- Rapid and smooth transition for patients who are transferred from the acute sector out into community.
- Timely access to domiciliary care for patients in their final 12 weeks of life, ensuring that consistent Cheshire Wide governance processes and monitoring of quality standards for EOL care will be achieved by commissioning NHS services for full EOL care provision for the local population.
- High quality care provided by a skilled and competent workforce, a consistent approach will be provided to training and support of the workforce across Cheshire.
- A trusted assessor approach to reduce multiple and duplicate assessments i.e., social services assessment for home care package provision.
- Rapid and smooth transition for patients who meet the criteria currently at home, to avoid unnecessary hospital or hospice admission.

- Increased cases of people able to die in their preferred place of care/death at home.
- Consistency of practice across the Cheshire system.
- Accessibility to shared resources across Cheshire such as Training and Education and senior clinical advice and support.
- Alignment to health, social care, and Third Sector systems, particularly within care communities and compassionate community's infrastructures.
- Work with Care homes, Community staff and other services as part of a whole health economy to facilitate efficient transfers of care to reduce use of secondary/acute care beds for 12-week fast track palliative care patients.
- The patient is treated with dignity and respect and receives the right care in the right place at the right time.
- Shared electronic information on people's needs and choices at end of life across organisations and professional groups. This will provide a total shared repository of health information, enabling patient information to be viewed by nurses, therapists, GPs (General Practitioner), Macmillan nurses, care staff, Band 3 Practitioners.

It is the policy at East Cheshire Hospice that no one will be discriminated against on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, or sexual orientation. The Hospice will provide interpretation services or documentation in other mediums as requested and necessary to ensure natural justice and equality of access.

3.0 Scope

This SOP (Standard Operating Procedure) is relevant to all East Cheshire H@H staff and all the staff who work within the hospice and who can inform, refer, promote, and support the service.

The service is provided to adults above the age of 18 years with a life limiting illness whose care is defined and judged to be in the last months of life.

The focus of the PCiP H@H Service is to provide outreach from a recognised Specialist Palliative Care unit that will support patients to remain at home during the end stages of their life and facilitate a dignified and comfortable death in the presence of their loved ones.

The Hospice will work in partnership and ensure the patient's key worker is informed of patient's progress, and will provide assessment and implementation of nursing, therapy and social care services that is regularly reviewed during the last 12 weeks of life for patients and their family members.

4.0 Philosophy and Models of Care.

The PCiP, East Cheshire H@H Service will offer patients registered with an NHS East Cheshire Clinical Commissioning group GP (General Practitioner) practice, "timely and equitable access to a high-quality service across all settings, delivered by appropriately trained professionals."

The service will provide planned and rapid access to a skilled and trained care workforce with community nursing support with the ability to be responsive to referrals from District

Nurses, Macmillan Nurses, acute hospital nurses, and GPs. We envisage that there is the potential to offer a timely responding service to support patients who deteriorate at home to prevent avoidable admissions.

East Cheshire Hospice aims to ensure that every person who chooses the H@H team to provide their support will have all their needs met, be kept safe and will be protected from the risk of abuse and/or harm by the robust implementation of its Safeguarding Adults Policies and Procedures.

The service is **not able** to deliver a long-term care package. It is a service that will support people at end of life for an assessed and agreed period by the H@H team.

All referrals will be overseen by a registered nurse from East Cheshire Hospice @Home Team who will act as a single point of access to receive referrals 7 days per week.

The Hospice @Home service has three pathways for referral and support:

- **Palliative Care in Partnership Service –**
    - Input from H@H daytime service can be requested in the last 3 months of life providing that funding is available, and the patient has been assessed to be in the last 3 months of life (under the old CHC fast track guidance) and H@H have capacity to commit to undertaking the care alongside other community services.
    - East Cheshire H@H health care workers will support patients requiring additional care support at home during the day at end of life alongside other community services.
    - East Cheshire H@H team will work with other care providers to provide overnight support for those who need increased care to enable them to stay at home to achieve their PPD

- **H@H Rapid Response Out of Hours and Night service –**
    - Providing Out of Hours support, symptom management, urgent care needs and psychological support to the patient and their carers.
    - H@H Rapid Response will support patients within residential and Nursing Home environments at end of life, in the absence of a District Nurse. The support given will be advice on symptoms and care, not hands on nursing care.

- **H@H Carer Break Service – where capacity allows**
    - Infrequent visits, adhoc care or carer breaks for those in the last 6 months of life.

All referrals will be triaged by a Registered Nurse or Care Co-ordinator from East Cheshire H@H Team.

All referrals will need a completed referral form emailed to the team via NHS mail.

Telephone referrals can also be accepted in emergency/exceptional cases and may take up to 15 minutes but will need to be supported by the receipt of an electronic referral as soon as possible via NHS email.

- The PCiP H@H service will support people who are recently discharged from hospital/hospice for an agreed fixed amount of time agreed via the patient's care plan.

- East Cheshire H@H service will support rapid discharge from the hospital for patients requiring end of life care, alongside other community services, if this is the patient and families wish to be at home.

4.1 Referral Criteria

Referral forms for the H@H services can be obtained via the East Cheshire Hospice website at www.eastcheshirehospice.org.uk.

East Cheshire Hospice holds data sharing agreements for Emis records with all General Practices within East Cheshire, District Nurses and Specialist Teams.

All patients will:

- Have a life limiting illness and be assessed as being in the three months of life (unless requiring Carer Break) with non-reversible deterioration.
- Need to have an understanding that the service is only available for the 12 weeks at end of life and that regular reviews will be undertaken.
- Be on their GP's GSF register or added at point of referral.
- Have an identified need for the East Cheshire H@H service
- Will preferably be known to the District Nursing team and have a plan of care in place.
- Agree to the referral
- Will be agreeable to having a risk assessment of their environment and a holistic assessment of need by the H@H team, to ensure they meet the criteria.
- Have home as their preferred place of care (or preferred place of death).
- May require assessment and management of unstable symptoms for patients with life limiting diseases.
- May require assessment for acceptance for inpatient symptom control, and terminal care.
- Have regular review of condition and need whilst receiving support.
    - *On review, if the patient is found to no longer be eligible for funding under the old 'CHC fast track' criteria of 12 weeks of care, a full DST CHC assessment would be offered to the patient and family. In the event that the patient is not eligible for ongoing CHC funding, the service would cease to provide care and a referral would be made to the relevant Local Authority and/or other relevant services.*

Acceptance/Exclusion Criteria

Patients for this service will have a clinical assessment and if eligible will be referred into the Service.

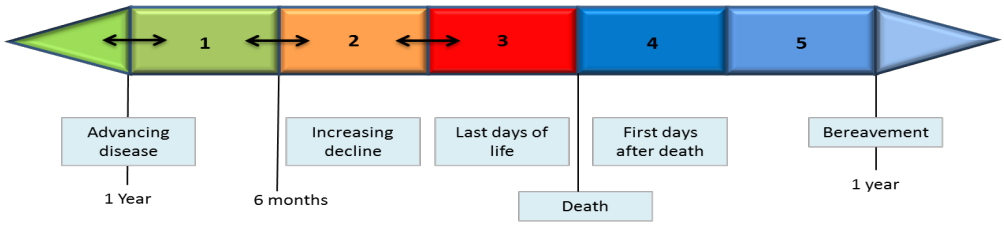
5.0 Compliance with Statutory Requirements, Evidence Base and Key Drivers:

- Care Quality Commission (Registration Regulations) 2017 (Part 4)
- Data Protection Act 2018
- DOH End of Life Care Strategy 2012 4th annual report
- Health and Safety Regulations 2019
- Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 (part 3)
- NICE Quality Standards, Care of the Dying Adults 2017
- National Palliative Care Strategy 2018
- RCGP Commissioning Guidance for End-of-Life Care (2013)
- Actions for End-of-Life Care: 2014-16, NHS England

- Our health, our care, our say: A new direction for community services (DH, 2006)
- One chance to get it right (2014)
- Priorities of care for the dying (2014)
- Ambitions for Palliative and End of Life Care: A National framework for local action 2021-2026 (2021)

This H@H service will align to the Northwest End of Life Care Model, which supports people to live well before dying with peace and dignity in the place of their choice. This service will provide care provision for patients that are in phase two – four on the model.

