LINDSEY LODGE HOSPICE AND HEALTHCARE

Inpatient Unit Operational Policy

Version 3 April 2021

Purpose of the policy

- To outline the aim and purpose of operation for the Inpatient Unit at Lindsey Lodge Hospice
- To outline describe the delivery of care offered within the Inpatient Unit, including Symptom management, End of Life, Rehabilitative Care and Respite care
- To provide clear information about roles within the Inpatient Unit
- To highlight the key principles involved in the delivery of care within the Inpatient Unit
- Guidance document for new and existing staff/volunteers
- To highlight criteria for direct access by ambulance service to the hospice during day time hours 7 days a week

Philosophy and model of care

The Inpatient Unit, implements a collaborative medical and rehabilitative model, providing holistic and patient centred care.

The Inpatient Unit follows National Guidance set out by National End of Life Care Strategy and NICE Guidance.

Lindsey Lodge Hospice is a member of the locality Multi-Agency End of Life Strategy Group and the relevant subgroups.

Care is delivered based on CQC Key Lines of Enquiry and Lindsey Lodge Hospice vision and values:

✓ **Our vision**

Lindsey Lodge Hospice provides specialist palliative care to patients with life-limiting conditions and supports their family and carer's during illness and into the bereavement period.
We aim to further develop the highest quality of care in North Lincolnshire, meet individual needs and facilitate choice.

We aspire to be a responsive and innovative organisation and become a centre of excellence with our service users at the heart of all we do.

✓ **Our mission**

We will ensure income generated from the local area is focused on our priorities of providing a safe and welcoming environment along with offering physical, emotional, social and spiritual support to patients, their families and carers.

We will invest in our workforce, nurture creativity and support empowerment in order to generate ideas that will deliver high standards and good practices.

Partnerships and collaborations will be encouraged, forming trusting relationships in the interests of our patients and staff.

✓ **Our values (key priorities)**

Caring, compassionate, facilitating choice

Acting with professionalism and respect

Responsive to the needs of our patients, families and carers

Excellence in all that we do

Patients admitted to the Inpatient Unit are able to access the following services:

- ✓ Nursing care, 24 hours. Registered Nurses on duty every shift
- ✓ Paid Respite care
- ✓ Medical review on a daily basis Mon-Fri and as required out of hours
- ✓ In house Physiotherapists, including access to managing breathlessness expertise
- ✓ In house Occupational Therapist, including access to fatigue management expertise
- ✓ Lymphoedema
- ✓ Complementary Therapies
- ✓ Family support(available to carers also)
- ✓ Counselling and Pre/Post bereavement support(available to carers also)
- ✓ Clinical Psychology (provided by NLaG, but pathway of referrals through the hospice)
- ✓ Chaplaincy
- ✓ Activities
- ✓ Meals tailored to their taste, consistency or portion size.
- ✓ Hairdresser (voluntary service)
- ✓ Foot care specialist (private business in partnership with the Hospice, costs applied to treatments)
- ✓ Beauty Therapist (private business in partnership with the Hospice, costs applied to treatments)
- ✓ Referral to other services as appropriate, i.e.: Dietician, SALT, Clinical Nurse Specialists, District Nurses, Tissue Viability Nurses etc….
- ✓ Family events are accommodated where possible, i.e. patient weddings, renewal of vows, birthdays and anniversaries

Introduction

The Inpatient Unit has 10 beds, one of which is a Respite bed. Specialist Palliative care for Symptom management and End of Life care are offered to patients with a life limiting illness after an initial referral is received from a Healthcare professional.

Any patient (18years+) with a terminal diagnosis registered with a GP within North Lincolnshire can access the services of the Inpatient Unit. A limited Service Level agreement is in place to take referrals from Goole and Lincolnshire. Out of area referrals are discussed with the Director of Nursing and Patient Services prior to acceptance.

