

Harlington Hospice Association Limited

Harlington Hospice

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

The last inspection took place on 11 October 2016 when we found breaches of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the provider not supporting staff with formal and regular one to one supervision and an annual appraisal, and the provider not demonstrating robust systems to assess and monitor the quality of the service delivered to people. At this inspection we found improvements had been made in these areas. However, shortfalls were identified with medicines management and the monitoring process had not improved sufficiently to have picked this up.

Harlington Hospice Association Limited is a registered charity which provides a range of specialist community services for people aged 18 and above with life limiting illnesses and end of life care needs. These services include personal care and nursing care for people living in their own homes, counselling and emotional support, and a Lymphoedema therapy service at the provider's premises. (Lymphoedema is a chronic condition that causes swelling in the body due to an accumulation of fluid in body tissues). The service is located in welcoming and comfortable premises with a range of facilities including a purpose built day centre and bespoke treatment rooms. There is also a large and tranquil rear garden that overlooks pleasant fields. The provider does not have any inpatient services and offers three different types of care packages to support people in their own homes. On the first day of inspection 21 people were receiving care in their own homes.

The 'Homesafe Night Service' provides a maximum of three nights' of night sitting to support people to safely settle back at home following discharge from hospital. This service is delivered by either a registered nurse or a health care assistant, in accordance with a person's needs. The provider also offers this service on request from the local rapid response or integrated care team in order to prevent hospital admissions. The 'Home2Assess' service provides short-term care packages of four visits a day for up to 10 days, in order to facilitate discharge from hospital and fill the gap between the discharge date and a sustainable care package arranged by social services being operational. This service is mainly delivered by healthcare assistants.

The 'End of Life Care at Home Service' is provided for people with an anticipated prognosis of six months or less. This service can offer up to four visits a day to provide personal care and social support. Visits are predominantly provided by health care assistants but sometimes a registered nurse can be supplied if people's needs determine the necessity for nursing care. A night sitting service can be included if required, which can be delivered by a health care assistant or registered nurse in accordance with people's assessed needs. The registered nurses are able to offer symptom management and the management of syringe drivers. (These are portable pumps used to provide a continuous dose of medicine through a syringe).

The service is required by legislation to have a registered manager in post. 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 legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The

previous registered manager deregistered in January 2017 and recruitment was ongoing for a new manager. The nominated individual was applying to register with the CQC as an interim measure.

Medicine administration records were not always completed fully and records did not always contain an explanation of any omissions of medicines.

Although monitoring and auditing had improved and the findings from the last inspection had been addressed, further improvements to ensure all aspects of the service were captured within the monitoring processes were required. We have made a recommendation relating to this. The nominated individual was aware of this and work was ongoing to ensure monitoring processes were made robust.

Procedures were in place to safeguard people against the risk of abuse. Staff understood what constituted abuse and knew to report any concerns. There was a complaints procedure in place and complaints were thoroughly investigated and responded to so they were robustly managed.

Procedures were being followed to ensure only staff suitable to work with people were recruited. Staff were available to meet the needs of people using the service and people received their care in a timely way. Risks to individuals had been assessed and plans were in place to mitigate any risks identified.

Staff received the training they needed to provide them with the skills and knowledge to care for people effectively. Supervision had been taking place and staff received individual and group supervisions to support their learning and development. Staff respected people's rights to make choices about the care and support they received and knew to report if a person's mental capacity deteriorated.

Where required staff provided people with assistance with food and drink to help meet their nutritional and hydration needs. The service worked with other health care professionals to ensure people's health needs were being met.

People confirmed staff treated them with respect and were friendly and kind. Staff took the time that was needed to meet people's care and support needs. Staff knew the importance of treating people well and providing kind and compassionate care.

Staff respected people's right to receive the care they wanted in a person-centred way so their individual needs were met. Care records were not always personalised and work was ongoing to address this.

The service sought the opinions of people, relatives and stakeholders about the service so they could take action to improve. Action was taken to address any areas identified for improvement. Regular staff meetings were held and provided staff with the opportunity to meet and discuss good practices and learning and identify any areas for work.

We found one breach of the Health and Social Care Act (Regulated Activities) Regulations 2014 in respect of medicines management. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement 

Some aspects of the service were not safe.

Medicine administration records were not always completed fully and records did not always contain an explanation of any omissions of medicines. This meant people were at risk of not receiving their medicines safely.

Staff were aware of and implemented procedures to safeguard people against the risk of abuse. Staff understood what constituted abuse and knew to report any concerns.