The North West End of Life Care Model



5.1 Related Policies and Procedures

- Complaints
- Governance
- Gift acceptance
- All ECH Health and Safety Policies
- All ECH HR Policies
- All ECH Insurance Policies
- All ECH IT policies
- All ECH Clinical Policies
- Lone Worker Policies
- Driving at Work policies
- Weather Conditions Policy
- Personal Safety Policy

6.0 The Team

The team will consist of:

- Clinical Lead/s weekdays
- 1 Co-ordinator weekdays
- A team of trained nurses for out of hours support
- Multiple health care assistants working out of hours and during the day weekends.

6.1 Hospice @Home Manager

To direct the overall running of the service and support the team with annual appraisal, clinical supervision, objective setting, and continual service development.

The Hospice @Home Manager will report to the Director of Clinical Services and will engage with regular 1:1's and receive a documented yearly appraisal.

Role of the H@H Manager with Support from the H@H band 6 (H@H Clinical Leads)

- To manage and develop the team as per the Operational Policy
- Communication with all stakeholders
- To manage the on-going development of operational policies
- To facilitate the service off duty rota and annual leave
- To monitor standards of clinical care of the team
- To manage absence as Hospice policy
- To liaise with the Hospice's Senior Management Team, District Nursing Managers and other stakeholders in the review and future development of the team
- Undertake holistic assessments of referred patients and building on the information recorded in the District Nurse assessment to reduce the number of times the patient gives the same information.
- To liaise with referrers, to ensure the referrals for packages of care are appropriate and are accepted dependant on capacity.
- To liaise with referrers when the team is at capacity and ensure that referrals are redirected to CHC to source care.
- To ensure data on clinical activity for PCiP care is recorded correctly, to enable correct reporting for Finance Team and achievement of KPIs (Key Performance Indicators).
- To support data collection and ensure regular reporting to CCICP is undertaken
- Undertake risk assessments
- Will support the family, registered nurses within the team and HCA (Health Care Assistant) and build and promote good working relationships with the families, referrer, and Hospice staff.
- Agree with the patient and family a plan of care that H@H will implement coordinating with the DN (District Nurse) Care Plans and will liaise with all members of the MDT (Multi-Disciplinary Team) to provide seamless care.
- Assist and support rapid discharge from hospice or hospital.

6.2 Care Co-ordinator

To support the clerical function of the team, including the collection and collation of activity data and feedback to demonstrate the worth and value of the service.

A care co-ordinator will have access to Clinical and Medical support and links with the Sunflower Wellbeing Centre and In-Patient Unit at the Hospice.

The Care Co-ordinator will report to the H@H Clinical Leads and will engage with regular 1:1's and receive a documented yearly appraisal.

6.2.1 The Co-ordinator: -

- Support the H@H Clinical Leads to review and prioritise the referrals and will be a contact for phone enquiries.
- Support the H@H Clinical Leads to manage the organisation of patient visits for the shift and delegate appropriately to other members of the team.
- Support the H@H Clinical Leads to ensure all care data is collated for reporting to finance and ICT team at CCICP.
- Liaise with the referrer and patient/carer if needed.
- Offer bereavement support via the telephone and signpost if necessary
- Support a handover of patient changes at the end of each shift

6.3 Registered Nurse

The Registered Nurse will report to the H@H Clinical Leads and will engage with regular 1:1's and receive a documented yearly appraisal.

The service will be supported by registered nurses out of hours. They will offer care and support to patients and their families within the patient's home.

- A full induction programme will be completed, including some practical clinical experience within the Hospice and community (see education programme).
- On-going education and training will be offered to all staff to enable the Hospice @Home Team to develop a good skill and knowledge base in the specialist and complex areas of end-of-life care.

6.3.1 Clinical Role of the RGNs in the H@H team

- They will provide cover in the absence of the Co-ordinator at weekends and carry out the necessary duties to ensure the service remains functioning.
- The registered nurses will support the Clinical Leads and Co-ordinator to ensure the service meets high standards of care delivery and support the HCA's in delivering the care.
- The ability to make a full assessment, plan care and document all details of visit on Emis.
- Regularly review the care provision for patients and liaise with Clinical leads when required.
- Liaise with the District Nurse Team following the assessment visit by phone or via Emis records outlining the plan of care
- Liaise with the District Nurse team and OOH (Out of Hours) GP if there any changes with the patient following Hospice @Home visits
- Assist OOH Doctors to support patients in their preferred place of care e.g., home, nursing home, and residential homes.
- Provision of high-quality palliative care to patients and carers, using enhanced communication skills, offering emotional, psychological, and spiritual support
- Support the administration of medication if required during the Hospice @Home visit, as prescribed on the blue community form following the 'Standard Operating Procedure – **Administering Medicines in the Community Setting -.** The SOP has been agreed between the Hospice and Foundation NHS Trust.
- Work to a shift pattern that covers a 24-hour period with differing levels of staff.
- Support nurse verification of expected death in the absence of a GP or DN.
- Support the discharging of patients from the service following review and support of their needs.
- Use moving and handling equipment as provided by the DN service and work directly with DN's providing nursing care to patients

6.3.2 non-clinical role of the RGN

- Participate in education, mentoring and support for new starters, HCAs (Health Care Assistants), students and other HCPs visiting the team.
- Participate in the collection of data and audits for the Hospice @Home service
- Ensure knowledge and skills are up to date
- Support for Health Care Assistants
- Participate in clinical support meetings.

6.4 Health Care Assistants

Will offer care and support to patients and their families within the patient's home.

- A full induction programme will be completed, including some practical clinical experience within the Hospice and community (see education programme).
- On-going education and training will be offered to all staff to enable the Hospice @ Home Team to develop a good skill and knowledge base in the specialist and complex areas of end-of-life care via the hospice and the EOLP (End of Life Partnership).
- Regular forums delivered by the EOLP will be available to gain staff feedback, provide senior and peer support and continued education and training.

The Health Care Assistants will report to the H@H Clinical Leads. The HCA's will receive regular 1:1 support from the Clinical Leads or nominated registered Nurse and receive a documented yearly appraisal.

6.4.1 Clinical Role of the Health Care Assistant

- Provision of high-quality palliative care to patients and carers, using effective communication skills, offering emotional, psychological and spiritual support
- To assist in the implementation and delivery of holistic patient care including personal hygiene, supervision or prompting of medication.
- Use moving and handling equipment as directed by the Registered Nurse and joint working with members of the DN team using recommended safe M&H procedures
- Use other equipment supplied on FP10, by AHPs or DNs within own knowledge, skills and limitations
- Work to a rota pattern covering 7 days a week 24 hours a day
- Organisation of daily workload in conjunction with the coordinator and other members of the team
- Documentation of care given on Emis as per policy and guidelines.
- Participate in daily handovers and ensure information regarding changes in the patient's condition is reported to the coordinator and/or DN team

6.4.2 Non-clinical Role of the Health Care Assistant

- Participate in education and training sessions for the team and Hospice staff
- Participate in the collection of data and audits of the H@H service
- Participate in regular HCA forums and provide feedback about the developing service
- Assist in the stocking and ordering of supplies for the East Cheshire H@H and ensuring equipment is returned and maintained correctly
- Participate in clinical H@H staff support meetings

6.5 Recruitment and Training of staff

The H@H service is a cost-effective high-quality service, all new staff will receive an induction which will include:

- Understanding standard operating procedure - Health and Safety; Moving and Handling; Undertaking risk assessments; Managing conflict; Lone working; and Infection control
- Communication skills
- Symptom management/ Symptoms experienced at the end of life
- End of Life Care (Personnel care, mouth care, suction if available at home)
- Medication management
- Management of palliative care emergencies
- Supporting families and managing distress
- Process of the verification of death
- Record keeping and Documentation
- Use of Emis and Lone worker devices
- Working safely- clocking in, contact numbers, partnership working, communication, handover

We envisage the staff may need to work with other health care providers during the induction period, which may include:

- Shadowing other community teams, working within other hospice services ie. IPU, SFC, Macmillan, District nursing team - twilight and overnight service and Social Care teams.

7.0 Accommodation/Contact

The team will be based at East Cheshire Hospice, Millbank Drive, Macclesfield, Cheshire SK10 3DR. tel: 01625 664999

Email address – cmicb-cheshire.echospiceathome@nhs.net

- Each member of staff on shift will be allocated a mobile phone, working iPad tablet for professional use only when attending a visit or an allocated sit and a lone worker device and a bag with supplies.
- Use of satellite navigation on the mobile phones
- Equipment required to assist a patients' needs will be assessed at the point of referral and form part of the risk assessment. Any equipment required and not in situ will be recommended by the team to the current nominated key worker i.e. DN during the handover process.

