

Herriot Hospice Homecare

Herriot Hospice Homecare

Inspection report

18 Omega Business Village
Thurston Road
Northallerton
North Yorkshire
DL6 2NJ

Tel: 01609777413
Website: www.herriothh.org.uk

Date of inspection visit:
30 August 2017

Date of publication:
01 November 2017

Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

This announced inspection took place on 30 August 2017.

The service was registered in 2013, it had an unrated inspection in 2014 and has been dormant (not in use) until recently. This will be the first rated inspection for the service.

Herriot Hospice Homecare is a domiciliary care service providing support and care for people in their own homes, who are on an end of life pathway. The service covers the local area of Hambleton and Richmondshire. Six people used the service at the time of our inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service worked under contract from the local Clinical Commissioning Group (CCG) and in partnership with a local hospice, MacMillan nurses and Marie Curie nurses as well as the district nurses as part of a community end of life team. There was some evidence of deficiencies in the management and oversight of risk across organisational boundaries within the partnership. The manager had recognised this and was actively working to mitigate any impact on people who used the service.

People told us they felt safe and well supported by the care staff. The provider followed robust recruitment checks, to employ suitable care workers, and there continued to be sufficient care staff employed to ensure home visits were carried out in a timely way. People's medicines were managed safely.

Care staff received appropriate training to give them the knowledge and skills they required to carry out their roles. They received regular supervision to fulfil their roles effectively and the manager planned to have annual appraisals completed when due.

People were supported to have choice and control of their lives and the care staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Where relevant, care staff helped people with their eating and drinking needs.

Care staff knew about people's individual care needs. People who spoke with us gave us positive feedback about the care staff and described them as, "Excellent, caring and knowledgeable." We were told the care staff treated people who used the service with compassion, dignity and respect.

People and staff told us that the service was well managed and organised. The manager assessed and monitored the quality of care provided to people. People and care staff were asked for their views and their

suggestions were used to continuously improve the service.

Further information is in the detailed findings below

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

There were processes in place to help make sure people were protected from the risk of abuse and staff were aware of safeguarding vulnerable adults procedures.

The manager was working with partner agencies to identify risks and take mitigating action to resolve these.

There were sufficient numbers of staff on duty to meet people's needs. Medicines were managed safely and staff applied creams as prescribed.

Is the service effective?

Good ●

The service was effective.

Staff received relevant training and supervision to enable them to feel confident in providing effective care for people. They were aware of the requirements of the Mental Capacity Act 2005.

People were provided with appropriate assistance and support and staff understood people's nutritional and hydration needs.

People received appropriate healthcare support from specialists and health care professionals where needed.

Is the service caring?

Good ●

The service was caring.

The people who used the service had a good relationship with the staff who showed patience and gave encouragement when supporting individuals.

Staff provided people with compassionate care, which respected their privacy and dignity.

People who used the service were included in making decisions about their care whenever this was possible, and they told us that they were consulted about their day-to-day needs.

Is the service responsive?

Good ●

The service was responsive.

Care plans were in place outlining people's care and support needs. The staff were knowledgeable about each person's support needs, their interests and preferences in order to provide a personalised service.

There was a complaints process in place, but people who spoke with us were happy with the service and had not needed to use it.

Is the service well-led?

Good ●

The service was well-led.

The service had a manager who supported the staff team. There was open communication within the staff team and they felt comfortable discussing any concerns with the manager.

The manager had recognised and was actively working to reduce deficiencies in the management and oversight of risk across organisational boundaries within the partnership.

Herriot Hospice Homecare

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 30 August 2017 and was announced. The provider was given short notice of the inspection because the service provides a domiciliary care service and we needed to be sure the manager would be available at the office.

One adult social care inspector and an 'end of life' specialist nurse carried out the inspection. During the inspection we visited the provider's office and also met with one person and their family in their own home after obtaining their consent to this. The other five people who used the service and their families were contacted about the inspection, but did not wish to speak with us.

Prior to our inspection we looked at the information we held about the service, which included notifications sent to us since the last inspection. Notifications are when providers send us information about certain changes, events or incidents that occur within the service. We contacted the local authority, the district nurses and MacMillan nurses prior to our visit. They had no concerns about the service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with the chief executive, the registered manager, two office staff and three care staff. We looked at three people's care records, including their initial assessments, care plans and risk assessments. We looked at medication administration records (MARs) where staff were responsible for administering medicines. We also looked at a selection of documentation pertaining to the management and running of the service. This included quality assurance information, audits, recruitment information for three members of staff, staff training records, policies and procedures, complaints and staff rotas.