Procedures were being followed to ensure only staff suitable to work with people using the service were recruited. Staff were available to meet the needs of people using the service and people received their care in a timely way.

Risks to individuals had been assessed and plans were in place to mitigate any risks identified.

Is the service effective?

Good 

The service was effective.

Staff received the training they needed to provide them with the skills and knowledge to care for people effectively. Supervision had been taking place and staff received individual and group supervisions to support their learning and development.

Staff respected people's rights to make choices about the care and support they received and knew to report if a person's mental capacity deteriorated.

Where required staff provided people with assistance with food and drink to help meet their nutritional and hydration needs.

The service worked with other health care professionals to ensure people's health needs were being met.

Is the service caring?

Good 

The service was caring.

People confirmed staff treated them with respect and were friendly and kind. Staff took the time that was needed to meet people's care and support needs.

Staff knew the importance of treating people well and providing kind and compassionate care.

Is the service responsive?

Good ●

The service was responsive.

Staff respected people's right to receive the care they wanted in a person-centred way so their individual needs were met. Care records were not always personalised and work was ongoing to address this.

There was a complaints procedure in place and complaints were thoroughly investigated and responded to so they were robustly managed.

Is the service well-led?

Requires Improvement ●

Some aspects of the service were not well-led.

The service had been without a registered manager since January 2017 and recruitment to this post was ongoing.

Although monitoring and auditing had improved and the findings from the last inspection had been addressed, further improvements to ensure all aspects of the service were captured within the monitoring processes were required. The nominated individual was aware of this and work was ongoing to ensure monitoring processes were robust.

The service sought the opinions of people, relatives and stakeholders about the service so they could take action to improve.

Harlington Hospice

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 was planned to check 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 unannounced inspection took place on 17, 18 and 22 August 2017.

The inspection visit was carried out by two inspectors. Before the inspection we looked at the information we held about the service including reports from spot check visits carried out by the local authority quality assurance monitoring team.

During the inspection we spoke with two people using the service, the nominated individual, the care coordinator, one referrals coordinator, the office manager, the complementary therapy and day service lead, the administrator, two registered nurses, eight healthcare assistants and a lymphoedema therapist. Following the inspection we spoke with the relatives of two people using the service and sought feedback from four healthcare professionals, one of whom responded. We also refer in our report to the clinical lead who was on leave at the time of inspection, who had completed audits and other documentation which we viewed.

We looked at the care records for four people. We viewed medicine administration records for two people. We looked at the staff recruitment files for four members of staff and records of staff training and supervision. We also viewed other records including quality monitoring checks, records of complaints and safeguarding, policies and procedures and meetings' minutes.

Is the service safe?

Our findings

Medicines were not always safely managed, which could place people at risk of not receiving their medicines correctly. We viewed the medicine administration records (MARs) for two people using the service. We noted gaps in signing and also where codes had been used to identify that a medicine had not been given, the explanation for this had not always been recorded in the daily log. For example, the code 'o' had been used for three days in a row to indicate a medicine had not been given, however no information was included in the daily log to identify why the medicine had been omitted. The MARs had been written up by the healthcare assistants and there was no evidence that these had been checked by a designated person to make sure they were accurate. Administration instructions had not always been included, for example, for a cream the name of the product was the only word written in the MAR entry. The care records of people using the service did not contain a list of medicines to be given with administration instructions and staff said they got the information from the packs the medicines were dispensed in.

The care coordinator said she checked the completed MARs when they were returned to the office, however there was no process of signing to identify which records had been checked or evidence that any action that had been taken to address the shortfalls and to prevent reoccurrence.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider took action during the inspection and new MARs were typed out and the medicines policy properly implemented so that all entries were checked by a registered nurse prior to the MARs being taken to people's homes for use. The new MARs also had a section to identify who had checked and signed completed MARs when returned to the office. Medicines' concerns were discussed at a staff meeting on the second day of inspection and all staff attending were shown the new MARs and were able to discuss any issues they had with medicines management.

By the third day of inspection the provider had completed an audit of all MARs completed in 2017 and was following up any issues identified. They put an action plan in place to address the medicine management shortfalls identified at this inspection and this included weekly monitoring of MARs in people's homes for six weeks and thereafter checks at intervals to ensure medicines were being managed safely. Staff involved with the administration and prompting of medicines confirmed they had received training in medicines and had been assessed and were able to explain clearly the process they followed to assist people with their medicines. Work was to be carried out around the drawing up and administration of liquid medicines so that healthcare assistants with the training and assessed competency to do so could provide assistance to people who received their medicines in this form.