Staffing structure

The following structure highlights the roles of staff working within and alongside the Inpatient Unit

<table>
<tr><td colspan="6">Chief Executive</td></tr>
<tr><td colspan="5">Director of Patient and Nursing Services/Deputy Chief Executive/Registered Manager</td><td>Medical Director</td></tr>
<tr><td>Senior Nurse (In-patient unit)</td><td>Wellbeing Centre Manager</td><td>Registered Counsellor</td><td>Volunteer Services Manager</td><td>Clinical Specialist Physiotherapist</td><td rowspan="3">Doctors/Medical Team</td></tr>
<tr><td>Deputy Senior Nurse
Clinical Development Sister
Hospice Liaison Nurse</td><td>Wellbeing Centre Deputy</td><td>Bereavement Support Worker/Administrator</td><td>Volunteers (co-ordination) incl: Chaplaincy</td><td rowspan="2">Lymphoedema Nurses/Therapists</td></tr>
<tr><td>Registered Nurses
Healthcare Assistants
Advanced Assistants
Volunteers (day to day)
Housekeeping</td><td>Registered Nurses
Healthcare Assistants
Counselling
Therapies incl: Complementary Therapy, Volunteers (day to day)</td><td>Bereavement Support Volunteers</td><td></td></tr>
</table>

The Inpatient Unit also supervises roles for medical students, student nurses, student therapists and work experience placements.

Clinical Staffing Levels

The Inpatient Unit runs to the following establishment:

- Inpatient Unit Senior Nurse (Registered nurse) – Band 7 - 37.5 hours (total)
- Inpatient Unit Deputy Sister / Hospice Liaison (Registered nurse) – Band 6 – 37.5 hours (total)
- Advanced Nurse Practitioner (Registered nurse) – Band 7 – 37.5 hours (total)
- Registered Nurses x 13 – Band 5 – 311 hours (total)
- Advanced Assistants x 3 – Band 3 – 42.5 hours (total)
- Healthcare Assistants x 11 – Band 2 – 236.15 hours (total)

The Inpatient Unit is open 24 hours a day over 7 days.
The day is divided into 3 shifts: Early: 7.00am-3.00pm. Late: 2pm – 10pm. Night: 9.30pm-7.30am.

The morning shift has as a minimum of 3 Registered Nurses and 2 Healthcare Assistants. (1 of these is the Senior Nurse 4 days out of the 5, as the Senior Nurse has one administration day per week)

The afternoon and nightshift has 2 Registered Nurses and 1 Healthcare Assistant.

Staffing levels may vary according to patient acuity/dependency levels. Acuity levels are undertaken during morning handover by the Senior Nurse or her Deputy. Authorisation for additional staff to support acuity of patients is agreed with the Director of Nursing and Patient Services.

A team of volunteers provide support in the operational running of inpatient unit by offering beverages and contributing to the social element and activities. Suitable roles are allocated by the Volunteer Services Manager. They are required to attend Induction and any relevant mandatory training. They are a vital part of the Inpatient Unit team.

The staff rota system is electronic and is developed and managed in line with the Hospice Rostering Policy.

If staffing levels are below the minimum requirement for the day due to unforeseen circumstances, attempts are made to supplement with permanent or bank staff. If staffing levels are below the minimum requirement and replacement staff cannot be sought, consideration would be made stop admissions into any empty beds until safe staffing can be resumed. This would be a last resort once all other avenues have been exhausted.

Medical cover

Medical cover for the Inpatient Unit is overseen by the Medical Director. There is one full time Speciality Doctor and one/two GP trainees.

Out of hours there is a rota of non-resident on-call doctors who provide telephone support or face to face assessment for inpatients who require clinical review. There are arrangements within medicines management policies to allow out of hours doctors to remotely prescribe medications other than controlled drugs, providing that doctor feels happy to prescribe without face to face assessment. Rotas are provided and stored in line with the hospice rota policy

Every doctor who works within the hospice undergoes formal appraisal and GMC revalidation outside of the organisation (local NHS Trust or GP appraisal) and a letter in support of their work is provided where this is required, following an informal appraisal process with the medical director.