Is the service safe?

Our findings

One person and their family told us that they felt safe when receiving care from the service. The relative told us, "The staff are good, every one of them."

Staff received training on making a safeguarding alert so they would know how to follow local safeguarding protocols. They told us they would have no problem discussing any concerns with the manager and were confident any issues they raised would be dealt with immediately. There was written information held in the service office about safeguarding and how people could report any safeguarding concerns. There had been no safeguarding alerts or whistle blowing notifications raised in relation to the service in the last 12 months.

The service worked with a local hospice and the district nurse teams to provide end of life care in people's homes and had a contract with the local clinical commissioning group (CCG). Referrals were sent to the service from the end of life care co-ordination team. The service had a risk assessment policy and procedure, which referenced that the district nursing team completed the initial risk assessments for people's care.

The manager told us they did not always get a copy of the risk assessments completed by the district nurse team prior to starting visits. However, the information was received from the district nurses, over the telephone, and was put onto the referral form by the manager. The referral forms we saw contained information of known risks and how staff were to mitigate these. Recorded risks included areas such as falls, moving and handling, environment and nutrition.

We noted that there was not always a copy of the initial risk assessments in the care file kept in people's own home. The manager had raised the issue about the risk assessments at the monthly operations meetings attended by all of the external teams. The manager had requested that the service had sight of these as a copy in the service office or within the care files in people's homes. The care staff observed for signs of on-going risk in people's homes during their visits, such as deterioration in mobility for example. This was fed back to the district nursing team, who were responsible for documenting the change in risk.

Accidents and incidents were recorded, analysed each month and audited to identify any patterns that might be emerging or improvements that needed to be made. Any changes to practice were used as part of the services' learning from events. For example, the manager found that staff were giving care to a person whose medical needs had not been disclosed to the service at the start of their care package. Staff had not received training on meeting these medical needs and this highlighted the poor discharge from the hospital and additional training required by the staff. The information from the incident was shared with the trainer at the hospice and its lead nurse, to prevent future errors. The manager then visited the person who used the service to ensure all appropriate documents including medication records were in place.

We looked at three people's medication records to check the way medicines were 'managed and administered' for people. Care staff were applying topical medicines such as creams for people who required assistance with this. The administration of the creams was documented on the medicine administration records (MARs). Information in people's care files indicated that either people were self-

medicating or their families took responsibility for administering tablets.

Medicines training was undertaken as part of the care staff induction process. The district nurses were responsible for writing the MARs in each person's home, so the care staff only had to sign to show when they had applied the creams. The manager told us that there were some delays in the production of the MAR charts, which had been fed back to the district nurse team. In these circumstances we saw that the care staff wrote in the daily notes when they had applied creams. We saw evidence in the operation meeting minutes – held with the service and end of life teams that the manager had raised this as an urgent issue. The manager told us that they also found it difficult to obtain the MARs for auditing from the district nurses who collected all documentation from a person's home following their death. The manager had raised this issue at the monthly operation meetings held with the partner services.

There were robust fire checks and processes in place for the office used by the service. However, fire training for the office staff required updating as it was last completed in 2014. The manager followed this up straight away with the provider's trainer and we received confirmation that it was booked for September 2017.

The provider employed the manager, two office staff and two permanent care staff plus seven bank care staff. They provided a total of 169 to 172 hours of care a month. The service operated from 8am to 10pm seven days a week, and the manager and another member of the office staff also provided additional cover for the care staff if needed. Families had an out of hours' palliative care contact number to ring if they needed assistance outside of the service operating hours. The out of hours' service run by the district nurses was called 'Fast Response'.

We saw copies of the rosters or 'run sheets' for the care staff. The office staff monitored and amended these on a daily basis. Changes to visits and people's needs happened very quickly due to the nature of the service and staff confirmed with us that any changes were relayed to them straight away. The office supplied each member of staff with a mobile telephone. Care staff sent a text to the services' on call system to say they were home safe at the end of their evening shifts. This was part of the services' lone working policy and procedure.