Once the referral has been accepted the Clinical leads / Co-ordinator/registered nurse will:
- Prioritise if a home visit is needed by the H@H service.
- If a home visit is appropriate make arrangements to visit the patient/family.
- Plan/undertake an assessment with the patient / carer.
- Prioritise the visit, keeping the referrer patient/family fully informed.

7.1 Hours of Operation

The East Cheshire H@H Service will operate

- **Day Time Care** - Monday – Sunday 7.30am -21.30hrs providing planned care for patients in the last 3 months of life that will be sourced through Continuing Health Care. (inc. Carer Breaks)
- **Rapid Response** - Monday – Friday overnight from 21.00hrs – 8am Weekdays and 24 hours a day Saturday and Sunday a rapid response to care provision and crisis support.
- There will be a co-ordinator on duty 9.30-5.30 Monday to Friday to answer calls and assist with the planning of care for the following 24 hours.

7.2 Shift Pattern
- 9.30-5.30 (variable) weekdays Co-ordinator/Clinical leads
- Monday - Sunday 7.30am -21.30pm planned care visits
- Weekends – 7.30-1.30pm planned visits, assessments & rapid response
- Weekends – 1.30 -9.30pm planned visits, assessments & rapid response
- Every Night - 9-8-night assessments & rapid response (night sits if available 10pm - 7.00am)

7.3 Night support/Sits, when capacity allows
- Night sitting hours will usually be from 10.00 pm to 7.00am
- PCiP Night support will be available following assessment of need, and will be provided either by the hospice @home rapid response team or Marie Curie

- If the required availability cannot be met, the patient's name will be added to a waiting list and the referrer and patient/ family will be notified by the Co-ordinator of progress and be given 24hrs notice (when possible) of service availability.
- The waiting list will be prioritised on clinical need based on discussion with the referrer and the Clinical Lead. (Waiting list data will be recorded to inform service development).

7.4 Response Times

This is a seven day a week service. The Clinical Lead will be available to accept referrals between the hours of 9.30am-5.30pm. Thereafter it will be the registered nurse on the evening/night service from 6.30pm and 24 hours during the weekend and Bank Holidays. On receiving the referral, the nominated nurse accepting the referral will use a RAG system to prioritise the referral and will respond accordingly with the family and referrer.

- RED – *high/urgent needs* – rapid change in condition, complex symptoms in the last hours or days of life, rapid discharge, carer crisis, pre-admission – Response to referral the same day. Attendance response as soon as capacity allows based on clinical assessment.
- AMBER – deterioration in the last days or weeks of life, awaiting care package, potential breakdown foreseen, respite for carers – Response to referral the same day. Planned intervention within 24-48 hours if appropriate.
- GREEN – may not be appropriate for H@H at this stage, or the team can make contact with referrer and hold on file for up to 12 weeks then medical records will be reviewed and potentially discharged from the service. Referrer will be notified if discharged from the service.

8.0 Systems of Working

8.1 Palliative Home Care

- H@H will have a palliative home care team available from Monday-Sunday 7.30-21.30 hours
- Will provide packages of care for patients who would have been accepted through the Continuing Health Care fast track criteria.
- Referrals for palliative day care will only be accepted if the team has capacity, all other referrals will be diverted back through to CHC utilising the CHC fast track paperwork to reduce the need of duplication on a H@H referral form.
- Palliative day care patients will automatically be accepted for rapid response should the need arise.
- All palliative day care patients will be subject to a review of need and will be formally assessed at week 10. If the patient's condition has stabilised and the patient is no longer thought to meet the FT criteria, a complete DST assessment will be required for ongoing care.

8.2 Rapid Response

- H@H will have a **Rapid Response team** available during out of hours Monday – Friday 9.30pm -8am and 24 hours a day Saturday and Sunday to respond rapidly dependant on patient need.
- The **Rapid Response** team will support patients OOH with a rapidly deteriorating condition, those in crisis or those who require support through CHC, but no care packages are available.

- Any patients referred to **Rapid Response** that require Domiciliary Care, need to be referred to CHC via the Fast-Track Referral procedure, to enable a package of care to be procured.

8.3 Assisted Discharge Home

- H@H can offer assisted discharge support in individualised cases that are considered by the discharging MDT to be complex in order to support patients to be transferred from Hospice to their own homes.
- In the case of a patient's own home being a residential care setting, support can be agreed in the discharge planning process with the residential home staff and community services.
- The support required will be patient centred and offered on assessment of identified need. It will not replace community support but enhance and enable an integrated care approach to sustain a discharge.
- H@H will offer support for a transitional, agreed time, in accordance with the care manager/s i.e. District Nurses and H@H team. This will be documented and agreed in the patient's record and care plan.
- A designated date will be set to review the support after the discharge to home to ensure a timely and co-ordinated handover to the community.

8.5 Night Sits

- If a night sit is required, referrals can be sent into the H@H team utilising the Marie Curie [MC] referral form.
- Patient referral will be added to Emis and address contact details and nursing and medical assessments will be shared with MC.
- H@H will know the weekly availability of night sits and will co-ordinate and allocate care for patients on a weekly basis
- The Co-ordinator/registered nurse will advise the referrer and family when a night sit is allocated, informing them of the time of visit. They will ensure the H@H contact details are given in case there is any change in condition or circumstances that the sitter would need to be informed of. The MC HCA will follow the Lone Worker Policy to maintain safety.
- The MC HCA will contact the patient/carer before arrival to gain consent and introduce themselves, and upon arrival at the house will offering their identification badge.
- On the first visit from H@H, the staff member will provide the patient/family with copy of the H@H information leaflet and contact details.
- At each visit the MC HCA will confirm with the family arrangements if patient's condition deteriorates (particularly if they are not staying at the premises) ie who should be contacted/ hand over of care arrangements.
- The MC HCA will access the care plan and district nursing notes either from the referral sent through to MC co-ordination centre prior to the allocation of the visit or via Emis taking particular note of the patient's care plan and risk assessments.
- The H@H team will inform the DN team and leave a voicemail to advise them that care has been allocated, and the MC HCA will have contact details for rapid response team and District nurse should they need assistance at any time.
- Any care delivered will be documented and emailed directly to the H@H team following the shift and will be scanned and attached to Emis or documented on Emis if the MC sitter has access to the system.
- During the sit the MC HCA will provide their own beverages and food which will only be consumed around the care needs of the client.
- Staff are not allowed to smoke during the whole sitting service being provided.

- The work mobile phone is only to be used for work related issues and should be kept fully charged for each sit.
- The Co-ordinator/registered nurse will have regular contact with the referrer regarding the service delivered and re-assessment of the patient.
- If for any reason the MC HCA cannot undertake a planned sit, he/she will contact the MC Co-ordination team who will re allocate a carer and will inform the H@H office if before 9pm.

8.6 Administration

- Staff will be informed of the process for gaining patient and carer feedback and will be given the resources to gather this information when the opportunity arises.
- If feedback has not been obtained during the period of care, following completion of each patient's period of care a feedback form will be sent by the H@H co-ordinator to the named carer/patient for feedback to inform further service development.
- Patients on the active caseload should meet criteria stipulated above and require regular contact from the H@H team (from several times a week to monthly depending upon need).
- The H@H co-ordinator will be responsible for supporting the Clinical Lead in recording the activity data and collating evidence of quality indicators as determined by the steering group.
- Team members utilising the H@H pool car will need to complete the required documentation inside the vehicle following each use – mileage, driver, passenger.
- Each team member will submit their mileage claim forms Electronically to be approved by the clinical lead (if using their own vehicle) which will be countersigned by the Clinical Lead on a monthly basis.
- The Clinical Lead will hold team meetings to gain feedback, offer support, discuss service development, and identify continual education and training.
- The Clinical Lead will set quarterly team meetings to ensure support and service development is maintained.
- The Clinical Lead will ensure clinical supervision and appraisal is available for the team.

8.7 Documentation

The H@H service complements existing care services and will support current assessments/care plans on Emis, provided by the Community teams ie. DN's GP's and SPCT. All Emis records provide the details of the patient's history and current clinical condition and recent consultations.

The H@H team will undertake an assessment which will identify the problem that they have been asked to help support and an overview of the patient's clinical condition. This will include clinical observations where appropriate, and the use of clinical tools to support the assessment. This will be completed on the Holistic assessment on Emis, ideally during the patient visit using the virtual desktop portal on the mobile tablet. An action plan/summary of care will be completed following the assessment. In the event that Emis fails there will be paper notes available which can be copied and will be scanned onto Emis at ECH.

