

Herriot Hospice Homecare

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Inspection Report

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Summary of findings

Overall summary

Herriot Hospice Homecare is a Charity that works in partnership with local hospitals, doctors, nurses and social services and is part of the local palliative care team delivering end of life care to people with sometimes only a short time to live. On the day of our inspection the service provided care for 20 people. The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

The Charity aims to enhance the quality of life and enable people with life-limiting illness, whose preferred place of care is at home, the opportunity to exercise the choice to do so by providing specialist palliative care workers and trained volunteers, who provide support for them and their families.

Each person's had a care plan and these included a personal profile which described their personal preferences in relation to their religion, food, drink, and daily routines. We saw these had been reviewed daily.

This helped staff to pick up on changes in people's behaviours, which may indicate they were anxious, in pain or in distress. Most people's care packages were only in place for a few weeks at a time.

Mental capacity assessments and best interest assessments required, if people were unable to make decisions for themselves. The care plans we looked at showed people were referred in to the service by doctors, specialist nurses, Macmillan nurses, district nurses, hospital nurses or social services. Each care plan we saw had been signed by the person using the service or a family member which confirmed their involvement in their care.

Members of staff we spoke with showed a good understanding of people's care and support needs and clearly knew people well.

At the time of our visit the registered manager was supported by two care managers. A total of five permanent care workers and six bank care workers were used on the rota. This meant there were enough staff to provide the required levels of care.

The registered manager promoted a positive culture that was person centred, open, honest and inclusive.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We saw mental capacity assessments and best interest assessments were in place, for people who were unable to make decisions for themselves.

The members of staff we spoke with were aware of their individual responsibilities to report any incidents or concerns and understood their employer's whistle blowing procedures, and this helped to make sure people were kept safe.

Each person had their needs assessed prior to the service starting. Each person's assessment included information from the person and their families about their needs, choices and health problems. This showed they had been involved in the assessment and planning of their care.

The care plans we looked at showed people's individual health care needs were addressed. Members of staff told us they were provided with and wore appropriate personal protective equipment, such as disposable gloves and aprons. The members of staff we spoke with showed they had a good knowledge of infection prevention and control procedures.

People were given their medicines as prescribed and relevant staff had attended training about the safe handling of medicines.

Are services effective?

People who used the service had usually been referred to the service at short notice and possibly only for a few weeks. The nature of people's life limiting illnesses meant that it was not always possible to involve people in the creation of their care plan since this was usually informed by the district nurses coordinating the person's care.

Where possible members of staff gave people choices about their care. People's care plans ensured they were made as comfortable as possible and assisted with pain relief. All care plans included an 'end of life wishes' section which allowed people's needs and choices to be recorded, so staff were aware of what was important to people.

We saw people's preferences were respected, for example, how they wished to be addressed was included in their care plans.

Members of staff had received specific training in dementia care and were able to tell us how they had put this into practice.

Summary of findings

Are services caring?

Members of staff told us they were given time to sit with people talking about things that were important to them. They told us they spent time watching their body language and facial expressions to understand how they were feeling. Members of staff spoke about how they made sure people's dignity was maintained, for example, when using a hoist.

People's care plans included up-to-date information on how to care for them and how to meet their individual preferences. We also saw in people's plans how people were encouraged to be as independent as possible.

People were able to express their views and these were listened to. We saw records from reviews with people and their relatives. These had taken place every two weeks, if this was possible. The records we saw showed the registered manager had acted on people's views.

Are services responsive to people's needs?

We saw people were encouraged to maintain their relationships with their friends and relatives.

People living in the home were aware of how to make a complaint. Information was provided in the 'service user guide'.

Are services well-led?

At the time of our visit the service had a registered manager in place.

The registered manager showed us minutes from staff meetings. This showed learning from incidents took place, such as group learning from safeguarding incidents. We also saw case studies which looked at how the service had provided care to people were discussed at the meetings.

We looked at the complaints received by the service and saw these had been acknowledged, investigated and responded to appropriately. We saw that learning from issues raised in complaints had taken place at staff meetings.

We saw people's level of dependency was assessed regularly and the registered manager explained how this was a determining factor for staffing levels.

The service had an internal audit manager and they and the registered manager carried out monthly audits on the quality of the service provided. We saw that when issues were identified action plans were put in place to address them, and this helped to make sure improvements were made.

Summary of findings

What people who use the service and those that matter to them say

We were unable to speak with the people who used the service as they were too ill to talk to us. The registered manager told us the organisation had a policy of not

allowing office staff to contact people or their families directly due the sensitivities of end of life care. Any contact was made through the palliative care professionals coordinating the person's care.