Allied Health professionals

Within the inpatient unit, referrals are made to other multi-professional teams within the hospice as appropriate – physiotherapy, occupational therapy, complementary therapy, lymphoedema, chaplaincy, family support, activities therapist. Referrals can also be made to allied professionals outside of the hospice –psychology, rehabilitation team, SALT, dietician, district nursing, community matron. We also liaise with other professionals involved in the care such as General Practitioner, specialist nurse, tissue viability nurse, hospital consultants.

Roles and responsibilities

Each patient admitted to the inpatient unit will be allocated a named nurse. During shifts that the named nurse is not working, an alternative nurse will be nominated. It is the responsibility of the named nurse (or nominated nurse) to look after the patient during their shift.
They are responsible for co-ordinating the care for the day and referring to other members of the team as appropriate.

Referral criteria

Patients may be referred to the Inpatient Unit if they fulfil the following inclusion criteria:

- Age over 18 years **AND**
- Palliative or terminal diagnosis **AND**
- Physical symptoms that are difficult to manage in their current place of care **OR**
- Complex psychosocial needs that cannot be managed in the current place of care and require a period of specialist input **OR**
- End of life care where there are difficult symptoms to manage or the preferred place of death is the hospice.

It is important that referrers understand the services provided and limitations within the hospice.

Referrals are received from any health professional involved in the care of the patient being referred (typically, Specialist Palliative Care teams in hospital or community, community matron, district nurses, GPs). Family members may also make enquiries for admission for their loved ones. Where a patient is currently in hospital, in a care home or the referral has come from a family member, it is preferable for a referral to the Specialist Palliative Care (Macmillan) Team covering that location to assess the patient first to assess whether the transfer is appropriate, necessary or in the patient's best interests. Referrals can be made via a direct referral telephone ***07434 860292***.

This telephone may be rung 24 hours/day, 7 days/week. The senior nurse on the Inpatient unit will be in charge of the referral phone. They will take down some details about the patient by way of completing all sections of a referral form and ensure the patient has consented to the referral. All referral forms are kept in the front of the referral file.

Following morning hand over with the medical team (Mon-Fri), a review of bed capacity is taken and a review of the existing referrals made. Prioritisation of the existing referrals takes into account the information on the referral form and any updates that are available. Staffing and dependency levels are reviewed. Admissions will be arranged for the patient with the highest priority into an empty bed, providing there are sufficient medical and nursing staff to support a safe admission. It is feasible to admit two patients in a given day, providing there is medical cover for the unit into the afternoon. It is rare that the Inpatient unit would admit three patients in a given day, and this would depend on the clinical urgency and at the discretion of the clinical teams working that day. The inpatient unit is not able to currently support admissions out of hours. Transfers into the hospice need to be timely to allow the completion of initial assessment within normal working hours. For purposes of obtaining hospital transport, it may sometimes be necessary to plan an admission the day before.

East Midlands Ambulance Service (EMAS) direct access to Hospice admissions out of hours/weekends

EMAS can ring through to the SPA which is managed by the Northern Lincolnshire and Goole FT (NLaG), for which EMAS are aware and undertake this process, During Mon-Fri during usual hours, the call may be passed through to the hospice IPU. At a weekend, the call may be passed to the Community Macmillan team for further advice and review the plan of care. This step is required to determine if direct admission to the hospice is appropriate, rather than transfer to the acute Trust. This is necessary as some patients may have reversible symptoms for which acute admission is still the right option for that patient.

If it is deemed that the direct admission to the hospice is appropriate it must be ensured that

- The hospice has the correct available bed
- The admission must be agreed by the on call team
- The admitting Doctor must attend the hospice in order to admit and prescribe
- The patient must have a known covid test prior to admission so that we are aware of covid status – this will be facilitated by EMAS and SPA by using the community rapid response team – a negative lateral flow test would be accepted with a PCR test being undertaken on admission.

If appropriate, the patient will require a negative covid test completed. This can be achieved through the community swabbing team via SPA, and be requested a as a rapid test. The patient may require some interim support from the district nursing team (eg in the event of symptoms) before transport is then arranged to convey the patient to the hospice.

In some instances, the above process cannot be achieved for timely admission in the same day. In this situation, a plan with the community team may need to be made to keep the patient safe until admission can be arranged the following day.

