

North London Hospice

# George Marsh Centre

## Inspection report

St Ann's Hospital  
St Ann's Road  
Tottenham  
London  
N15 3TH  
  
Tel: 02083438841

Date of inspection visit:  
15 November 2016  
16 November 2016

Date of publication:  
28 December 2016

### 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 inspection took place on 15 and 16 November 2016 and was announced. This is the first inspection of the service since its registration in December 2014.

George Marsh Centre is the base for one of the North London Hospices community teams that are registered with the Care Quality Commission. This service offers community services to people living in the London Borough of Haringey who have life-limiting or life threatening illnesses. At the time of the inspection they were supporting approximately 150 people. The other community services operate from Finchley and Enfield, in addition to inpatient beds at Finchley.

The North London Hospice offers an integrated service for people who have life limiting or life threatening conditions. It also provides educational support and advice, a bereavement service and district nurse support. There is a single point of contact for people in the community who are then referred onto the most appropriate service.

The community team consists of 10 people which includes clinical nurse specialists (CNS), an assistant practitioner, a social worker, administrative support, and a consultant and team leader. Anyone in the community is initially able to refer themselves or other people who have a life-limiting or life threatening illness. The service offers advice and support to people and their families. They also take on a broader role of educating others involved in end of life care.

The community team works with primary healthcare professionals to manage people's symptoms particularly around pain management. They provide an advice line over a 24 hour period, practical financial support, bereavement/counselling and support for people through their illness and death.

The service had a registered manager in post who was the Director of Clinical Services. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People were very positive about the support they received and told us staff were kind and compassionate. They told us staff listened to them, were respectful and tried to ensure they received care in line with their needs and wishes. The team works as part of Haringey partnership to offer an all-inclusive approach to people and their families.

New staff initially received an extensive induction programme and were consequently well trained. There was a focus on continuous professional development and learning. Staff told us they were well supported by their peers and managers. There were a number of forums where staff could raise issues and be supported to undertake their roles.

People received care that was personalised to their needs. They were supported to take as much control as they wanted of their lives and of their death. Care plans reflected their choices about specific needs and preferences; this included any cultural and spiritual needs. Care plans were continually revised so they were up to date and reflected the person's current needs.

Staff knew how to safeguard people at risk. They knew what action they should take if they considered people were at risk of harm or abuse. People received their medicines as prescribed and staff knew how to manage medicines safely. Risks to people's health and well-being were regularly assessed and action taken to minimise those risks.

The provider showed a commitment to providing high quality care and was continually striving for improvements. The trustees and managers of the service learnt from incidents and accidents. They actively sought feedback from people who used the service and their families. People felt able to raise any issues or complaints and the provider took any issues seriously. There was a rolling programme of audits so the provider could monitor the quality of the service provided and make improvements where required.

People's needs were carefully assessed and reviewed frequently. People told us they felt involved in care that was provided and that staff always carefully explained the treatment options available to them.

People told us that staff always sought their consent prior to care being given. Staff were trained and aware of the issues relating to the Mental Capacity Act 2005. If people were not able to give their informed consent, then best interests meetings were held and decisions were made with the involvement of the person's relatives and other healthcare professionals as required.

People told us they felt the service was safe. We checked the recruitment records for staff and saw that checks prior to employment were undertaken to ensure only suitable staff were recruited.

## 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. Staff ensured people received their prescribed medicines when they needed them and were as pain free as possible.

People told us they felt safe. Staff knew what action they should take if they suspected anyone was at risk of abuse.

The provider undertook recruitment checks prior to employment to make sure only suitable staff were employed. The provider tried to ensure there were enough staff to meet the needs of the local community.

The provider had arrangements to identify potential risks to people and put measures in place to mitigate against the risks.

### Is the service effective?

Good ●

The service was effective. Staff received extensive training which was refreshed regularly. Staff felt they were well supported by their peers and managers in their roles.

Staff knew about the Mental Capacity Act 2005 and how it impacted on their work. If people were not able to make decisions for themselves, then staff were aware of how to make decisions in people's best interests.

People were supported to receive the healthcare they needed both from staff who worked for the service and other health and social care professionals.

### Is the service caring?

Good ●

The service was caring. People and their families told us staff were kind and compassionate. They felt staff listened to them and their needs, but also considered the impact on their families.