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 was planned to check whether the provider is meeting the regulations associated with the Health and Social Care Act 2008. It was also part of the first testing phase of the new inspection process CQC is introducing for adult social care services.

We visited this service on 27 April 2014. We used a number of different methods to help us understand the experiences of people who used the service. These included talking with members of staff and external health professionals. We also looked at documents and records that related to people's support and care and the management of the service.

The inspection team consisted of a lead inspector and an expert by experience. This is a person who has personal

experience of using or caring for someone who uses this type of care service. The inspection team gathered information by speaking with care staff, external palliative care professionals and analysing the post-service questionnaire completed by people's relatives after their death. They also reviewed the quality assurance (QA) reports by NHS nursing staff after people's death.

Prior to the inspection we spoke with a representative from the local clinical commissioning group who provided positive feedback about the service. We also contacted a representative from the local Healthwatch.

Upon arrival at the inspection the provider gave us access to their completed 'provider information return'. They told us they had submitted this to the Commission electronically.

On the day of our inspection the service provided care for 20 people. We were unable to speak with the people who used the service as they were too ill to talk to us.

Are services safe?

Our findings

The service had a clear policy and procedures in place that provided staff with guidance to follow if an incident of abuse was reported or suspected. In discussion with members of staff, they demonstrated a good understanding of their responsibilities in terms of safeguarding people from abuse and communicated a desire to ensure the safety and wellbeing of people who used the service.

Records showed that training in the area of safeguarding was provided to all staff including all support staff. Members of staff told us this training provided them with the necessary guidance in order to be able to report any instances of abuse.

The three members of staff we spoke with were aware of their individual responsibilities to report any incidents or concerns and understood their employer's whistle blowing procedures. Members of staff said they were confident managers would deal with any such concerns effectively and support them as whistle blowers. We looked at the care records and saw mental capacity assessments and best interest assessments were in place where required, for people who were unable to make decisions for themselves.

The care plans we reviewed showed people's individual health care needs were addressed. Each care plan we viewed had been signed by a member of the person's family which confirmed their involvement in their care.

Each person had a set of risk assessments which identified hazards people may face and provided guidance to staff to manage any risk of harm. Care plans and risk assessments were reviewed daily to ensure they were current and relevant to the needs of the person. We saw reviews were meaningful and informative. People's pain and symptoms of pain were assessed daily. We saw information about increased pain being communicated to district nurses and other relevant professionals.

Arrangements were in place to administer medicines safely. Records showed people were given their medicines as recommended by the manufacturers, especially with regard to food. Appropriate arrangements were in place to make sure that medicines were obtained in a timely way.

People were given their medicines as prescribed. The records about the management of medicines showed they were handled safely. Information was available to guide staff how to administer medicines which were prescribed to be given "when required". Appropriate arrangements were in place for the recording of medicines. The records showed that medicines, including creams, had been given as prescribed and directed by the specialist teams.

We saw that relevant staff had attended training about safe handling of medicines. The registered manager had a system to audit medication in place and actions were taken to resolve any concerns found as a result of the audits.

We noted written consent was obtained from the person or their families and carers before the service handled any medication belonging to them. Consent was given by signing the front sheet of the care plan. Where people had been assessed as not having capacity to consent this was noted in their care plan.

We reviewed the service's policies and procedures designed to recruit appropriate staff. We checked staff files and confirmed that at least two references had been received for each new member of staff. Checks had been made with the disclosure and barring service (DBS) to confirm the person had not been registered as being unsuitable to work with vulnerable adults.

Members of staff told us they had good supplies of personal protective equipment (PPE) and that they had read the service's infection control policy and received training on it. However, when we asked the registered manager about the content of the training we were told this consisted of working through a workbook provided by the NHS in order to assess competency. We suggested that the service may wish to seek specific training for staff in this area and also include specific observations about the use of PPE in the spot checks on staff.

Are services effective?

(for example, treatment is effective)

Our findings

Given the nature of the service we were told that it was difficult to involve people in creating their care plan. We saw that wherever possible the service had involved people who were important to the person such as their family.

Each person had their needs assessed before the service commenced. Each assessment contained information from the person and their families about their needs, choices and health problems. Information was also provided by health and social work professionals such as district nurses, GPs and social workers. This meant the staff had the appropriate information about people's health and wellbeing at the start of the care.

We reviewed four care plans. We saw each person had a personal profile which described their personal preferences in relation to religion, food, drink, and daily routines. We saw this had been reviewed daily. One member of staff told us, "We try to give people choice as much as we can but given many people are nearing the end of their life and possibly in pain; it can be difficult for them to express their views."