Robust recruitment practices were followed to make sure new staff were suitable to work in a care service. These included application forms, interviews, references and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups.

Is the service effective?

Our findings

One person and their family told us they were very satisfied with the service and staff. One relative said, "I have the support I need and staff are good with [Name of family member using the service]. Staff know how to handle them and raise their spirits when they are down or if they are not in the mood for support. Staff know how to talk with them too. They don't rush and always take time to listen to us. They are friendly and chatty."

Staff induction, training and supervision was completed jointly by the service and the hospice as part of their agreed partnership with the end of life teams. The hospice provided staff from the service with a training workbook as part of a three day programme of induction to ensure basic competencies of staff. Following induction staff took part in a training programme arranged during team meetings (also carried out at the hospice). This covered all aspects of training deemed mandatory by the hospice. It included subjects including infection prevention and control, dementia care and safeguarding. All care staff working in the service had a National Vocational Qualification (NVQ) level three or its equivalent. One member of staff told us, "Really good training, covering all aspects of the work we do and the care of palliative patients. It includes all of our mandatory training. It was really good, can't fault it."

Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. The responsibility for staff supervisions was a joint one between the service and the local hospice as part of its contract with the CCG. The manager carried out documented observations of staff practice; these were made available to us for viewing. These evidenced the manager monitored staff capabilities and competence levels and ensured their practice was effective. Staff who spoke with us said they were well supported by the manager. One staff told us, "I know I can have one to one supervision if I need to with my manager. I can speak to them in the office any time, but I have not needed to so much. It would be written down if I have." The hospice carried out two monthly clinical supervision meetings with staff and, on the day of our inspection, staff were attending a team meeting followed by their personal supervisions.

The service had only been operating since April 2017 therefore no annual appraisals for staff had been undertaken. The manager said they were aware of the need to get these planned into their diary in the future.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. Where people live in their own homes, applications to deprive a person of their liberty must be authorised by the Court of Protection.

We checked whether the service was working within the principles of the MCA. We found that training was provided for staff on the MCA. Staff we spoke with showed they understood the importance of consent and

we saw that capacity issues were explored when planning people's packages of care and support. People who used the service were asked to sign their care records to document that they consented to the care and support provided. At the time of our inspection no one who used the service was deprived of their liberty.

Emergency contact details for people's GPs and other professionals involved in their care were documented in their care records. People had access to 24 hour support through out of hours teams provided by the fast response service, local hospice, MacMillan and Marie Curie nurses.

Care staff offered support to people with eating and drinking where it was needed. One person who used the service told us, "I have no appetite now so I am not eating anything." Their family also said, "They are drinking plenty of juice, but our family mainly help them with this. The care staff would give [Name of person using the service] a sip of drink if they needed it."

Is the service caring?

Our findings

Positive feedback was received from the person and relatives who spoke with us. One relative told us, "The care staff come three times per day, give [Name] a full wash, do their hair, shave if they need it, move them up the bed because they slide down and do their creams. The care staff don't give [Name] their tablets, I do that. Usually two care staff attend."

Visit information was sent to the care staff the day before the visits were due. People were given approximate time slots for their visits prior to staff coming into their homes. One person said, "Yes we get everything we need from them" when we asked if they felt the support and care met their needs.

People were given information on the end of life care service in their area. The leaflet explained what the service was, how it worked and how it was funded (there was no cost to the people using it). It explained to people what other services were available in their area to help them identify if they needed further input from other health care professionals or community services.

The service worked alongside the district nursing team and the local hospice to provide end of life care. One health care professional told us, "There is no doubt that the team who are in place work hard and do everything they can to respond to patient needs. They are keen to work in partnership with the other providers involved in the patients' care. Certainly since Herriot (in collaboration with St Teresa's hospice) have set up the community hospice team there has been a significant improvement in the quality of end of life care and we have been able to support more patients wishes to die at home. They attend a monthly operational meeting for the new service and every effort is made to work in collaboration with the other agencies, respond to constructive comments and make changes where they are able."

We asked one relative what the service meant to them. They told us, "I can get on with other things when they are here. I didn't realise I'd get so tired and they give me a break."