Recruitment procedures were in place and being followed to ensure only suitable staff were employed by the service. Staff confirmed pre-employment checks had been carried out as part of the recruitment process. Staff had completed application forms and the information included an employment history and, with one exception, explanations for any gaps in employment. Two references had been obtained including one from the previous employer, although documents did not always include the company stamp or other

identifying mark from the previous employer. Disclosure and Barring Service checks had been carried out and health questionnaires, proof of identity documents including the right to work in the UK were available in the files viewed. Photographs of staff were seen on the computer system and staff were issued with identity (ID) badges, which staff were seen wearing when they attended the office and confirmed they wore when going to people's homes. The office manager said she always discussed any gaps in employment but had not written this information in the interview notes. They obtained an explanation for the gap in employment at the time of inspection and added this to the file. We also spoke about obtaining verification of any workplace references that did not contain evidence of the previous employer and email evidence was printed off and added to the recruitment files concerned.

The care plans we looked at demonstrated that people's safety was promoted through the use of specific assessments to identify and address individual and environmental risks to their safety, wellbeing and health. The individual risk assessments were in place to guide staff to protect people from a range of risks that included falls, choking, pressure ulcers and malnutrition. Risk assessments had been developed to mitigate risks for people attending the day centre services and/or receiving personal care in their own homes.

The service had a business and continuity policy and plan in place, providing detailed procedures to be followed in the event of emergencies including Information Technology systems failure, severe weather conditions and critical reduction of staff due to sickness.

Policies and procedures for safeguarding were in place and being followed to protect people from the risk of abuse. Staff confirmed they had received safeguarding training and were clear to report any concerns to the office staff and said they would escalate the concern to the nominated individual if action was not taken promptly. Staff understood whistle blowing procedures and said they would contact other agencies such as the local authority or the Care Quality Commission (CQC) if their concerns were not addressed by the provider.

Is the service effective?

Our findings

At the inspection in November 2016 we found a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with shortfalls in staff supervision and appraisal. At this inspection we found that action had been taken to address these findings. Staff supervisions had commenced and staff confirmed they had attended supervision sessions. Appraisals were being scheduled for the anniversary of the healthcare assistants working at the service and were also being planned for the nursing staff, all of whom worked on a bank basis for the service. The nominated individual was carrying out supervisions with the care coordinator in the absence of a registered manager. The complementary therapy and day service lead informed us that they were looking at the idea of group supervisions for registered nurses, which would be provided in addition to the programme of one to one supervisions. This was intended to support registered nurses with issues such as revalidation. (This is the new process that all nurses and midwives need to go through in order to renew their registration with the Nursing and Midwifery Council).

Staff informed us that they had completed online training in topics including safeguarding, records and record keeping, communication, death, dying and bereavement, infection control, diversity and inclusion, dementia care and equal opportunities. They had also attended practical training sessions including moving and handling, palliative care, percutaneous endoscopic gastrostomy (PEG) tube feeding, stoma care and continence management. The records we looked at confirmed that the provider was committed to supporting staff with their mandatory and specialist training needs.

Staff spoke positively about the quality and scope of the training, which was delivered in a classroom setting or through online training. (This is electronic learning using a computer to deliver part or all of a course). One member of the staff team told us, "Records are kept by the administrator to check what training we have done and we are contacted if anything is overdue. They (provider) are strict that we keep up to date" and another staff member explained, "I work at [a different local service for people with end of life care needs] and do occasional night shifts for Harlington Hospice night sitting service. I am expected to attend regular meetings here which include training sessions and carry out the e-learning courses. The training is intensive and very helpful."

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. We checked whether the service was working within the principles of the MCA.

Staff had received training around mental capacity and were aware to act in a person's best interests. Staff told us they would contact the office staff if they felt someone's mental capacity was deteriorating. At the time of the inspection we were told all people using the service could make their own decisions about the

care they wanted to receive. We noted that care records did not always include signatures from the people using the service to show they had agreed to their care and the nominated individual said they would review this to ensure this was in place.

The service was not responsible for providing all meals and drinks for people using the service, however staff said they did make or heat up simple meals and encouraged people to drink and maintain their hydration, leaving drinks people favoured within easy reach. People, and relatives where applicable, told us they were pleased with the thoughtful approach of staff in terms of the support and encouragement given to assist them to meet their nutrition and hydration needs. Care records identified those who needed assistance with meals and drinks and staff demonstrated a good knowledge of the assistance each person required to ensure they received the nutrition they required.

