Havens Christian Hospice

Fair Havens Hospice

Inspection report

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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 26 and 27 October 2016 and was announced.

Fair Havens is a ten bedded hospice for adults providing palliative medicine and nursing care on an inpatients and day care basis. Other services are co-ordinated from the establishment that include: Macmillan nurses, bereavement support, chaplaincy and home care services.

There was a registered manager in post. At the time of our inspection they were on long term leave and the service was being managed by a manager who was in the process of submitting their registration to CQC. They were supported by the Chief Executive Officer (CEO) and management team.

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.

People felt safe. Staff had received training to enable them to recognise signs and symptoms of abuse and how to report them. People had risk assessments in place to enable them to be as safe and independent as they could be.

Effective recruitment processes were in place and followed by the service to ensure staff employed were suitable to work with people who used the service. There were sufficient staff, with the correct skill mix, on duty to support people with their care and treatment needs.

Medicines were managed safely. The processes in place ensured that the administration and handling of medicines, including controlled medicines, was suitable for the people who used the service.

Staff and volunteers received a comprehensive induction process and on-going training. They were well supported by the manager and the management team. Staff had attended a variety of training to ensure they were able to provide care based on current practice when providing care and treatment for people.

Staff gained consent before supporting people or providing care and treatment. People were supported to make decisions about all aspects of their life; this was underpinned by the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff were knowledgeable of this guidance and correct processes were in place to protect people.

People were able to make choices about the food and drink they had, and staff gave support when required.

Staff provided care and support in a caring and meaningful way. They knew the people who used the service well. People and relatives, where appropriate, were involved in the planning of their care and support.

People's privacy and dignity was maintained at all times.

A complaints procedure was in place and accessible to all. People knew how to complain. Effective quality monitoring systems were in place. A variety of audits were carried out and used to drive improvement.

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 were knowledgeable about protecting people from harm and abuse.

There were enough trained staff to support people with their needs.

Staff and volunteers had been recruited using a robust recruitment process.

Systems were in place for the safe management of medicines.

Is the service effective?

Good

The service was effective.

Staff and volunteers had attended a variety of training to keep their skills up to date and were supported with regular supervision.

People could make choices about their food and drink and were provided with support when required.

People had access to health care professionals to ensure they received effective care or treatment.

Is the service caring?

Good

The service was caring.

People were able to make decisions about their daily activities.

Staff treated people with kindness and compassion.

People were treated with dignity and respect, and had the privacy they required.

Is the service responsive?

Good

The service was responsive.

Care and support plans were personalised and reflected people's individual requirements.

People and their relatives were involved in decisions regarding their care and support needs.

There was a complaints system in place and people were aware of this.

Is the service well-led?

Good

The service was well led.

People and their relatives knew the manager and were able to see her when required.

People and their relatives were asked for, and gave, feedback.

Quality monitoring systems were in place and were effective.

Fair Havens 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 inspection took place on 26 and 27 October 2016 and was announced.

We gave the provider notice of the inspection to ensure the correct people were available on the day of the inspection to speak with us.

The inspection was carried out by one inspector, a specialist advisor, an expert by experience and a member of the CQC medicines team. The specialist advisor was a specialist in end of life care and the expert by experience was a person who had personal experience of using and caring for someone who had used this type of service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We checked the information we held about this service and the service provider. We also contacted the Local Authority. No concerns had been raised and the service met the regulations we inspected against at the last inspection which took place in June 2013.

During our inspection we observed how staff interacted with people who used the service.

We spoke with five people who used the service, three relatives, the manager, the CEO, the ward manager, the chaplain, the chef, the head of Human Resources (HR), a HR consultant, senior administrator, family support councillor, site support manager, three registered nurses, four Health Care Assistants (HCAs), a palliative care consultant and two trustees.

We reviewed five people's care records, four medication records, four staff files and records relating to the management of the service, such as quality audits.

Good

Is the service safe?

Our findings

People told us they felt safe at the service. One person said, "What makes me feel safe is the attitude towards me, it's great; they always come up trumps for me every time."

People were kept safe from avoidable harm by staff and volunteers who had received safeguarding training. Staff and management were aware of their responsibilities to protect people from avoidable harm and abuse. They were able to tell us what constituted abuse and how and when they would report any suspicions.

Each person had individualised risk assessments in place to enable staff to support them safely but keeping their independence where possible. These included moving and handling and tissue viability. Risk assessments had been reviewed as and when required. There were generic risk assessments for the service and for the environment.

The service had contingency plans to be used in the event of an emergency. Notices of emergency contacts for the provider's management team and names and numbers for external contractors were displayed in the office.

The provider checked the premises were maintained to minimise risks to people's safety. Checks had been carried out by contractors on fire extinguishers, call points and alarms. These were all documented. There had been no actions required. The provider's site support manager showed us a computerised system which ensured all checks were carried out as required.