One person said they were treated with compassion, dignity and respect. Their relatives confirmed to us that staff addressed them by their preferred name, gave them eye contact when conversing with them and were always polite and respectful when in their company. They told us, "The care staff are friendly and they always treat us with respect. They know our likes and dislikes as we can talk to them and they listen. We are not worried about the care and support being given as it is discussed with us and meets our needs (person and family)."

The manager understood the role of advocacy and had contact details available if anyone who used the service required the support of an advocate. An advocate is someone who supports people, particularly those who are most vulnerable in society, to ensure that their voice is heard on issues that are important to them.

Is the service responsive?

Our findings

One person and their relatives told us the service was responsive to their needs and went out of their way to assist them with any problems or changes to care and support that they might require. The manager told us that they constantly monitored the input from their staff and used feedback from staff, people and relatives to reassess the current care packages with the district nursing team.

The information given to us by the manager on the end of life referral process showed that the service was not responsible for the completion of the needs assessment, risk assessment and care planning of each person wishing to use the service. The district nurses completed the assessment, risk assessments and determined the package of care to be provided and this was referred on to the end of life co-ordination service provided by the Fast Response team. The co-ordination centre completed the referral form and sent this onto the service.

The district nurses wrote the care plans, which were kept in people's homes. If care staff from the service had any concerns or other feedback on people they contacted the office. Care staff were alerted to any changes to visits by the office staff.

We looked at the documentation present in the home we visited and found this was kept in two plastic A4 wallets and was a mix of documentation from the MacMillan team, district nurses and Herriot Hospice Homecare. The relative of the person who used the service knew what belonged to which organisation. There was a fast track care plan in place, which had been provided by the hospice; the information in this had been encrypted and emailed to the care staff upon the person's discharge and prior to the care staff's first visit.

The person we visited remained in their bed due to their physical condition. We saw that care staff were monitoring the person's pressure areas and documenting any concerns on the evaluation record in their file, although there was no evidence seen of a care plan for this. All entries we saw were dated, signed and the notes were legible.

We discussed with the manager the fact that the care notes required the person's name on the contact sheets and they said they would make sure this was amended straight away. We also spoke about better information sharing between the agencies making up the end of life support team. The manager was already aware of this and had brought it to the attention of the other services at their operation meetings.

There had been no complaints received since the service reopened in April 2017. The complaints policy and procedure was a joint one shared with the hospice and end of life team. The manager told us they had contributed to its development. We were shown a number of thank you letters from people's families who all praised the service and its staff for their care, support and professionalism.

Is the service well-led?

Our findings

The manager worked with partner agencies and the service staff team to ensure people's end of life needs were met. We asked people if they felt the service was well managed and they told us, "Very much so." In a recent audit of people's feedback (April 2017 to June 2017) 11 people noted that the care was "Absolutely brilliant" and "Outstanding."

The service was a registered charity and had a board of trustees. We met the chief executive during our inspection. The board of trustees met every three months and discussed the service and its progress. The manager attended these meetings and brought evidence from their quality assurance process to show how the service was performing and where any issues of concern may be. The partner agencies met with the manager every month to discuss how the partnership was working and what could be improved. The minutes of these meetings showed that there was assessment, monitoring and review of the service and discussion about its future and development.

We received positive comments about the service from the person, relatives and staff we spoke with. They told us the culture of the service was open, transparent and the manager sought ideas and suggestions on how care and practice could be improved. Reviews of people's care were carried out after two weeks and any issues discussed were recorded in people's notes. Staff attended meetings and had the minutes emailed to them.

Our observations of the staff workforce indicated that they were all motivated to support people to the best of their abilities; they were caring, patient and kind with people who used the service. Staff spoke warmly about the people they cared for and each other. They told us they felt proud to be a member of the team. Staff told us they were happy with communication within the service and felt that the encryption and email to their work phones of care plans was good practice, which enabled them to be effective in their jobs.

Staff had access to hard copies of policies and procedures within the office, but also had these emailed to their phones or could request a hard copy to keep. The policies had been developed with the partner agencies and were used throughout the teams.

The manager and a lead nurse from the hospice were responsible for completing audits of the service including spot check documents. There was some evidence of deficiencies in the management and oversight of risk across organisational boundaries within the partnership. We saw that the manager had recognised this and had raised the concerns for discussion within recent operational management meetings.

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager had informed CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