The service worked with healthcare providers and had regular contact with the district nurses, the rapid response multi-disciplinary team, GPs and the palliative care medical team. Referrals were received from healthcare professionals and the staff used the documentation provided by them to follow and provide the care and support people required. We spoke with one of the four members of staff employed by the hospice to provide lymphoedema therapy. They informed us that the lymphoedema therapy service was continuing to expand since the previous inspection and there were currently approximately 70 people using the service. The lymphoedema therapist confirmed that they had received formal one-to-one supervision from the complementary therapy and day service lead and was scheduled to attend further supervisions. Their training and development programme included specific training in relation to their role and responsibilities, in addition to mandatory training such as fire safety, first aid, and moving and handling people.

Is the service caring?

Our findings

People using the service and their relatives spoke very favourably about the compassionate and considerate way that staff delivered their care and support. Comments from people included, "I look forward to the lovely girls that come to my house, I wouldn't want to be without them" and "They are friendly and so kind." Relatives told us, "I know [my family member] is in very safe hands and tells me they are happy with the carers" and "We would recommend this service. I am at home when they come to [my family member] and each one of them has been very nice and patient."

We looked at the written remarks that the provider had received since the previous inspection, which were positive and complimentary. Comments from relatives included, "We thank-you from the bottom of our hearts for all the support you showed at this difficult time. [My relative] would certainly be saying the same", "Thank-you for the amazing work you do", "The respect, dedication and kindness made a difficult situation all the more bearable, I will always be grateful", "One of your lovely nurses stayed with [my family member]. We were so grateful for the respect and care [staff member] showed" and "[He/she] received excellent care in [his/her] last few days."

All the staff we asked said they would be happy to have a loved one cared for by the service and some had recommended the service to people. When we asked staff what was important to them when caring for people, their comments included, "Listening to what they would like, giving them choice and making their care person-centred", "To treat them with dignity and respect. For them to be treated how I'd like to be treated" and "Make them feel happy, treat them the way I would like my mother to be treated. Treat people like people."

Staff explained how they ensured that people were treated in a respectful way, for example they ensured that doors were shut and curtains pulled when they supported a person with their personal care, and they checked with people how they wished to be addressed. Staff said if they were caring for people with identified cultural or religious needs they would respect these and care for them appropriately.

Is the service responsive?

Our findings

People and their relatives were consulted by the provider about their needs, interests and wishes. This was confirmed by relatives we spoke with, who felt that their family members were provided with an individual service that took into account their unique circumstances and requirements. The care plans we looked at were up to date and provided an accurate daily account of how people's needs were met. However, these care plans did not fully reflect the good standard of bespoke care and support that was provided to people. We discussed this finding with the care coordinator, who stated that they were reviewing the care records so that the documentation would accurately reflect the bespoke service that the organisation endeavoured to deliver.

The service has an electronic recording system called Charitylog and information was inputted onto this from referrals and assessments received for new people to receive a service. The information could be accessed securely by staff so they could read about the person's needs prior to visiting them and have a good picture of the person.

The provider informed us that they sought the views of people who use the service and external professionals in order to provide services that responded to people's changing needs. For example, the complementary therapy and day service lead told us that they were looking at ways to expand the lymphoedema service in response to the needs of the local community. They had recently engaged in discussions with the local tissue viability service about this aim, which included a proposal to extend the lymphoedema service to include people who experienced lymphoedema not secondary to cancer. The provider had supported members of the staff team with the necessary training and guidance to deliver weekly exercise classes, which were due to commence in September 2017. These classes were for people with lymphoedema and other people who would benefit from gentle exercise.

The service had a complaints procedure and copies were included in the care files in people's homes. Healthcare assistants said if someone was unhappy they would try and sort out the problem locally but if they wished to raise a concern or complaint they would direct them to read the complaints procedure in their file and to contact the office to discuss any issues. We noted that complaints received by the provider since the previous inspection were subject to a thorough investigation and complainants received a sensitively written response. The provider had agreed timescales for responding to complaints and informed people if there were any extenuating circumstances which required a longer time period for the investigation to be concluded.

Is the service well-led?

Our findings

At the inspection in November 2016 we found a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with shortfalls in monitoring of areas including waste management, store cupboards being left unlocked and lack of risk assessments for people using the day centre. At this inspection we found action had been taken to address all these findings and work was ongoing to improve monitoring processes.