People were involved in decisions about their care and the service was able to address people's diverse cultural and emotional needs.

The service provided a range of information, advice and access to additional support so people were enabled to be as independent as possible.

### Is the service responsive?

Good ●

The service was responsive. People's needs were comprehensively assessed and continually reviewed so they met people's changing needs.

People felt they were in control of the care they received and were kept informed of changes to their health needs and possible treatment options.

The provider had a positive approach to complaints and used them to improve the quality of the service.

### Is the service well-led?

Good ●

The service was well-led. There was a clear management structure in place. Staff were aware of the vision and direction of the service. The provider worked collaboratively with other health and social care agencies to achieve the best outcomes for people.

There was an open culture within the organisation. Accidents and incidents were monitored and used as a way to reflect on the quality of the service. There was a rolling programme of checks and audits within the service.

Feedback was actively sought from people and their relatives through a variety of mechanisms to enable the provider to monitor the quality of the service.

# George Marsh Centre

## 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.

This inspection took place on 15 and 16 September 2016 and was announced. We gave the provider 48 hours' notice of the inspection as the service is community based and we needed to be sure staff would be available to speak with us. The inspection team consisted of two inspectors, a specialist nurse advisor and an expert by experience who had personal experience of end of life care. We used the expert by experience and an inspector to make telephone calls to people in the community.

Before the inspection we reviewed information we held about the George Marsh Centre. This included statutory notifications of significant events the service is required to provide to the CQC.

We also looked at the hospice's most recent annual quality accounts report which services' commissioned by the NHS are required to complete. This report gives information about the quality of the service they provide.

During our inspection we spoke with 16 people who were receiving support from the community team based at George Marsh Centre and nine relatives. We spoke with various staff which included four community nurse specialists, an assistant practitioner, a consultant and the registered manager of the service. We also met three other head office staff. We attended the weekly multi-disciplinary team (MDT) meeting and accompanied clinical nurse specialists on two of their home visits.

We looked at documentation which related to the running of the service and its governance. We also looked at computer and paper records relating to nine people who used the service and staff recruitment and training records for three members of staff.

After the inspection we talked over the telephone with two community healthcare professionals who have contact with staff based at the George Marsh Centre.

# Is the service safe?

## Our findings

People told us they felt safe receiving a service from staff. One person said of the staff member that visited them at home, "They are more of a friend and they keep me secure and as happy as possible". Another person said, "They [nurses] contacted my GP on my behalf, when I didn't want to trouble him, and made sure I was safe."

People consistently told us how the Community Nurse Specialists (CNS) assisted them with their medicines to ensure their pain relief was managed as well as possible. Some comments we received included, "The nurse helped us get some new medicines after my [family member] said they were in pain and needed something to help ease it." Another person told us, "The nurse helped me change my pain relief medication and ensured I was put on the right drugs, so I'm in less pain these days."

Medicines were managed safely, although in general the service did not prescribe or administer medicines. People in the community were instead supported by their own GP with prescribing recommendations made by the service. If medicines were required urgently, the service had access to their own medical professionals who could prescribe medicines. The registered manager told us about their plans to extend training so in the future CNS's would be able to prescribe medicines if necessary.

We saw that CNS's would occasionally administer medicines and record they had done so. However, their continued competency to administer was not refreshed or reviewed. We discussed this with the Associate Director of Community Nursing who told us they had already identified this as an issue and had put measures in place to address the shortcoming. The Associate Director was able to show us a 'medication assessment test' they had already devised and were in the process of rolling out to all nursing staff in the community.

The service had taken reasonable measures to protect people from harm. Staff we spoke with were aware of their responsibilities to safeguard people and what action they needed to take if they thought anyone was at risk of harm or had been harmed. Staff received safeguarding people at risk training which was refreshed annually. Additionally, staff received face to face training which gave them an opportunity to discuss and share scenarios they may have come across to consolidate their learning.

The provider had safeguarding policies and procedures in place which made clear the services' role and guided staff through the process they might need to take. There was also a safeguarding lead within the organisation who was responsible for undertaking training and developing links with the local authority. Staff told us they could contact the safeguarding lead for advice when they needed to. We saw safeguarding people was regularly discussed at the MDT meeting which helped to ensure all staff were aware of issues for people and that appropriate referrals could be made if necessary.