All accidents and incidents were reported and reviewed by a member of the management team to identify any trends or patterns. These were then fed into the governance meetings. This enabled the service to put into place any actions required to stop the accident/incident happening again if possible. We saw documentation which showed this had happened and fed back to the appropriate staff team.

There was an adequate number of staff on duty to provide care and support to people appropriately. Rotas we looked at showed a good skills mix of staff on each shift. One staff member told us there was a ratio of one registered nurse and one health care assistant for every two people who used the service. Every one we spoke with thought there was enough staff on duty at all times. The service had their own bank staff to call on to cover sickness and holidays. This helped with continuity of care as they knew the service well.

Safe recruitment practices had been followed. Each staff member or volunteer had provided proof of identity, references and had a Disclosure and Barring Services (DBS) check. Staff confirmed that they had not been allowed to start to work until all checks had been completed. Nurses PIN numbers showing registration with the Nursing and Midwifery Council (NMC) had been checked. Staff files we looked at confirmed this.

People told us they had their medicines when they needed them, and they were involved in choices about

their treatment including when medicines were used outside their licence (the use of medicines outside their licence is widespread within pain and palliative care for example mixing medicines together in a syringe pump). One person said, "Yes I take medication, 10 pills in the morning, some at lunch time and some at night and if I need more pain relief they do increase it. And no, they haven't told me about the side effects but I'm not worried, just the pain relief." Another said, "Yes I take medication and we do know what I take but I can't tell you what they are. And yes I have been told about the side effects but it went in one ear and straight out the other!" A third person said, "I self-medicate at home but the pain got out of control and I went to Southend hospital and that was yesterday and they wanted to send me home but while I was there I met doctor [hospice consultant's name] and she said I had to feel safe and she rescued me and bought me here. They're going to get my drugs managed properly."

Staff involved in medicines administration had regular training and their competency was assessed. The four prescription charts we examined showed that regular medicines were given as prescribed, however the medicines that were prescribed on an 'as required' basis did not always include instructions for how frequently to administer them, leaving the nurses to determine when to give them. There were no locally agreed policies or protocols in place to govern this but nurses had access to up to date reference materials to guide them on the safe use of these medicines.

At the time of our inspection no-one was administering their own medicines, but there was a system in place for them to do so.

There was an effective process in place to obtain medicines from a local hospital and a community pharmacy. Prescriptions were not regularly reviewed by a pharmacist, however staff could contact a pharmacist by telephone for advice, including out of hours.

We saw minutes to show that pharmacists from each supplying service attended drug and therapeutics meetings and were involved in policy review. Medicine incidents were reviewed and resolved individually and lessons learnt where appropriate. This meant that the service was working to the latest policy to ensure best practice for people who used the service.

There was a system in place to deal with safety alerts and recalls of medicines.

Medicines, including controlled drugs which require extra checks and special storage arrangements because of their potential for misuse, were stored securely and monitored regularly. There was a system in place to check that all medicines were within date. There were medicines available for use in an emergency and these were checked regularly. At the time of our visit the medicines refrigerator was not working reliably so a new one was being installed. Staff had recorded the temperature regularly, but had not taken action when the temperature went above the recommended range. This delay in reporting the fridge failure to maintenance staff meant the nurses could not be sure the medicines kept in the fridge were fit for use. The provider confirmed during our visit that they had ordered replacement stock.

We saw that when people were admitted to the hospice their medicines were checked by the admitting nurse and then the doctor continued the prescription if appropriate. Medicines no longer required were returned to the person's home or disposed of appropriately. When people left the hospice they were given a list of their medicines which explained how to use them. Their GP's were also advised that the list could be accessed on the person's electronic health record. Take home medicines were obtained from a local community pharmacist and could be supplied in a blister pack which made it easier for some people to manage their medicines.

Good

Is the service effective?

Our findings

People received effective care and support from staff who had the necessary skills and knowledge. People we spoke with told us they thought the staff were well trained and always knew what they were doing.

The provider had an intensive induction programme in place for all new staff, and a separate one for volunteers. We saw completed programmes had been signed off by a senior member of staff to state the staff member or volunteer had been found competent. Staff we spoke with told us they had found the induction informative and very useful.

We spoke with the senior administrator regarding staff training. He explained that they had regular team days. At the team day's staff completed a number of mandatory training sessions to update their skills and to ensure they followed best practice. The provider also offered nationally recognised qualifications, degrees and the opportunity to train at other hospitals which specialised in end of life and palliative care. One member of staff explained how they went on a recent training session given by a funeral director to learn the different rituals that needed to be adhered to for different faiths when someone has died. They expressed how important and helpful this was in helping them understand the different needs required when caring for people with different faiths. This information had been shared with other staff. Staff informed us the training they had received had been responsive to their needs and felt there were plenty of opportunities to develop their knowledge around palliative care. Topics for learning were advertised on the In-house Intranet as well as additional information being available in the hospice staff and volunteers newsletter. This assisted staff to know what training was available and to apply to attend.

