Helen & Douglas House

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Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inadequate**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 6 December and was unannounced.

Helen and Douglas House is a hospice charity based in Oxford providing palliative, respite, end of life and bereavement care to life limited children, young adults and their families. Helen House can accommodate up to eight children and Douglas House up to seven young adults. At the time of our inspection there were four children in Helen House and two young adults in Douglas House.

This inspection was prompted in part by a notification of a significant incident. The information shared with CQC about the incident indicated potential concerns about the management of risks in relation to medical equipment. This inspection examined those risks and reported on the findings in the safe and well led domains.

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 registered manager worked closely with the director of clinical services and a deputy manager.

People who required specific medical support around activities such as breathing, eating and elimination did not always have the necessary risk assessments in place to keep them safe. Where they were in place they were not always completed. Risk assessments for people suffering from seizures were not always completed.

People's care plans were not always current and did not always reflect changes in care.

Staff received training and support. However, the provider did not have an overview of the training matrix therefore it was difficult to determine whether staff were appropriately trained to carry out their roles.

The provider had quality assurance systems in place. However, these were not always effective. The provider had been reactive following the incident and made changes to minimise risks posed for people using breathing equipment. However learning had not been applied more widely and the provider had not identified, assessed and mitigated potential risks associated with other types of associated medical equipment. The provider did not have overview of staff training and there was lack of leadership around ensuring staff were competent in their roles.

Risks in relation to ventilation and breathing circuits had been identified following the incident and there were risk management plans to support staff on how to minimise such risks.

People who were supported by the service felt safe. Staff had a clear understanding on how to safeguard

people and protect their health and well-being. Safeguarding was well embedded into everyday practice.

The registered manager informed us of all notifiable incidents. Accidents or incidents relating to people were documented, thoroughly investigated and actions were followed through to reduce the risk of further incidents occurring.

Transitioning of care with other services was effective and allowed consistency on care. Families were involved in comprehensive handover processes to ensure staff captured all the information they needed.

Leadership within the service had a clear structure which aided in the smooth running of the hospice.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activity) Regulation 2014. You can see what action we told the provider to take at the back of the full version of this 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?

Inadequate

The service was not always safe.

Risks to people were not always managed and assessments were not always in place to manage the risks and keep people safe.

People's care plans were not always current and did not always reflect changes.

People were protected from the risk of abuse as staff had a good understanding of safeguarding procedures. Safeguarding was embedded into everyday practice.

Is the service well-led?

Requires Improvement

The service was not as well led as it should be.

The provider had quality assurance systems in place. However, these were not always effective at identifying risks and driving improvements.

Accidents and incidents were managed safely and learning was shared across the board.

Transitioning of care between services was effective and ensured consistency.

There was a clear leadership structure.

Helen and Douglas House

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.

We inspected Helen and Douglas House as a result of concerns over safe care and treatment. This was an unannounced focused inspection looking at safe and well led domains. The inspection took place on 6 December 2016. The inspection team consisted of two inspectors and a specialist advisor in nursing care.

We spoke with four people's relatives. We looked at four people's care records including medicine charts. During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We spoke with the director of clinical services, deputy manager, clinical staff which included a doctor, a community physiotherapist and six nurses. We reviewed a range of records relating to the management of the hospice. These included four staff training files, minutes of staff meetings and incident reports. We also attended a nursing staff handover session and reviewed handover notes.

Inadequate

Is the service safe?

Our findings

The provider had a risk management policy in place, however, this was not always followed to minimise risks. Risks to people's safety were not always assessed and people did not have plans in place to minimise the risks. For example, one person had a nasogastric tube, (a tube that goes into the stomach through the nose that can be used for feeding and administering medicine). The nursing record did contain a document called 'Nasogastric Tube Position Confirmation Record'. Staff recorded a test which would inform them if the tube was in the correct position before administering any medicines. However, this person did not have a care plan which identified potential risks and how to deliver safe care for people with this medical intervention. Therefore staff did not have clear guidance on how to manage any risks associated with the tube.