We reviewed the provider's recruitment processes to make sure only suitable staff were employed by the service. We saw staff files contained completed application forms with proofs of identity and two references. Health and social care professionals remained registered with their professional body to ensure they

continued to be suitable to practice. Staff within the service were subject to criminal records checks at the point of being employed. However we noted the provider did not have a policy of renewing criminal records checks every three years in line with good practice. This meant the provider could not assure themselves of the continued suitability of staff to be employed by the service. We discussed this with the registered manager who told us they were in the process of reviewing this policy.

The provider had systems in place to identify and manage possible risks to people. We saw there were risk assessment documents which covered areas such as the environment, moving and handling, falls and personal safety. Each possible risk was assessed and management plans were developed to outline what action needed to be taken to minimise the risks, for example the use of two nurses to support some people who needed help with moving and handling.

We saw the provider had also identified areas of concern which may affect the continuity of the service provision and plans were in place to minimise their impact on the service. These areas were reviewed by the Quality, Safety and Risk committee on a three monthly basis so the effectiveness of the plans could be monitored and reviewed. We were told for example, that the landline telephones to the George Marsh centre were affected in adverse weather. There were contingency plans in place to use mobile telephones if landlines were affected and also there were ongoing discussions with owners of the property to resolve the problem longer term.

The service was likely to experience a shortfall in staffing levels. There were six CNS in post but the number was soon to drop to four people in post. The registered manager told us they had advertised the vacant posts, but so far had been unsuccessful in appointing any suitable candidates. At the time of writing this inspection report the possible consequences were unclear. The service had a stated aim to contact people within 24 hours for urgent requests, otherwise it was within 72 hours for any other requests. Staff told us they received a daily allocation which allowed them to focus on people in the greatest need. We were informed that the service could also make use of inpatient hospice beds if necessary for people referred to the service who could not be seen in the community and needed support promptly. The registered manager told us they would continue with their efforts to recruit into the vacant CNS posts and would keep staffing levels under review to ensure they continued to meet their stated aim.



# Is the service effective?

## Our findings

People who used the community service told us they were confident in the quality of the care and support they received from staff. A person told us, "I couldn't have managed without my nurse. I feel I'm in the best of hands." Another person's relative described the nurses that visited their family member at home as 'professional'.

Staff received the training and support they needed to undertake their role. Two members of staff who had been in post for approximately a year, told us about their induction period. One staff member told us, "They've shown that they [senior managers] are willing to invest in me." Both staff members told us about their extensive induction period during which they visited other parts of the service, completed mandatory training and other relevant courses such as 'Advanced Communication - discussing difficult issues with people' and shadowing more experienced staff. In this way the provider was ensuring newly recruited staff had the necessary skills to undertake their roles.

We saw staff had their knowledge refreshed on a regular basis. There were a total of 14 e-learning courses which staff were required to complete annually, such as infection control, record keeping and promoting dignity. Additionally there were a range of other courses such as dementia awareness, moving and handling and emotional resilience which were completed on a regularly basis so staff were up to date with best practice. Attendance at training was monitored by the human resources department and regularly evaluated to consider any improvements. Nurses and other professionals who held registrations for their professional bodies were encouraged to maintain their continuous professional development. Staff also told us there was a training budget available which they could access for further and higher training, if they wished. For example, a member of staff told us about the master's degree they were completing.

Staff commented positively about the support they received from their peers and managers. Comments included "Can't underestimate the support we get on a day to day basis," and "There is a lot of support amongst the team." In addition to this informal support there was a range of other meetings in place which staff could use as a forum to discuss issues of concern. There was a weekly MDT meeting, a fortnightly team meeting and one to one supervision meetings with their managers. We noted that whilst the policy stated staff should receive monthly supervision, the meetings occurred less frequently. However staff told us they received considerable support in varying formats and they felt they could approach their managers for support whenever they needed to, this included after-hours and at weekends.

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 Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take 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. The application procedures for this in care homes, hospitals and hospices are called the Deprivation of Liberty Safeguards (DoLS).

Whilst people supported by the community service at home did not come under the remit of DoLS, we needed to check staff were acting within the MCA framework. We saw staff had received training on the MCA and had a working knowledge of its impact on people. Care plans showed people's capacity to make decisions and guided staff to seek consent prior to care being provided. For example, we saw there was a description of how a person communicated with hand gestures and how the gestures and facial expressions could be interpreted. If people did not have capacity to make decisions for themselves, then the service arranged for best interests meetings to be held so decisions could be made with the involvement of relatives and healthcare professionals in the person's interests.