Deputy Sister / Hospice Liaison Nurse

The Hospice Liaison service has been developed to work alongside the specialist palliative care team to facilitate appropriate and timely transfers to the Hospice from both the Acute Trust and the community.

The role involves daily visits to the Acute Trust to liaise with the Discharge liaison team, operations team and the specialist palliative care team. Ward visits take place within the role to assess suitability for the Hospice and to signpost if not appropriate.

The Hospice Liaison nurse may undertake a home visit if deemed appropriate.
Hospice Liaison contact number 07966 137422 - Monday to Friday.

Assessments

A number of assessments and screening tools are used within the Inpatient Unit to ensure holistic evaluation of the patients.
Most assessments and care records are on Systmone.

The plan of care for each patient is individualised for the patient's needs according to the problems raised or goals set by the assessments made.

Medical Assessment and review

On admission to the inpatient unit, all patients are seen by a member of the medical team for an initial medical assessment, covering past medical history, assessment of current problems, review of medications, details of any advanced care plans (including CPR status), agreement of the level of care to be delivered and a management plan. Current medications are then prescribed onto the hospice medication chart as appropriate, including appropriate anticipatory medications. Medical review is provided daily Mon-Fri and out of hours as required by the doctor who is on-call.

Initial Nursing Assessment and nursing care

On the day of admission, the named nurse for the patient will go through an initial nursing assessment, covering basic demographics, activities of daily living, likes/dislikes, dietary requirements, contact details for family/carers and a variety of risk assessments.

As part of our commitment to deliver patient centred care The Alzheimer's Society 'This is me' document is given to all patients to complete on admission. A family member or carer will complete this document if the patient is unable.

Carers' needs assessment will be undertaken during the patient's stay on the Inpatient Unit and carers may be signposted to other agencies as appropriate. The CSNAT is the assessment tool used at Lindsey Lodge Hospice. Carers will be supported at the Hospice or signposted to the appropriate agencies.

Ongoing assessment is undertaken whilst the patient is in the Inpatient Unit by both nursing and medical staff.

Hourly care rounds are undertaken by nursing staff.

Nursing Care Plans and Risk Assessments

All patients will have a clinical care record, and this will contain the following mandatory risk assessments and care plans:

Assessment type	Location	Process for completion
Initial assessment	Systmone/Paper	Completed during initial assessment visit. To be documented on Systmone. Paper copy to be filed in folder on IPU.
Consent to share information	Paper	Completed during initial assessment. Scan onto Systmone.
Integrated Palliative Outcomes Scale (IPOS)	Systmone	Completed on admission. To be repeated weekly or sooner if condition improves or deteriorates.
Karnofsky Performance Score and Phase of Illness	Systmone	Completed on admission and reviewed weekly or sooner if condition improves or deteriorates.
Moving and Handling (Inc: Falls)	Systmone	Completed on admission and reviewed as condition improves or deteriorates.
Post Falls Checklist	Systmone	Complete within 24 hours of a patient sustaining a fall. (May impact on moving and handling risk assessment).
Personal Emergency Evacuation Plan	Systmone	Completed on admission and reviewed weekly or sooner if patient improves or deteriorates.
Malnutrition Universal Screening Tool	Systmone	Complete in accordance with hospice policy.
Pressure Damage Risk Assessment	Systmone	Complete on admission within 6 hours. Complete in accordance with Hospice policy.
Pain assessment	Systmone	Complete in accordance with hospice policy.
Accessible information standard template	Systmone	Complete on admission and if any significant change in the patient's condition.

Delirium	SystmOne	Complete on admission and if significant change in patient's condition.
Mental capacity	Paper	Complete on admission and whenever consent is required, i.e. clinical procedure or decision is required from the patient.
Infection Control	Systmone	Complete on admission in accordance with Hospice Policy.
Wound assessment	Systmone	Complete on admission if wound/pressure ulcers present. Complete if Hospice acquired in line with Hospice Policy.
Emotional Pathway Assessment (including initial EMP form, emotional thermometer)	Paper	Complete as per IPU Emotional Pathway flowchart and in accordance with Hospice Policy.