We saw people's care files included advanced care plans (ACP). The aim of an ACP is to make clear the person's wishes and will usually take place in the context of an anticipated deterioration in the individual's condition in the future. The ACPs contained information about their wishes about the end of their life. This showed the service had taken steps to respect people's dignity.

People who used the service had their care coordinated by district nurses, so that they received input from specialist palliative care nurses and associated professionals. In addition, the Charity offered people aromatherapy, reflexology and acupuncture to help them feel more comfortable. People's relatives were offered a respite sitting service and a befriending service in order to support them through this difficult time. A bereavement service was also provided by the service and a specially designed bereavement counselling room had recently been established within the office building.

We spoke with two district nurses who worked closely with the service's care workers. Their comments included, "They operate to the highest standards" and "Very professional". They said care workers would contact them whenever a change or deterioration was observed in the person's condition.

The two members of staff we spoke with demonstrated a good understanding of people's care and support needs and clearly knew people well.

We confirmed that all staff had received training in end of life care. This ensured staff had the skills to manage end of life care appropriately.

Members of staff were supported through a programme of staff training, supervision and appraisal. These ensured staff were supported to deliver care safely to people. Core training for all staff included the administration of medicines, moving and handling, fire safety, infection control and food hygiene.

We reviewed the staff training records and found there was a system in place to identify the courses staff had completed and to highlight those for which new training or updates were required. Training records showed staff received training in specialist areas relevant to the needs of the people they cared for. These included nasogastric care, lymphedema massage and post radiotherapy care. Staff had also been trained in caring for people with forms of dementia.

We reviewed risk assessments to see how the staff protected people from developing skin damage and how they cared for people who had pressure sores. We found people who had been assessed as being at high risk of developing skin damage, as a result of being nursed in bed for example, had charts in place showing they had been re-positioned in accordance to district nurse instructions.

Pain assessments provided information to staff on how to identify if people are in pain and were especially important for people living with dementia and who may not be able to communicate when they were in pain.

Are services caring?

Our findings

We reviewed the agency's equality and diversity policy which included information for staff about different faiths and cultures and the potential implications for care and dietary requirements.

Members of staff told us they took time to understand the needs of people who were not able to communicate as well as others, particularly those with dementia. They described how they spent time watching their body language and facial expressions to understand how they were feeling. One member of staff told us, "Due to the illnesses our patients have they are often not able to communicate with us so we take time to look at their expressions." The members of staff we spoke with were all able to explain in detail about people's needs and behaviours including their facial expressions if they were in pain.

We reviewed four people's care plans. We saw each person had a personal profile which described their personal preferences in relation to religion, food, drink, and daily routines. We saw this had been reviewed daily. This allowed staff to identify any changes in people's behaviours which may indicate anxiety, pain or distress. We saw the service offered a face-to-face review with people and their families after two weeks, although we were told many families chose not to take this up at this sensitive, end of life stage. Each plan contained up-to-date information on how to care for the person and how to meet their individual preferences.

Correspondence from families after the person's death confirmed kindness and compassion. Comments included, "They made her feel relaxed and peaceful in her last few days", "Thank you for all the love, kindness and professional help you gave to my sister", "The staff were fantastic and treated my father with the respect he deserved" and "I would like to say how compassionate and excellent they were in every respect".

A district nurse told us, "The patient couldn't praise the service enough. Very grateful for the carer's support, professionalism and care".

One care worker we spoke with confirmed they always tried to comply with the views of the person and/or the family but would, if she thought the actions unsafe or potentially harmful, discuss this with the person and the family and try to persuade them a different course of action was more desirable or beneficial.

People were able to express their views and these were listened to. We saw records from telephone or face-to-face reviews undertaken every two weeks, providing the person consented to this and was able to participate. These showed the service had acted on people's views. People's relatives in the post-service questionnaire indicated they felt able to make comments to the registered manager and the provider and knew these would be acted on.

One person's relative described the care provided as, "Empathetic and sympathetic". One member of staff told us, "I have a lot of experience in care, especially for those at the end of their lives and I think this organisation is wonderfully caring; I wouldn't want to work anywhere else."

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

People's capacity to make decisions for themselves was considered under the Mental Capacity Act (2005). When people did not have capacity, decisions had been taken in the person's best interest and this had been recorded. We were told independent mental capacity advocates (IMCAs) were often involved when people were first discharged from hospital and could make some of the decisions about their care. We noted information was provided in the 'service user guide' about independent advocacy services.

We were told people's health was monitored at each visit. The care workers and district nurses we spoke with confirmed they would report changes requiring additional interventions.