8.8 Discharge Criteria

- Patients on the active list will be assessed at least every 4 weeks by the clinical lead & MDT as this service is not a long-term care package.
- If the patient's condition stabilises and is deemed to no longer fit the criteria for the H@H service longer term care packages will be pursued vis CHC or Social care (and discussed with care managers ie District Nurses) if the care is needed for longer than 3 months.

- Assessments will be carried out in a timely way to ensure the patient has ongoing support beyond the 12 weeks via another health care provider.
- Admission elsewhere. The POC will remain open for up to 7 days (if discharge is a possibility) upon admission, therefore the POC will not be allocated to another patient.
- Death

8.9 Re- Referral
Patients can be referred back into the service after discharge if their care needs change and they meet the referral criteria.

9.0 Contacting the Hospice @Home Service

Health Care Professionals can contact the service on the land line number 01625 664999 (with answerphone availability) or mobile. Answer phone messages will be checked on a regular basis and out of hours calls will be diverted to the mobile phone.

In the first instance, patients should contact the District Nurse (Key Worker/caseload holder) for medical and nursing support. Patients and relatives can contact the Hospice @Home team to make visit changes.

10.0 Patient / Professional Information

Information regarding the service is available in a booklet for patients and professionals. There is also accompanying information to support the referral form. Patients will be given a booklet on the first assessment with details of the service and the visits planned. All leaflets are available on the East Cheshire Hospice website for downloading/printing by other HCP's.

11.0 Service Communication

The team will communicate with the GP and District Nursing Teams as follows:
- Completing the clinical documentation on Emis at each visit contemporaneously
- RGNs administering medication will follow the **Administering Medicines in the Community Setting - Standard Operating Procedure** as agreed with the ECNHS Trust.
- The team will attempt to make contact with the District Nursing prior to any trained input that may be required and following any input of care as they remain the main co-ordinators of patient care.
- The team will coordinate the allocation of night support visits with the Marie Curie service
- The team will handover between each shift.
- If a Night sit is to be supported, the MC HCA on the night shift will contact the H@H Rapid response team to inform them they have arrived at the house and to introduce themselves, this is an opportunity for the H@H team to update the MC HCA with any clinical information about that patient and offer support during the night if required
- Team Meetings will be planned Quarterly to review the service, discuss compliments and complaints, incidents and changes to the service.
- Team Meeting will be minuted and disseminated as appropriate

12.0 Handover and Review of Patients

The Hospice @Home team will participate in a dial-in handover at 7.30am and 9.30pm with district nursing colleagues if appropriate, or leave a voice mail with any important information, to support the transition of care from Nights to Days and vice versa.
If contact cannot be made, then email confirmation will be sent via NHS mail.

Patients known to district nursing services will be visited as standard the following day by the district nursing team if a rapid response visit has been facilitated overnight. A handover, either by phone or Emis, will be given directly to the DN team involved if any interventions have been required overnight.

Handover contact details for Tel numbers of all DN services locally can be found in the H@H office.

13.0 Multidisciplinary Team

A Global multidisciplinary team meeting will be held with hospice and community health care professionals at 09.15am on a Thursday. The H@H team will prepare the MDT proforma (Handover list) for all patients on the current caseload for discussion. This MDT will provide clinical supervision for staff.

13.1 Referral to the Specialist Palliative Care Team

Patients known to H@H will be handed back to the district nursing service for review, if the patient is unknown to the SPCT and staff feel a visit is required, a discussion will take place and a referral to the service actioned in the usual manner.

13.2 Referral to District nursing services

Patients assessed by Hospice @Home who are not known to District nursing services, a referral can be made for district nursing input via the usual referral process.

13.3 Referrals to other services Ie Night Support from Marie Curie

Referrals for night care will come directly into the Hospice @home team via NHS email on a Marie Curie referral form or within the CHC fast track referral. The H@H service will co-ordinate the night support and work in collaboration with Marie Curie. (see SOP for PCiP H@H and Marie Curie)

13.4 Assessing for an inpatient admission

Following an assessment, if an admission to the inpatient unit is required for a patient from the H@H service, it will be presented to the senior nurse on duty on the IPU, and discussions with the admitting Medical Officer undertaken. The IPU will liaise with the family and community teams if an admission is appropriate.

An admission should have the full consent of the patient or family member and the patient should be well enough to be moved safely.

14.0 Verification of Death

If the patient dies whilst the H@H team is on duty, the registered general nurse will follow the guidance as per policy for verification of death and complete the required documentation, ensuring all partner agencies are notified. Verification of death can only be carried out by a nurse if GP Authorisation form is in situ and available or it is clearly documented in the patients Emis notes as per Nurse Verification of Death Policy.

Patients whose death is witnessed by the team - a CQC form requires completion

15.0 Confidentiality

- All patient information is confidential. You must follow and adhere to the Confidentiality Policy and Procedure and the Data Protection Policy and Procedure.
- All information regarding patients and documentation that is identifiable to your role, or the visit should not be left on view in the car.

- All documentation relating to patients should not be left on view in the office including patient names on office whiteboards and message books. All documentation with patient identifiable information should be locked away when not in use.
- Patient details should not be discussed in open places where there is a possibility of being overheard.
- All information relating to staff and patients at East Cheshire Hospice is confidential and should not be shared outside or commented on social network sites (see NMC guidance and hospice policy)

16.0 Equality and Diversity

East Cheshire Hospice @Home service aims are to create a workforce that is diverse, promotes positivity, and instils a can-do attitude in everyone, no matter their background or characteristics.

East Cheshire Hospice will not discriminate any member of staff, patient or carer on the grounds of any protected characteristics and will promote an environment free of discrimination and prejudice. Everyone will be treated fairly, with respect, and will be given equal opportunity in every aspect of their working role or care.

17.0 Absence

17.1 Annual Leave

Annual leave entitlement is pro-rata depending upon hours worked within the service. The annual leave will be requested via SMI and await authorisation from Team Co-Ordinator/Lead. Annual leave should be recorded on the shared calendar.

17.2 Sickness

All staff should ring and speak to the Clinical Lead (or nurse in charge) to report sickness, if possible, the day before the shift or 2 hours before the commencement of the shift. Night staff should ring by 12 noon. Text messages or emails are not acceptable. If possible, they should indicate how long the absence will be and inform the manager when they will be returning (see employee handbook for details of fit notes and pay). If there is no Hospice @Home nurse available, the sickness needs to be reported directly to the IPU nurse in change.

All staff will have a return-to-work interview at the beginning of the first shift after sickness. The Clinical Lead will stay in contact with staff when absent on sick leave (see handbook).

17.3 Other Absence

See handbook, Dr's appointments etc. should be arranged for days off. Other absence to discuss with Clinical Lead.

18.0 Off Duty and Requests

Off duty is completed for the current and the following month only. A minimum of 6 weeks off duty will be published. Requests maybe declined for operational reasons and will be accommodated if the service provision allows. Five requests per month are allowed for full-time RGNs and HCA's and 3 requests for part-time staff.

19.0 Claiming Expenses

- The base will be the Hospice. Therefore, their mileage will be calculated from the Hospice to patient's home and return to Hospice.
- The H@H pool car is available for use by the team delivering care. ID checks and supply of documentation needs to be completed and given to HR by each member of staff before they can drive the car. All mileage needs to be documented before and after journey on the paperwork supplied in the vehicle.
- All mileage forms when a staff own vehicle is used, should be completed with the postcodes of the homes visited and the mileage covered during the day. Mileage starts when leaving the Hospice and finishes at the Hospice at the end of the shift.
- Mileage forms are completed, signed and given to the Clinical lead by the dates supplied on a monthly basis, by the finance team.

20.0 Data Collection

The team will:
- complete an admission and KPI template on Emis when referred into the service for each patient.
- complete a discharge template on Emis when discharged from the service for each patient.
- Qualitative user feedback will be requested from collected each patient or their identified carer/NOK after each intervention period and analysed for key themes and trends.
- MDS reporting.
- Audit

Clinical Audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care and the implementation of change. Aspects of the structures, processes and outcomes of care within the Hospice @Home team will be selected and systematically evaluated against explicit criteria.

Where indicated changes are recommended, they will be implemented at a service level and further monitoring will be used to confirm improvement in health care delivery within the service.

The Hospice @home service will have identified Audits within the Hospice Annual Audit plan.

21.0 Gifts/Donations

No gifts or money for personal use can be accepted by staff. Donations for the Hospice should be placed in an envelope and countersigned by the donator and member of staff accepting the donation.

22.0 Health and Safety

22.1 Health and Safety within H@H Team

All employees must adhere to the East Cheshire Hospice Health and Safety Policy and have suitable training and be competent to be able to do their job. With respect to health and safety training all new employees must attend induction training on the first day of employment.