Person centred care plans are reviewed daily and risk assessments are reviewed weekly unless there is a significant change in their condition. Additional care plans and risk assessment (such as Safeguarding and DOLS) will be carried out as clinically appropriate.

Emotional Pathway Assessment Form

All patients are assessed for their suitability to undertake the Emotional Pathway Assessment during their first 48 hours of admission. Exclusions will include End of Life patients and patients who lack mental capacity. The assessment aims to highlight any emotional difficulties the patient is experiencing and assesses emotional risk. This is undertaken by Registered nurses using the IPU Emotional Pathway flowchart as a guide to suitability.

Integrated Palliative Outcomes Scale

Within the first 24 hours of admission and at weekly intervals patients are taken through the Integrated Palliative Outcome Scale. This is completed as much as possible by the patient, but where the patient is too unwell, proxy measures may be taken by staff as appropriate. This is used to highlight any outstanding issues that are not already known about or being addressed. The results are documented onto the questionnaire template within the SystmOne record and can be used to compare trends and monitor progress.

Karnofsky Performance Score, Barthel, Phase of Illness and Level of Care/OACC Measures

On admission and at weekly intervals, the Karnofsky Performance Score, IPOS, Barthel, Phase of illness and Level of care is reviewed and documented. This is recorded within the templates on the SystmOne record where applicable.
Phase of illness and levels of care are also reviewed where there is a change in the medical condition of a patient.

Advanced Care Planning

During admission, patients are offered the opportunity to discuss Advanced Care Plans. As part of these conversations, patients may be offered a My Future Care Plan document for them to read and start to complete with their family or loved ones. All patient rooms have blank copies of the My Future Care Plan document available of patients to look at. Patients will be asked about their preferred place of care and preferred place of death, if this was not covered on initial assessment. Any specific plans will be recorded within the Palliative Care Template on SystmOne. CPR status should be reviewed and discussed with patients as part of the initial medical assessment. There are local Trust 'What Happens if My Heart Stops' leaflets available to aid with the discussion. It may not be appropriate to have that discussion on first meeting a patient, in which case this may be deferred until later in the admission. Attempts at CPR should be made in the event of cardiac arrest unless there is a DNACPR form completed in the case notes. As per national guidance, it may occasionally be necessary to make a medical decision not to attempt resuscitation, but it is anticipated that discussing this with the patient would cause them significant distress. If this occurs, then attempts to discuss this with patient's family/carers should be made and a clear explanation documented within the case notes and on the DNACPR form.

Multidisciplinary Meetings

All hospice inpatients from the preceding week are discussed in the weekly Locality MDT that involves consultants in Palliative Medicine, hospice doctors, Macmillan Nurses (community and hospital), Macmillan Therapists, hospice physiotherapist, Macmillan Social Worker, Family and Bereavement support team, a senior nurse from inpatient unit and member of the wellbeing team. Current issues, plans of care and advanced care plans are discussed. The regional Palliative Care Template on SystmOne is updated where appropriate and a record of the discussion is also recorded within the template. This is held within Lindsey Lodge Hospice.

Handover of patient care

SBAR Handover takes place at fixed times to support the changeover of clinical teams. Nursing handovers are at 7.00am, 2pm and 9.30pm.

Handover to medical staff and allied health professionals takes place at 9am Mon-Fri. Medical staff may also attend the nursing handover at 2pm to enable continuity of care and updates.

Handover is supported by the use of Systmone within the Inpatient unit. SBAR Handover sheets are available for all staff during these handovers. Handover is part of the Audit calendar.

SBAR is a structured method for communicating information to ensure increased patient safety and effective escalation. It reduces the incidence of missed communications and reduces barriers across different disciplines and levels of staff.