The four care plans we reviewed included copies of 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms in place. The registered manager told us the original forms were kept in people's houses, in yellow envelopes and clearly marked. We were told that if there were any sensitivities around this such as children in the house or families not being aware of the person's wish, a blank envelope with a certain sensitive sticker would be present.

We saw people were encouraged to maintain relationships with their friends and relatives. The registered manager told us friends and relatives were often actively involved in people's day-to-day care. They told us in cases where people had no one to care for them it was unlikely they would be discharged from hospital and be cared for by the service.

We reviewed the staff rotas and confirmed that whilst most people received their care in blocks of 30 minutes, staff were afforded the opportunity to stay with people longer if

necessary. Although the service covered a wide geographical and rural area, staff schedules allowed for this. This showed the service could be responsive to people's needs. Members of staff also told us about the arrangements for when they carried out care which required two care workers to be in attendance. Comments included, "If we are 'double staffing' we are very particular to arrive together and also try to go in one car so that only one car arrives and doesn't upset the people with lots of comings and goings" and "We are very appreciative that we are going as guests into their home so we are very mindful of the approach we use."

We were told that if people's care was changed quickly due to deterioration in their condition for example, the staff team had each been issued with a facsimile machine to which the information was securely transmitted. We saw care workers were also sent text messages to inform them of small changes to people's care packages. We confirmed that codes were used to identify people in order to protect their identity. These systems of communication allowed the staff to operate flexibly across a large geographical area without the need to attend the office which could be some considerable distance away.

People who used the service were given information about how to make a complaint in the 'service user guide'. We noted there was an easy read version of the complaints procedure available using pictures and simple text. This meant that people were given information on how to make a complaint in a suitable format if they had difficulty in reading and understanding relatively large amounts of text. One member of staff told us, "When we first go in to the patient we are encouraged to go through the complaints section of the patient guide."

Are services well-led?

Our findings

At the time of our visit the service had a registered manager in place, although we were informed they were due to retire in the summer. The registered manager was supported by two care managers. One care manager told us they promoted a positive culture that was person centred, open, honest and inclusive. Members of staff told us they felt empowered to act professionally and make day-to-day decisions; comments included, “We have a very committed and experienced team here; the managers know that and respect that. We have an ethos of good communication. Due to the nature of the job we do, it’s absolutely vital we communicate well between us and with the district nurses.”

We saw there was a whistle blowing policy in place. Members of staff confirmed they were aware of the policy and would feel able to use it without fear of any adverse redress.

The registered manager showed us records of the monthly internal quality assurance programme carried out by the provider. Recent audits included checks that people’s care files were complete in content; all records were legible, readily identifiable, secure and correct. We also records of spot checks carried out on staff at periodic intervals.

We saw where corrective action was required the registered manager had signed to indicate when actions, such as updating risk assessments, had taken place.

The registered manager showed us minutes from staff meetings that showed learning from mistakes and incidents took place. We saw one occasion the team had openly discussed a problem with the completion of medication administration records (MARs). At every staff meeting we saw the team had discussed specific cases and used them to learn about good and safe practice. We asked the staff members about the culture for reporting incidents; one said, “Staff aren’t afraid of reporting incidents. There is open door policy, we feel very supported. At staff meetings we share information about difficult case studies.”

We looked at the service’s complaints monitoring system and reviewed three complaints received in the last 18 months. One complaint was from a staff member about the conduct of a colleague. All complaints had been dealt with effectively and had been acknowledged, investigated and responded to appropriately.

The service operated a quality assurance report system whereby every month at least four patients, randomly selected, were followed up after death by requesting the district nurse with overall responsibility for the person who used the service to complete a report on the care workers who attended. No complaints were identified during the course of reviewing these reports. All reports were audited and checked by representatives of the Charity’s Trustees. However, two reports had no evidence of an audit being completed. One report indicated that additional training was required, but did not specify what area needed to be covered. We discussed this with the registered manager at the time of the inspection and they assured us they would make sure every report had an action plan if needed.

We saw the registered manager completed a monthly audit of accidents and incidents including any falls people may have had. We reviewed the minutes from staff meetings and notes from individual staff supervisions. We saw any accidents or incidents had been talked through openly with members of staff in order to promote continual improvement and learning. Since all of the people who used the service at the time of our visit were too ill to move out of bed no falls had been recorded.

We saw people’s dependency was assessed regularly and was a determining factor for staff levels. We were told that staffing levels were adjusted when people’s needs changed. The service did not employ any agency staff and shortfalls as a result of sickness or holidays were covered by other members of staff in the team.