The Clinical Lead will ensure all staff have access to training.
It should cover:
• The basic rules and procedures for the department
• Explanation of what to do in an emergency situation

• First aid arrangements i.e. The Nurse in Charge is a nominated person
• Health and safety responsibilities on a day-to-day basis
• How to report incidents and near misses
• How to report faulty equipment

Departmental environmental risk assessments will be completed yearly

All patients will have environmental and moving and handling risk assessments completed on during the first assessment and will be updated at a change in condition or reassessed weekly.

22.2 Incident Reporting

All patient and staff accidents should be reported by completing the hospice incident e-form on the East Cheshire Hospice intranet which will be distributed to relevant managers automatically. (See ECH Incident Reporting Policy). Any Significant Events should be reported to the shift coordinator and an RCA (Root Cause Analysis) completed, with any PCiP significant events being reported to CCICP also.

23.3 Skyguard Devices/ Lone worker devices

Team members are issued with a device for their personal protection and safety whilst on domiciliary visits. This remains the property of the Hospice (see Employee Handbook for care of Hospice equipment). Training will be given and procedures must be followed including the testing of the device monthly. It must be fully charged whilst on duty and switched off at other times.

N.B. Each employee is responsible for replacing the hospice mobile phone and Skyguard device once they have finished with its use.

23.4 Laundry

Slide sheets may need to be laundered - soiled slide sheets should be placed in a red bag inside a clear bag and labelled “to be returned to H@H team”. The bag should be left in the laundry bin outside the laundry office, located near the in-patient unit. The slide sheet should then be replaced in the team bag

24.0 Medication Checking and Monitoring

- The H@H service will use the medication checking pro-forma when instigating medications in the patient’s home for the management of symptoms.
- This form /blue book should be completed at the time of the intervention and used to assist the RGN and HCA to document fully what has been administered on Emis. This acts as a reference point for the hospice and district nursing service.
- Blue prescription booklets and pink prescription sheets will be used for administering medication.

25.0 Stock

Catheters, a limited supply of dressing, gloves, aprons etc will be available in the equipment bags which each team will take with them during the shift. Hospice @Home administrator will complete an order form for supplies and in preparation for ordering on a Friday morning along with the IPU stock requests. This will enable Hospice @Home to keep a comprehensive list of consumables.

26.0 Quality Monitoring

ECH prides itself on providing the best End of life Care and is keen to measure the levels of quality within this new service. Quality can be measured in a number of ways and as an organisation we are keen to capture and engage services users and their families.

Key performance indicators are used to assist in the monitoring and effectiveness of the service.

We will measure quality using several strategies which include:

- OACC suite of measures in palliative care.
- Accompanied and supervised visits
- Monitoring of the complaints, compliments, and incidents processes
- Undertaking Audits
- Monitoring our key performance indicators for the service
- Training of staff/ Mandatory training
- Fulfilling our obligations for CQC monitoring

As an organisation, we believe that our staff are our biggest asset, we will provide supervision to staff to assist in maintaining their own health and resilience in supporting families with distressing and complex psychological needs.

27.0 Responsibility and Accountability

- The Hospice CEO and Clinical Director has ultimate responsibility for the strategic direction of the service and the reporting outcomes to the board of trustees.
- The H@H Manager has overall management responsibility for the service, and for managing the staff within the team
- The co-ordinator for the team will support the day to day running of the service
- Each team member has the responsibility to adhere to the hospice policies and best practice when delivering care.
- Staff need to remember that the behaviours of the team will impact on the reputation of the entire hospice.

28.0 Governance

Clinical governance ensures that patient care is the main focus and priority in hospices and each patient receives safe, high-quality care from everyone involved in looking after them.

The term hospice governance is used to emphasise the governance framework of East Cheshire Hospice and its policies apply to all areas of the organisation. The governance principles apply to all employees and volunteers.

See East Cheshire Hospice Governance Policy

The five pillars of the framework are set by the CQC are:

- **Safe**
- **Caring**
- **Effective**
- **Responsive**

❖ Well-led

28.1 Policies and Procedures, Monitoring and Review

- The service will operate within this standing operating procedure and utilise the East Cheshire Hospice organisational policies. The staff can access the policies via the hospice intranet.
- Additional policies include
- Lone worker
- Personal safety
- Weather conditions
- Driving
- Administration of medicine in the community

28.2 H@H KPI's & Operational Standards

KPI 1 – To maintain utilisation of all clinical services at specified levels as set out within the operational standards
KPI 2 – The impact and quality of care given at ECH will be measured and evaluated for all patients accessing clinical services
KPI 3 – Patients accessing clinical services within ECH will have the opportunity to discuss and plan for their future care

ECH	Unit	KPI
1	All Clinical Units	90% patients have a POS and AKPS OACC Outcome Measurement documentation
2	IPU & H@H only	85% of patients have documentation that that shows discussion and recording of PPC and /or PPD
3	IPU & H@H only	90% of patients have documentation that shows discussion and recording of Resuscitation status
4	IPU & H@H only	75% of people using these hospice services will be supported to die in their preferred place of death
5	H@H	90% of referrals requiring H@H assessment / support are actioned within 24 hrs of referral receipt (patient acceptance permitting and clinical triage)
6		90% of referrals accepted into the service (H@H) will have an active EPaCCS record within 7 days. (include a pop up)
7		90% of H@H patients will have a GP OOH notification completed.
8		LOS within the PCiP day service (should not exceed 12 weeks)
14		Average Length of time care support is given (LOS Days)
	All Clinical Units	Number of referrals received per service
	All Clinical Units	Number of referrals accepted / supported per service
	All Clinical Units	At least one member of the senior clinical team will attend joint MDT meeting each week

	All Clinical Units	All clinical incidents are reviewed & responded to by a senior clinician within 24 hours (or the following working day)
	All Clinical Units	All CQC & HSE SAEs reported within specified timeframes (24 hours and 1 week)

28.3 Palliative Care in Partnership Hub KPI Data Collection

KPI ID	KPI detail
KPI-1	90% of people known to the service will be recommended to be on the GP Practice Gold Standards Register or equivalent
KPI-2	75% of people using the service will be supported to die at home where this is their Preferred Place of Death
KPI-3	90% of caseload will have Actual Place of Death recorded on EPaCCS
KPI-4	Coordinated point of access to the service in place
KPI-5	90% care packages set up within 48 hours (as per pathway)
KPI-6	No. of referrals received for service
KPI-7	No. accepted and supported with care packages
KPI-8	Length of time patients supported through service (or no. of patients receiving package over 12 weeks)
KPI-9	Case Manager (e.g., District Nurse / Macmillan Nurse / GP) notified of all significant changes in patient needs within 48 hours
KPI-10 i	90% of referrals accepted to the service will have an EPaCCs record set up within 7 days that shows discussion and recording of: • Advanced Care Planning • CPR Status • Preferred Place of Care • Preferred Place of Death
KPI-10 ii	Advanced Care Planning recorded
KPI-10 iii	CPR status recorded
KPI-10 iv	Preferred place of care recorded
KPI-10 v	Preferred place of death recorded
KPI-11	GP Out of Hours to be notified of all patients accepted by the service as an expected death by the co-ordinating hub through the “special notes” system within 48 hours
KPI-12	Care will be provided to support 90% of patients without delay to enable Preferred Place of Care to be achieved
KPI-13	Patients are offered volunteer led support on referral to the service

28.4 Applicable National Standards

Compliance with national standards and evidence of appropriate NHS good practice guidelines for information governance and security, include: -

- NHS Confidentiality Code of Practice.
- Appropriate information security standards.
- Use of the Caldicott principles and guidelines.
- Policies on security and confidentiality of patient information.
- Risk and incident management system.
- Good practice guidelines for maintaining patient electronic records.

http://www.nice.org.uk/guidance/qualitystandards/endoflifecare/home.jsp

- NICE Guide for commissioners on end of life care for adults - http://www.nice.org.uk/usingguidance/commissioningguides/endoflifecare/endoflifecareadults.jsp
- The Preferred Priorities for Care End of Life Programme, December 2007
- Gold Standards Framework www.goldstandardsframework.nhs.uk
- Department of Health. New Deal for Carers. 2007. www.dh.gov.
- http://www.nice.org.uk/guidance/qualitystandards/endoflifecare/home.jsp
- NICE Guide for commissioners on end of life care for adults
- http://www.nice.org.uk/usingguidance/commissioningguides/endoflifecare/endoflifecareadults.jsp
- NHS operating framework 12/13 - http://www.dh.gov.uk/health/2011/11/operating-framework/
- Palliative Care Funding Review - http://palliativecarefunding.org.uk/wp-content/uploads/2011/06/PCFRFinal%20Report.pdf
- NHS Institute for Innovation and Improvement The Productive community www.institute.nhs.uk/productivecommunityservices
- NHS Institute for Innovation and Improvement The Productive Community Hospital www.institute.nhs.uk/productivecommunityhospital

28.5 Applicable Local Standards

- Always act in accordance with professional Codes of Conduct and guiding documents.
- Adhere to all organisational policies, procedures, guidelines, and standards of behaviour.
- Ensure that any issues are reported which are a risk to the health and safety of themselves and/or others.
- Maintain up to date skills and knowledge.
- Ensure the promotion of safety, well-being and interests of patients, staff, and visitors to the department.
- Comply with Infection Prevention and Control policies and procedures as appropriate to their role and responsibilities in their individual work setting.