Situation	Identify patient, Ceiling of care, CPR status, reason for admission
Background	Medical history, next of kin details, password
Assessment	Care plans
Recommendation	Tasks to do, expectations, discharge plans,

Emergencies

Occasionally unexpected medical events occur. As much as possible these are anticipated, to understand patient wishes for the management of such emergencies. This forms part of Advanced Care Planning and Ceiling of Care discussions. Anticipatory medication may have been prescribed for predicted events. There is a set of clinical guidelines stored on the hospice L Drive in the Guidelines folder that may be helpful. In the event of uncertainty, it may be necessary to discuss with the duty doctor or call an ambulance for transfer to A&E. Any admissions to hospital must be reported via the Incident reporting database in accordance with Hospice Policy.

Intravenous (IV) therapies may be provided within the Hospice where deemed appropriate. It is not envisaged that patients on the Last days of Life Care Plan will receive IV therapies. Decisions to commence/continue IV therapies will be part of the Hospice MDT daily discussions.

Any admissions to hospital must be reported via the Incident reporting database in accordance with Hospice Policy.

There is an automated defibrillator located on the wall outside the 'Meet and Eat' restaurant just off main reception. An emergency trolley is available in the treatment room on the inpatient unit.

Respite Care

Criteria:

- Anyone who would be eligible to receive services from Lindsey Lodge Hospice.
- Patients with a life limiting condition.
- Two weeks maximum can be booked per episode of Respite.
- Respite can be booked on a regular basis subject to availability.

Respite can be booked for between 1-14 nights per episode. There are no limits to how many respite stays can be booked, this is subject to availability of the respite bed.
The bed cost is £100 per night, inclusive of all nursing care and meals.
During respite patients will also have an opportunity to access a range of activities and complementary therapies, which are bookable and payable through the Hospice team.

Emergency respite may be available subject to availability on the Inpatient Unit.

Respite care contact number 07396 561692 - Monday to Friday.

Respite Care Funding

There are several ways respite may be funded:

- Private/Self-funding
- Social Services – If in receipt of funding from social services for care, they may fund respite care
- Continuing Healthcare – May fund if currently in receipt of funding from them for care

If patient becomes unwell during respite stay

The Senior Nurse or her deputy will triage the situation and refer to the medical team for review if required.
The doctor will examine the patient and provide immediate assessment and treatment if required. The patient will then be "discharged back to respite".
If the patient requires on-going medical assessment then he/she will be reviewed by the medical team and will be "virtually transferred" to a hospice bed at the earliest opportunity for further management. If the patient requires hospital intervention the Hospice medical team will arrange this.

Discharge from Respite care

Discharge will occur on the planned day and will usually be 10am.
Transport will be booked in advance of the day of discharge.

If additional care needs have been identified as being required, during the period of respite, which may result in discharge not being safe, then:
Contact with carers and appropriate members of the MDT will be made during the respite period to arrange an additional review and an increase in care package if required.
Arrangements will be made for the patient to be moved to an alternative respite facility if appropriate whilst the review takes place.

Discharge from the Inpatient Unit

The Inpatient Unit is a finite resource and therefore cannot provide long term care for patients who do not require ongoing specialist input. This should be made clear to patients and family/carers on admission. Average length of stay on the inpatient unit falls in line with national averages for hospice inpatient units (14 days). Length of admission is not a fixed term and is dependent upon clinical need. If the clinical team (or the patient themselves) feel that the patient's clinical circumstances have been optimised and needs could now be supported via community teams or social care, then discharge will be discussed.

If the patient has ongoing deterioration and prognosis is very short (days to very short weeks) and the patient wishes to stay in the hospice, then they may stay for end of life care. Patients may decide to take their own discharge against medical advice and would be supported with this, providing they are assessed to have the capacity to make this decision.

Discharge planning and process follows the hospice discharge policy. Fast Track or Continuing HealthCare applications are completed where appropriate. Discharge planning meetings may be held for complex discharges to patient's home, involving community nursing teams and therapy staff, to ensure a smooth transition to home following discharge.

When a patient is discharged home and the Clinical/Medical team have concerns that 'things may go wrong', but the patient has capacity to make the decision to go home, a bed will be kept 'open' for 48 hours.

When a patient is transferred into the Acute trust for treatment the bed will also be kept 'open' and daily discussions will be undertaken with the hospital regarding the need for the bed to be held.