We saw the provider worked with other healthcare professionals to ensure people's health needs were met as far as possible. The nature of the service meant that staff did not provide or support people with eating and drinking. They did however provide advice regarding nutritional needs if required. We were given an example where someone had difficulties in eating and the nurses had carefully selected and sourced a food which they could tolerate, and this had made 'all the difference to the person's health'. CNS's were attached to general practitioners surgeries and would undertake joint visits, if necessary to review people with end of life care needs. They also had links with district nurses and care homes in the local area and undertook an advisory and sometimes educational role.

## Is the service caring?

### Our findings

People told us community staff always treated them with kindness and compassion. Typical feedback we received from people and their relatives included, "The nurses are always kind to us", "The nurse who regularly visits us at home is like part of the family. Always warm, friendly and polite" and "Sometimes I'm too frightened to go on living and yet too frightened to die but they [CSN] has always been there, a calming influence."

People were equally complimentary about other staff in the team. The assistant practitioner helped people to fill out forms for welfare benefits. A person told us "She encouraged and helped me fill in my Attendance Allowance forms which has made such a difference." Another person said, "They are first class at finding their way round these complicated forms and they are difficult if you are in the best of health!"

A number of people were positive about the all-inclusive approach of the service for them and their family. One person commented on the fact the service had arranged care for them, "My son was exhausted getting up every night to look after me, they organised some care so that he has a peaceful night every so often." Other people told us about the support they had received from staff which included having difficult conversations with their children or other family members.

Staff were committed and able to meet people's diverse needs. We were given an example where the service supported someone with a learning disability and care home staff during a person's illness. Staff were also aware of the different cultural and religious needs of people living in the local community, and several staff told us they were continually learning about different rites and practices. In this way, the service was trying to ensure that people's wishes for their end of life care could be met and it was in line with their cultural and religious needs.

The provider published a range of information for people and their carers. We saw that leaflets covered practical and important topics such as 'what to look out for when death is approaching' and 'how to register a death'. There was also information about how to get leaflets translated into different languages. Bereavement support and counselling was also available to people. The service could act as an information point for people and refer them onto other organisations if relevant and appropriate.

People were fully involved in their end of life care planning process. This included ensuring they made their wishes known to relatives and professionals. Care plans showed advanced care planning had been put in place which outlined people's preferences for end of life care. People told us they could discuss these arrangements with staff who took time to listen and explain to them what their options were.

Community staff operated a contact advice line between 9am and 5 pm, seven days a week. Outside of these hours calls were taken by hospice staff. The advice line was for people to get support and advice when they felt it necessary. One person told us, "They have an excellent out of hour's service. Our nurse gave me a number which they said I could call anytime if I needed any help." And another person said "I can ring them at any time and the service is always supportive."

People told us how they were supported to be as independent as possible. CSN's were able to provide certain equipment such as commodes themselves within a very short timescale, rather than going through the usual referral process which sometimes caused a delay. This enabled people to stay at home longer if they wished. People told us their privacy was respected by staff at all times and their dignity maintained. We observed this during our home visits to people's homes and at the MDT meeting when discussing each person receiving a service.

## Is the service responsive?

### Our findings

People gave us some positive examples of how the service was responsive to their needs. One person said, "The CNS came in and has moved mountains, she listens to me not just assuming what I want. I've had a night's sleep since she first visited. Something I've not had for months." Another person gave us an example of how the CNS had responded immediately to an urgent text they had sent when they had asked for advice on some medicines they had been prescribed. In addition to the advice line, the service could respond to people's requests for further support. Staff could access Marie Curie overnight carers and nurses and carry out regular visits to support a person if they wished to remain at home. Alternatively, if people chose to receive end of life care away from their homes, staff had links to hospices and care homes.

Records showed people received a comprehensive assessment of their needs from initial contact by the hospice's staff. Anyone could refer themselves or others to the service, at this point information was gathered in order to gain a full picture of the urgency of the referral. People were contacted within 24 hours if the referral was urgent. We saw there was a 'first visit' pro-forma which outlined every aspect of a person's care which included social, psychological and spiritual needs and symptom control. New referrals were discussed at the weekly MDT so appropriate services could be allocated to people. MDT also ensured people's needs were met in a timely way. We were told and saw that initial referrals were reviewed at every home visit to ensure the information was accurate and reflected people's changing needs.