29.0 Partner Agencies

Interdependencies within the PCiP H@H hub

The Palliative Care Hub will be required to establish positive working relationships with other providers including local authorities, social services, the independent and voluntary sectors.

- CCICP
- CWP - CART
- East Cheshire NHS Trust
- St Johns Ambulance
- Northwest Ambulance Service (NWAS)
- District nursing services
- Community Matrons
- Community Macmillan Team
- Marie Curie
- Social care
- Discharge Team
- Commissioners from CCGs (Clinical Commissioning Groups)
- End of Life Partnership

29.1 Services Available across East Cheshire at Evenings/ Night

- **East Cheshire OOH**
  Provide medical cover across East Cheshire
- **Northwest Ambulance Service (NWAS)**
- **District nursing services evening and night service**
  Twilight service- 5 members of staff working from 6.30-10pm based at MDGH
  Night service- one qualified nurses covering East Cheshire supported by an HCA 10pm-8am
- **Social Care**
  Marie Curie- Primary Night Service working in collaboration with East Cheshire Hospice
- **Continuing Health Care Team [CHC]**

NHS funded continuing healthcare is the name given to a package of care arranged and funded by the NHS for people outside of hospital who have ongoing healthcare needs.

People receiving continuing healthcare can be living in any setting including their own home or a care home. NHS continuing healthcare is free, unlike help from social services for which a financial charge may be made, depending on your income and savings. This means that the NHS will pay for assessed health care needs. In a care home, the NHS also pays for care home fees including board and accommodation.
01625 663 808.

29.2 Discharge Team

Based at MDGH, the service works from 9-5 pm Monday-Friday and 9-12 Saturday, Sunday, and Bank Holidays. The team support ward staff to facilitate complex discharges, and fast track discharges for patients at the end of life wishing to be at home. They support the commissioning of packages of care and support discharges to home or nursing home environments and undertake Continuing health care assessments and place patients in nominated homes

30. Education/Learning Requirements

PCiP will provide a consistent approach will be provided to training and support of the workforce across Cheshire, in conjunction with partners who will deliver a robust training program and to ensure that staff competency is assessed to enable high quality palliative care

is provided to patients and their families. The training for the unregistered members of staff will consist of physical needs, psychological support, communication, and bereavement care.

The End-of-Life partnership organisation will provide support to all Hubs as part of the Education and Learning requirements and co-ordinate monthly staff forums, supported by a Facilitator/Educator in each of the three Hub areas.

Staff Forums will include an element of ongoing education and training. Content will include the following, but can also be adapted in response to staff feedback and issues/risks highlighted: -

- Palliative and End of Life - what to expect.
- Communication skills and difficult conversations.
- Symptom management.
- Advance Care Planning.
- Safeguarding.
- Emotional resilience.
- Loss, grief, and Bereavement.
- In the event of a death/care after death.

Location of all Provider Offices for PCiP

The provider's head office is located at:
Cheshire and Wirral Partnership Trust
Redsmere Building
Countess of Chester Health Park
Liverpool Road
Chester
CH2 1BQ

Appendix 1

INTERNAL PROTOCOL FOR HOSPICE @HOME

PURPOSE

An internal protocol for the Hospice @Home team to ensure that all staff are aware of housekeeping, organisation of the team and expected standards and behaviours.
Reference –

- East Cheshire Hospice Employee Handbook
- NMC Code of Conduct
- East Cheshire Hospice Policies and Procedures

OFFICE EQUIPMENT

Mobile Phones

All team members are issued with a mobile phone to use whilst on duty. This remains the property of the Hospice and staff should read the relevant section in the Employee Handbook before signing for the phone.

The phone is to be switched on whilst on duty and turned off at other times. The phone is integral to the Lone Worker procedure and important for communication with other members of the team. All mobile phones should be put on silent whilst in a patient's house and diverted to voicemail.

Use of Personal mobile phones are prohibited whilst on duty.

Laptops / Tablet devices

For shared use within the Hospice @Home team

- All staff are to start and finish their shift at the Hospice
- All laptops/tablets must be taken on patient visits to complete the documentation whilst in the patient's home
- It must be signed out at the beginning of each shift in the designated book
- It must be signed back in at the end of the shift and placed on the docking station to be charged for the next person
- Laptops/tablets must be transported in the bags provided and always stored out of view in the car
- Laptops/tablets must be taken into the patient's home to complete documentation unless there are exceptional circumstances discussed with the team manager or coordinator
- The laptop/tablet should be cleaned with Clinell wipes between visits and when returning to the Hospice (including the case).
- Refer to the Employee Handbook re personal use

Clinical bags

- All bags must be signed in and out at the beginning and end of each shift
- At the end of the shift ensure that the bag is restocked ready for the next user
- Bags must be stored out of view whilst in the car and not left in cars overnight
- Bags must be taken into the patient's home

STANDARDS FOR CONDUCT

Appearance

Remember that you are a visitor in the patient's home and a representative of the Hospice. As such your appearance must be smart and professional. Your uniform should be clean and ironed and free of any badges other than hospice identity badges. You are supplied with a coat and cardigan. Cardigans must not to be worn during any clinical procedures.

Smoking

Smoking by staff is not permitted in any area of East Cheshire Hospice, the Hospice Pool Car or in vehicles that are being used during community shifts. For staff working overnight it is always prohibited on duty. The use of electronic cigarettes is also prohibited; the charging of E-cigarettes is against the Fire Policy.

Sickness/absence reporting

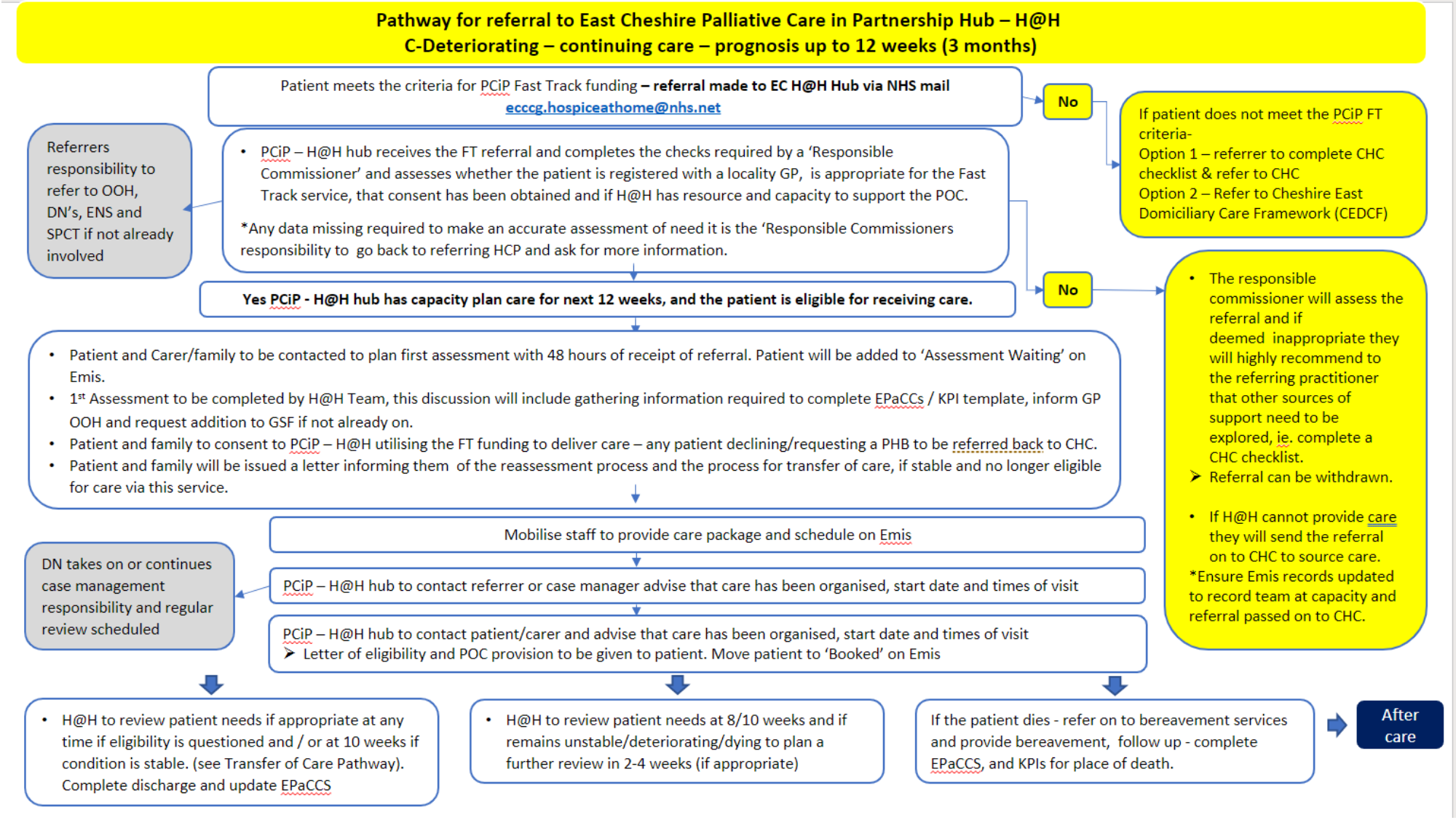
Report to Clinical Lead as soon as it is apparent the staff member is unfit for duty. In hours, this should be via the hospice telephone number. Should a member of staff become unfit for duty during the shift this should be reported to the nurse on duty in the In-patients unit and arrangements be made for the other team member to return to the unit in accordance with the lone working policy. Patient visits should be re-organised and communicated to the district nursing service.