End of Life Care

Patients who are recognised to be nearing the end of their life are commenced on the locality Last Days of Life Document that guides the care of patients within the 5 domains of the Priorities of care. Family/carers are given the option to have open visiting and to stay in one of the family rooms at the hospice overnight if they wish or at the patient's bedside.

Following the death of a patient, nursing staff looking after the patient will formally verify that death has occurred and communicate this to the family/carers. They will also perform last offices. Family/carers are supported to stay with the deceased as long as they wish and may assist with last offices if they also wish. The family/carer's preferred funeral director is contacted for transfer of the deceased into their care by the nursing staff. The Medical certificate for the registration of death will be provided by the medical team at the earliest opportunity. Family/carers will also be provided with a booklet that offers them advice and guidance on the practical concerns following the death of their loved one.

For funerals involving a cremation, the medical team will also complete part one of a cremation form and arrange for part 2 to be completed by an independent doctor. The fee for completing the cremation forms may be donated to the hospice if the doctor wishes but they are not obliged to as sometimes this requires travel to the funeral director in their own time and at their own cost.

Bereavement Support

Initial bereavement support is given to the family/carers by the clinical team when a patient dies. This will usually include emotional support and also practical advice regarding funeral plans and registering the loved ones death. A letter is sent to the designated next of kin a week later offering condolences and support. There is an option on this letter to access Bereavement support at the Hospice.

A bereavement call is made to the family/carer by the nominated nurse after 4 weeks. If there is a wish to be referred for bereavement support then a referral is made to the Family and Bereavement Support Team following this phone call. A referral to the Family Support Team may have been undertaken prior to the patient's death to enable pre bereavement support to be given to the family/carers. The deceased patient's family/carers are encouraged to contact the Hospice if they need extra support at any time.

Training of staff

Induction

All new clinical and voluntary staff at the hospice undertake an induction programme that covers Information Governance, Infection Control and Prevention, Fire Safety Awareness, Health and Safety, Safeguarding Adults, Moving and Handling, Equality and Diversity and Communication Skills. In addition, clinical staff are also required to complete Medicines Management, Drug Calculations and practical Moving and Handling training.

Mandatory training

All clinical staff receive mandatory training that covers information Governance, Infection control and Prevention, Basic life support and use of automated defibrillator, Anaphylaxis, Risk management, Conflict Resolution, Dementia Awareness, Moving and Handling, Fire Safety Awareness, Safeguarding Adults and Children Level 2, Mental Capacity and Deprivation of Liberty Safeguards.

On-going training and development

Learning and development needs are reviewed on a continual basis and at annual appraisal to ensure that all staff are trained to provide safe, effective and compassionate care. There are opportunities to attend internal and external training events to reflect individual and organisational needs.

Supervision

All clinical staff at Lindsey Lodge Hospice attend mandatory clinical supervision. Attendance is reviewed through an annual appraisal process. There are nominated trained Clinical Supervisors within the Hospice. Records of attendance are maintained by the Clinical trainer.

Clinical Governance

Governance at Lindsey Lodge Hospice is overseen by the Board of Trustees. There are a number of board subgroups that meet on a quarterly basis. Clinical Governance (including Information Governance) is overseen by the Quality Assurance Subgroup. There is a separate Information Governance Team that meet quarterly. In addition, the Clinical Senior Management Team meet each week to discuss issues at operational level, and heads of departments attend monthly Team Leaders meetings.

Clinical audits are carried out on a regular basis to ensure the highest standard of care is being delivered. An Audit Calendar is maintained and reviewed quarterly by the Quality Assurance subgroup.

Incidents are reported in line with Lindsey Lodge Hospice Risk Management Policy, supporting an open and honest environment in accordance with Duty of Candour.

REFERENCES:				
ISSUE DATE October 2019 **Approved by Quality Assurance Sub-Committee November 2019**				**Frequency 3 years**
TO BE REVIEWED	REVIEW COMPLETED	BY	APPROVED BY	CIRCULATION
October 2022	April 2021	MG	QA Sub-Committee 19.05.2021	L:Drive Policies and Guidelines