People told us staff were proactive in keeping them informed of changes in their needs or those of their relatives. One person told us, "The nurses are really good communicators and are always talking to us about what's happening and what the treatment options are." A relative went on to say, "Our regular nurse often calls us to let us know how my [family member] is doing." In this way people felt informed and involved in the care they were receiving from the service.

The service worked collaboratively with other agencies to broaden and improve the care to the local population. The managers within North London Hospice took on specific topics so they could increase the knowledge within the organisation. For example, care for people with dementia, infection control and increasing user involvement. The provider was also pivotal in working with the London Borough of Haringey's end of life steering group to look at all aspects of palliative and end of life care.

The service supported people to engage with others to help prevent social isolation. A number of people commented on the importance of staff helping them to obtain a blue badge for their car so they could have better access to parking. People commented how significant this had been for them as it allowed them to access supermarkets and shops that they may not have otherwise been able visit. We were given other examples, such as contact with a local priest so that volunteers from the local church could accompany someone to weekly church services. In another example the service arranged for a volunteer to help someone attend the local knitting club, which was an activity they had previously enjoyed.

The provider had a complaints policy, a summary of which was given to people new to the service. The policy outlined how to complain and how complaints would be dealt with and the timescales for each stage.

People told us they knew how to make a complaint and felt able to raise issues directly with staff. We saw the provider kept a log of the complaints and how they had been dealt with. Additionally the service kept a log of 'critical feedback' forms. This was where people had commented on the service about possible improvements but had not made a complaint. We saw evidence the provider had acted upon the critical feedback forms they had received. We noted the service received many more compliments than complaints which are compiled and shared with staff.

## Is the service well-led?

### Our findings

People and their relatives were positive about the care provided by the George Marsh Centre. We also received feedback from healthcare professionals. One commented on improvements there had been in the last year and went onto say "It was now a positive relationship with everyone working hard together." Another professional said, "Service is great. Very professional and easy to work with, we can just pick up the phone and do a joint visit."

The service had a clear management structure in place and staff were aware of the lines of responsibility. The provider worked to ensure staff understood the values of the organisation and these were supported through an extensive induction programme and ongoing training. We were told the provider had introduced a 'policy of the week' which a member of staff took turn to read and then discussed at the team meetings. Staff received direct email alerts from the Human Resources department when key policies were updated or amended. In this way the provider was maintaining the direction and vision of the service.

The provider had systems in place to monitor the quality of the service and where necessary make improvements. The Quality, Safety and Risk sub-committee had overarching responsibility for governance and was made up of a Board of Trustees and the Chief Executive. There were various sub-committees that fed into the board and we were told there was good two way information exchanges between managers and the trustees.

There were systems in place to monitor any incidents and accidents which took place, to then evaluate them and take action to prevent re-occurrences. Accidents and incidents were immediately recorded onto the computer system when they occurred and flagged up to managers. They were discussed at a monthly meeting, and then every three months taken to the Quality, Safety and Risk sub-committee, where the provider tried to identify any patterns or trends. We were given an example where practice had been improved following an incident. A member of staff had written to a GP advising them on medicines and doses to be administered to a person. However, the GP had identified the dose was incorrect. The provider had changed their policy which now stated any advisory letters had to be read and checked by two CNS prior to being forwarded onto other professionals. In this way the risk of re-occurrences of errors was minimised.

The provider continually monitored the quality of the service by conducting a rolling programme of audits. There was a full time quality and audit manager in post for the organisation. We were able to view some of the audits they had completed since being in post which included reviewing care plans which were used in the community and the waiting time for people to be seen once they had contacted the triage referral team. We saw the provider also maintained a risk register for the running of the overall service which included potential and identified risks to people and how to mitigate against them, for example the impending staffing situation with two vacancies.

People's views about the service were continually sought by the provider so they could improve the quality of care. Included within the information packs people initially received was a feed-back leaflet which

encouraged them to contact the provider with any issues or concerns they had. There were also annual questionnaires sent to people who had received a service in the last six months. In this way the provider was capturing information from people whose relatives may have died in the preceding months. The provider employed a user involvement lead whose role was specifically to increase participation from people and their families regarding the quality of the service.