Complaints, Compliments and Concerns

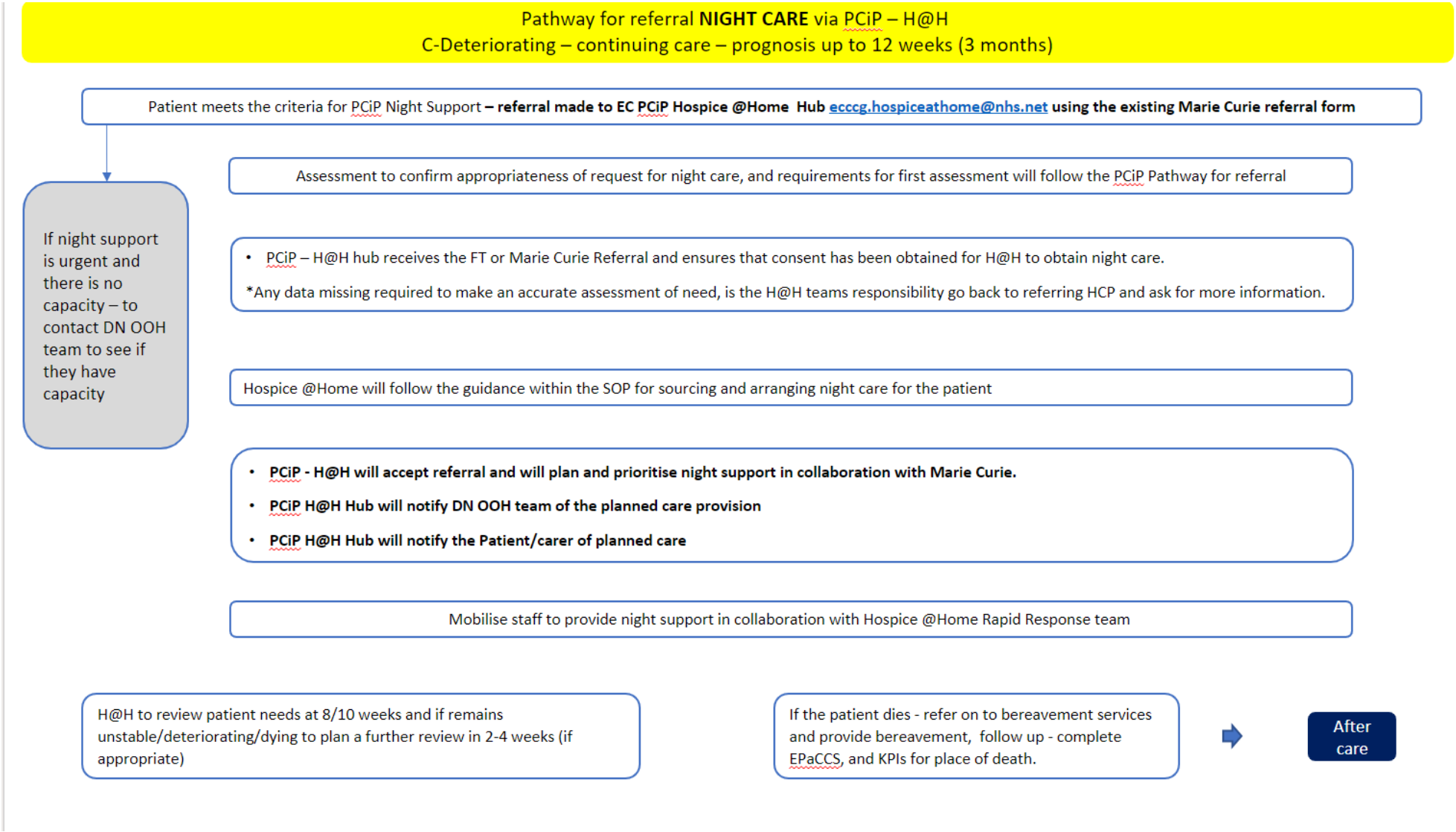
The appropriate Hospice policy should be followed in relation to complaints and concerns.

Compliments provide a balanced view for the service, any compliments, verbal, in writing should be forwarded to the Clinical Lead to be included in the clinical governance report.