We did identify other areas where monitoring had not been effective. This included the checking and review of completed medicine administration record charts and the checking of recruitment records. An action plan had been drawn up following our last inspection to cover all aspects of quality assurance for the service and work on this was ongoing. Some areas had also been identified in a recent local authority quality assurance monitoring visit report and an action plan had been put in place for this with timescales for completion. The nominated individual and the care coordinator were working on this and acknowledged greater attention to detail was required to ensure shortfalls were identified, recorded and addressed in a timely way. The Charitylog record system was expandable and at the time of inspection a section was added to record details of each medicine a person was prescribed along with information for administration and any side effects.

We recommend that the provider seeks national guidance in relation to having effective quality assurance processes at the service.

The service had not been completing statutory notifications for all events reportable to The Care Quality Commission (CQC). Notifications are for certain changes, events and incidents affecting a service or the people who use it that providers are required to notify us about. We discussed this with the nominated individual who took action during the inspection to submit notifications for any allegations of abuse that had occurred since the last inspection. They confirmed there were occasions when staff were present to provide a regulated activity when someone passed away. They submitted the death notifications for 2017 shortly following the inspection and said they would add submissions of notifications into their processes for the future. The appropriate notification had been submitted by the nominated individual in January 2017 when the last registered manager had stood down.

Shortfalls we identified during the inspection were addressed promptly by the nominated individual and they were open and transparent in their acceptance of the issues and the need to improve auditing and monitoring across the service so all its aspects were included. The service had been actively recruiting for a new registered manager and this process was ongoing. During the inspection the nominated individual started the process to take on this role until an appointment to the post was made.

Feedback from a healthcare professional included, "I can say that I have found [Harlington Hospice] to be keen to be involved in service development, forthcoming with suggestions and an excellent service. Their executives are available and responsive, their staff engaged and patient focused." The healthcare assistants were positive about the office staff and said they were all approachable and supportive. Staff said the

teamwork was good and that they enjoyed working for the service. Their comments included, "It's brilliant – this is the best job I've had. I'm so happy here, it's given me a new lease of life. It's a lovely team, they are great" and "These are good people, a good company to work for."

The care coordinator had carried out an audit of care records for people receiving personal care, both the records completed by staff from the service and also those by other agencies. Where gaps had been identified action was being taken to address this, either by reviewing and expanding the care records completed by the service or meeting with the agencies responsible for the records to ensure detailed care plans and assessments for people were available in the person's home prior to the first visit by a healthcare assistant from the service.

The quality lead had carried out telephone monitoring for people using the service in January 2017 and the feedback had been positive. The care coordinator said they carried out spot checks to people's houses to monitor the care and support people received but they had not been recording these visits. The nominated individual said this would be addressed and showed us the paperwork for these visits and was also adapting the form to cover satisfaction reviews during the visits.

The quality lead had also drawn up an action plan relating to Information Governance which covered reviews and updates to policies, records, client information, training, human resources and auditing and reporting. This contained timescales for each aspect and these were being worked through and identified when completed. A 'priorities and risk task and finish' group had been set up to identify any areas needing work and had put a plan in place to address this. For example, areas for training and updates had been identified and action taken to identify trainers to carry out practical training such as the percutaneous endoscopic gastrostomy (PEG) tube feeding, which had been carried out by a specialist in this field.

The provider was part of the 'H4All' partnership, working together with other charities in the borough providing support to a wide variety of people with differing health and social care needs. These included Hillingdon Age UK which supports older people, Disablement Association Hillingdon (DASH) which supports people with a disability, Hillingdon Carers, which supports carers looking after loved ones and Hillingdon MIND which supports people with mental health needs. We saw how these links supported people who used the service, for example people who used the domiciliary care service, and their relatives, could be signposted to other services at the hospice or to resources provided by other local charities.

The service had a monthly 'News and Reminders' newsletter that was sent out to everyone working or volunteering for the provider. This covered all aspects of the service including fundraising, volunteering in their shops, therapy updates and care and nursing aspects. Where issues had been identified, the actions being or to be taken were included in the newsletter, so everyone knew what was being done and any action they needed to take. For example, cascading information about the supervision and appraisal processes, ensuring waste management procedures were understood and being followed safely.

Staff meetings took place and we attended a meeting on the second day of inspection, in which staff participated well and demonstrated a good understanding of people's individual needs and discussing ways in which they could ensure people's needs were being met safely and effectively. The issues with the medicine administration records were discussed and staff were receptive and there was a good atmosphere, with staff working together to identify solutions to issues.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Nursing care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Personal care	The registered person did not protect service users against the risks associated with the safe and proper management of medicines.
Treatment of disease, disorder or injury	Regulation 12(1)(2)(g)