The same person also had a stoma, (an opening on the surface of the abdomen which has been surgically created to divert the flow of faeces or urine). This person did not a care plan which identified potential risks and how to deliver safe care for people with this medical intervention. The nurse looking after this person told us, "We liaise with the stoma care nurse. I have not had specific training in stoma care". We reviewed training records which showed stoma care training had been offered by the provider but not all nurses had attended.

Another person had a tracheostomy, (an opening surgically created through the neck into the windpipe to help with breathing). Staff told us they knew how to look after the tracheostomy. However, this person did not have a care plan which identified potential risks and how to deliver safe care for people with a tracheostomy. Staff did not have clear guidance on what they should be monitoring to ensure the risks associated with the tracheostomy were mitigated.

A third person suffered from seizures. This person had an 'epilepsy protocol' in place which guided staff on how to monitor or manage the seizures. However, there were no risks associated with seizures identified and no risk management care plan in place to manage such risks.

People's care records were not always up to date and did not always reflect the care that was given. For example, a person had a pain management care plan dated 5 December 2016. However, the information about medication did not match the information documented on the symptom management plan (SMP) also dated 5 December 2016. We spoke to the doctor about the SMP and they told us they had 'updated it yesterday morning and printed three copies'- one for the clinical records, one to be kept with the medical chart and one for the nursing notes. We asked the nurse in charge why there was not a copy in the nursing notes and they said, "We might put the symptom care plan in the folder if it was relevant". This put the person at risk of receiving incorrect pain treatment resulting in unnecessary pain.

Another person was admitted to the service on 5 December 2016 and a care plan from a previous admission on 30 November 2016 had been used, the date was crossed out and changed to 5 December 2016. The care plans had not been altered or updated to reflect changes in care needs between the two admissions. For example, in handover nurses were informed oxygen should be delivered '1 litre oxygen when awake and 1.5

litres oxygen when asleep'. The breathing care plan stated 0.5 litres to 1.5 litres could be delivered. The hospice doctor confirmed the care plan contained details of the previous admission. The care plan also documented bowel medication which the doctor confirmed had been discontinued prior to this admission. This meant an accurate record of this patients care was not maintained and could result in the person receiving the wrong medicine and amount of oxygen. We discussed this with the senior nurse and doctor who told us nursing staff would use the medication chart which reflected the correct medicine.

We reviewed staff training records to ascertain if the training provided enabled staff to deliver care safely. Records showed staff received mandatory training which included record keeping, routine oxygen, artificial ventilation and medicine administration. Staff were also offered specific training which included stoma care, tracheostomy care and laryngectomy care. Staff signed attendance sheets for these training sessions. However, records showed not all staff had attended. The provider did not have an overview of the training matrix therefore we could not be sure staff were appropriately trained to carry out their roles safely. There was no system in place to ensure that only staff who had received the training, provided care to people with these interventions. We asked senior staff about training and they told us, "We are transitioning to new training records so we can have an overview [of training]".

We asked staff if they received specific training for breathing equipment. One member of staff told us, "We do not receive training for specific equipment. Physios gave us general training in ventilation". Another member of staff said, "The families go through the equipment with us when they come in". The provider had no clear process of ensuring staff were familiar with different breathing equipment.

These findings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our visit we asked the provider to forward an action plan to immediately address these concerns which they had not identified prior to our inspection. The provider told us some of these concerns had been addressed and forwarded a robust action plan with completion deadlines. We will follow up with the provider to ensure people are receiving safe care and treatment.

Risk assessments specific for people with breathing equipment had improved following an incident. The provider had introduced a 'breathing and ventilation' assessment form to capture possible risks associated with each piece of breathing equipment. This also guided staff on how to manage those risks. Staff also used pictorial guides to specify different breathing machines for different people.

Staff told us, "Since the incident, we've had lots of training; It's made us more aware. If I'm not familiar [with a task] I'd say I don't know. I can say I can't do that. People [other staff] don't always like it but we can speak up most definitely" and "Since the incident, we've had lots of training". Records showed staff had received training on breathing equipment from other healthcare professional.

People's relatives told us they felt their family members were safe staying at Helen and Douglas house. Comments included, "We have never had any safety issues. We are lucky to have access to this service", "The support here is safe and amazing. We really like it" and "We have been using this service for a very long time and have had no issues".

Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Safeguarding was well embedded into everyday practice. Staff were aware of their responsibilities in this area and this was discussed during the supervision session. There was evidence in clinical records that where there were safeguarding concerns, the services safeguarding policy had been

followed.

People's relatives told us staff were knowledgeable and skilled to look after their family members. They said, "Staff are competent and knowledgeable enough. They have been exceptional", "I feel confident with staff skills" and "I have no doubt the nurses are skilled and knowledgeable to do their jobs". One healthcare professional visiting the service told us, "Staff are knowledgeable and well trained. Communication is good".

Requires Improvement

Is the service well-led?

Our findings

The provider had quality assurance systems in place. However, some of these systems were not always effective. For example, record keeping audits had not identified the shortfalls we found in risk assessments and care plans. The provider had been reactive following the incident and made changes to minimise risks posed for people using breathing equipment. However learning had not been applied more widely and the provider had not identified, assessed and mitigated potential risks associated with other types of associated medical equipment. The provider did not have overview of staff training and there was lack of leadership around ensuring staff were competent in their roles.

These findings were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our visit we asked the provider to forward an action plan to immediately address these concerns which they had not identified prior to our inspection. The provider told us some of these concerns had been addressed and forwarded a robust action plan with completion deadlines for the other action plans.

Helen and Douglas House was led by a registered manager who had support from the director of clinical services and a deputy manager. On the day of the inspection the registered manager was away. The service was being run effectively in the registered manager's absence which showed good leadership. There was a clear leadership structure which aided in the smooth running of the service.

Throughout our inspection we observed strong leadership and direction from the management team and the doctors. There was positive engagement with all staff. Communication amongst staff was good and systems such as the diary and handover book were used effectively to support verbal communication. We observed a nurse's handover session which was comprehensive and detailed enough to allow continuity of care.

We spoke to families about how care was coordinated between services to ensure consistency. They told us, "Transition to Helen House was smooth. They [staff] are meticulous with handovers. The process can take up to one and half hours", "Lengthy handover process. We go through the care plan, book in medicines and the doctor will do their checks" and "They go through everything with us every time we go there".

Staff told us transitioning between services was good. They said, "We rely a lot on family information. Medical handovers are received if a person is coming from hospital and they will have a discharge letter" and "We now request more even more information from families before they come in".

The provider had a clear procedure for recording accidents and incidents. Accidents or incidents relating to people were documented, thoroughly investigated and actions were followed through to reduce the risk of further incidents occurring. For example, staff noticed settings on a breathing machine did not match the prescription that was faxed from hospital. Provider arranged for a spare breathing equipment to be picked up from the person's home. Emphasis was put on during admissions for families to provide spare

equipment. The provider audited and analysed accidents and incidents to look for patterns and trends to make improvements for people who used the service. Staff knew how to report accidents and incidents.

We talked to staff about changes following the incident. One member of staff told us, "It's made us more aware. If I'm not familiar [with a task] I'd say I don't know. I can say I can't do that. People [other staff] don't always like it but we can speak up most definitely". Another member of staff said, "I can see a difference in practices as a result of the incident. We now ask for prescription for setting for the actual equipment, we did not do it before. We ask them [families] to bring risk assessments and care plans from home or operators manuals and a spare machine or spare tubes. We now fill in (as from June) breathing and ventilation assessment, settings and how often. We always ask patients to come with a discharge letter".

The management team told us lessons had been leant following the incident. One management team member said, "Huge learning as an organisation at leadership level. We are more aware of risks included-heightened our awareness". One member of staff told us, "It's now 100% safer. Before we'd only switch on the machine and got on with it. Now we have two nurses responsible for setting up equipment or changing night to day circuit". One management team member told us the provider was in the process of completing an independent root cause analysis investigation following the incident and would share their findings in due course.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The management team were aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Nursing care Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not always have risk assessments and risk management plans in place. People's are plan records were not always up to date. The provider had no clear process of ensuring staff were familiar with different breathing equipment. Regulation 12 (2) (a) (c)

The enforcement action we took:

Warning notice with 2 week time frame

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance systems were not always effective at identifying risks and driving improvements. Regulation 17 (1)

The enforcement action we took:

Positive condition. Service to send regular audits.