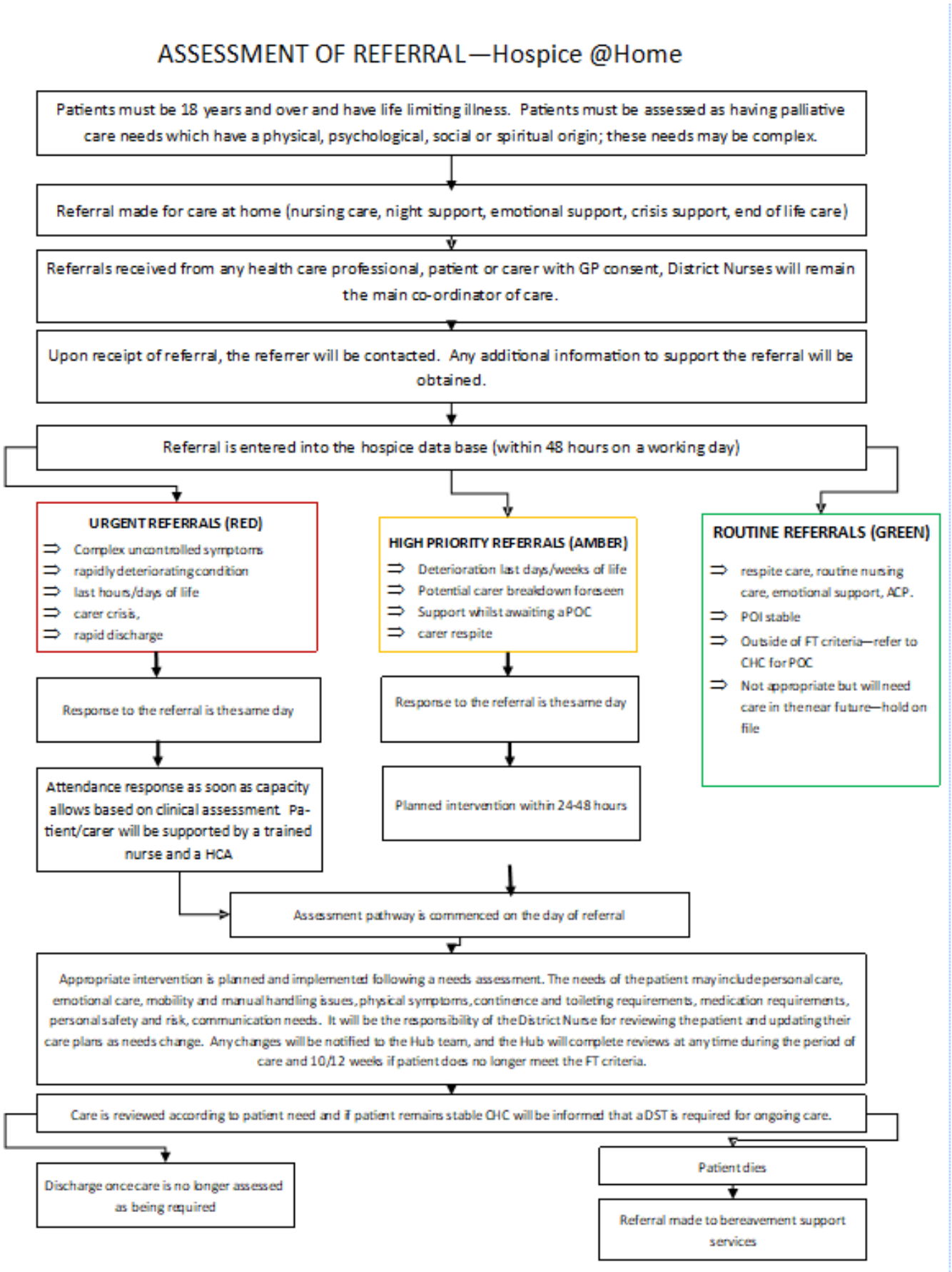
Appendix 2a Pathway for Referral



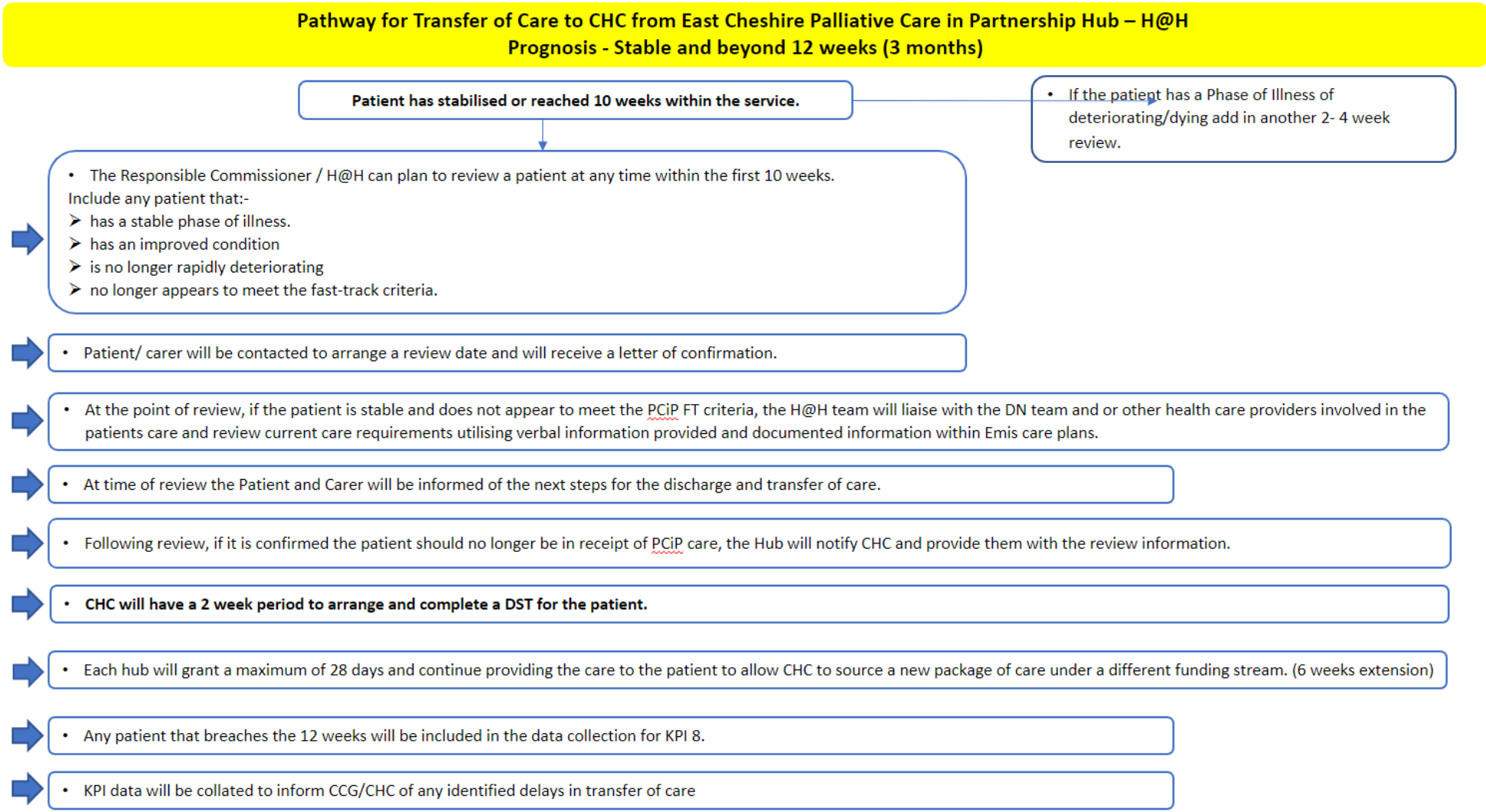
Appendix 2b Pathway for Referral for Night Support



Appendix 3 Acceptance of Referral Pathway



Appendix 4 Transfer of Care / Discharge Pathway



Appendix 5 PCiP H@H and Marie Curie SOP

East Cheshire Hospice @ Home
Changing the future of hospice care

Palliative Care in Partnership – East, Night Care Provision

Hospice @Home and Marie Curie Standard Operating Procedure

Marie Curie
Gofal a chefnogaeth drwy salwch terfynol
Care and support through terminal illness

Marie Curie are commissioned to deliver 5 x guaranteed overnight support visits per week (Sunday – Thursday)
Marie Curie [MC] will populate a rota and send to Hospice @ Home every Monday morning for that week , including update if HCAs visit pets/smokers. The rota will be sent to Hospice @Home via secure NHS mail to **ecccg.echospiceathome@nhs.net** and Hospice @Home hub will acknowledge receipt of email.
Patient allocation is on a daily basis before 5:00pm (Monday – Thursday). Sunday's patient to be allocated on a Friday . A Reserve List will also be compiled by Hospice @ Home should the original patient be cancelled.

Hospice @Home will register the patient on Emis, ensuring KPI data is entered, prioritise and allocate the night care to an available MC Health Care Assistant [HCA] . The MC referral will be populated through Emis, containing all essential information, date of care delivery and care plan. This is shared with the MC HCA on the day of the visit. Ensure COVID screening questions are asked and included

Hospice @Home will send patient details, Care Plan and Risk Assessment to MC Care Co-ordination Centre via secure NHS mail. lat.northwest.mariecurie@nhs.net (Data Sharing agreement in place) MC Care Co-Ordination Centre is Operational from 08:00am – 22:00 telephone contact 0151 541 7808 . Hospice @Home request a 'Read Receipt'

Hospice @Home will advise patients/families of the planned visit (names of the MC HCA will not be given at time of booking due to potential last minute changes occurring). The MC HCA will make a curtesy call at 9pm to the Patient as a formal introduction and to gain consent for the visit. The MC HCA will also contact the H@H rapid response team at the beginning of their shift, to introduce themselves and ensure there are no clinical updates H@H – 01625 664999

* If care is cancelled at late notice and no patient available on a Reserve List, H@H will contact MC Co-ordination centre before 5pm to inform them and reallocate the HCA if possible. This relocation will need to be communicated to the MC staff.

*Sickness will continue to be reported directly to MC CNM/SN in hours, and PCiP hub will be notified of any updates asap. MC will be responsible for finding alternative cover for this shift where possible. If sickness occurs out of hours MC will liaise with the PCiP and advise.

*Any Complaints or Incidents involving MC staff will be reported directly to MC CNM/SN in hours and logged and investigated through MC processes. H@H will be notified ASAP to log within the PCiP incident reporting system.
MC will be responsible for investigating incident involving the staff member, and will keep the PCiP hub informed of the process and outcome via NHS mail.

Patient Death to be communicated to the H@H Rapid response team overnight including the MC Hub and MC Admin Team. Any future bookings will need to follow the reallocation process.

Handover notes following the shift will be uploaded to Emis byt the HCA if they have access via their remote tablets or emailed through to the H@H team and scanned and attached to the patient notes