Within staff files we found copies of staff supervisions and annual appraisals. Where required action plans for personal development had been put into place with dates for completion. We saw senior staff had been trained to carry out effective supervision. Staff we spoke with told us they felt very supported by the management team and could speak to any of them at any time.

The provider had introduced Schwartz rounds. These provided a structured forum where all staff, clinical and non-clinical, came together regularly to discuss emotional and social aspects of working in healthcare.

We found there to be good external links with the specialist palliative care team in the community, hospital palliative care team and In-house day care services. A weekly Multi-Disciplinary Team (MDT) was held at the local hospital and clinical representation from the service attended this clinical meeting. All newly referred persons who had complex palliative care needs were referred to the MDT for discussion and the outcomes of the MDT meetings were fed back at the clinical handovers.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. At the time of our inspection no one using the service was subject to a DoLS.

People had signed consent forms where they had been able, for treatment and care. Some people had lasting power of attorneys in place and staff were aware of these. Copies of these had been kept for referral. Staff had an understanding of their responsibilities under the MCA and we observed consent being sought throughout the inspection for a variety of reasons including; when people received personal care and medication administration.

People spoke highly of the food at the service. One person said, "The food is lovely and yes I get a good choice. At 2am one morning I had eggs and bacon and at 2am this morning I had toast and tea." Another told us, "You know, I've been here one day and they already know what I like – chocolate biscuits! Food is very good; you get what you ask for. It's very good." The chef was aware of who needed specialist diets and these were catered for. He told us all food was cooked fresh on site, including cakes baked daily. He said, "The food is a very important part of the day for people, they can have what they want when they want it. If we have not got it in stock someone will go out and purchase it for them. He also told us that he had recently carried out a sausage tasting. They purchased sausages from a number of suppliers and had a tasting session to make sure people were involved in the choices. There was a plan in place to do this with other foods as it had been a success.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion. One person said, "The staff are great I wouldn't have a bad word said against them." Another said, "Staff are brilliant, never too much trouble for them, very caring and if I'm feeling down they come and talk to me." A relative said,
"The staff are fantastic here. My husband was very poorly when he came here and he's been in here for just over a week now and should be going home tomorrow."

Staff we spoke with knew what person-centred care was and how important it was. We asked a member of staff if they could give an example of how a person's care needs were met. The staff member described how one person who had recently been admitted to the hospice expressed how important their dog was too them. Staff had then arranged for the dog to be brought into the hospice to visit the person. It was obvious from our observations that staff knew the people they were caring for. Staff were able to tell us about each person and their individual needs.

The service had an onsite chaplain who was available at any time to provide spiritual and emotional support. We spoke with the chaplain who was very supportive of the service and staff. He explained that staff could sometimes find the demands of their role stressful, so they were always available to listen to staff if they needed someone to talk to. He told us that there was an on call rota to ensure there was spiritual support for anyone 24 hours a day. There was a prayer room with facilities for a number of different faiths and staff were able to contact religious leaders from the local community for different faiths at people's request. The chaplain explained that although they carried out a lot of funerals, as part of their role in supporting people with their spiritual welfare, they also conducted weddings and told us of a few they had conducted in the service.

We were told that staff did a Bistro Buddy session for people. This was a meal served in a restaurant setting for people who were not well enough to go out but wanted a nice meal. Staff told us they made it as special as possible; this included a spa session or complimentary therapy and the meal. All of the ladies had a floral corsage made for them and they served drinks and wine if people wanted them.

We found that all the people who used the service had advanced care plans in place. One person said, "I've done my 'end of life' care, I don't want to go into hospital." When discussing with one person about their future care, they were aware they had an advanced care plan in place and discussed with us and told us how reassuring this was. They were confident the staff knew their preferred place of death, which was to be at home. However the person expressed that if things became difficult for their partner they knew they would be well cared for in the hospice. Any changes to people's wishes were updated in their care plan, together with evidence of any discussions. The changes were shared at the clinical handover and the person's wishes were then updated in the clinical records.

A member of staff explained how they manage dignity and privacy. They recalled an incident when a young couple wanted some time on their own. Staff respected this by using a privacy curtain and a 'Do Not Disturb' notice on the bedroom door to allow the person and their partner to have some private time. During our

visit we observed people being treated with dignity; staff knocked on each door and waited for a response before entering. Staff spoke with people and their visitors in a polite and dignified way.

We spoke with one person who told us they were allowed to be as independent as possible, they said, "I make all of my own decisions." And "It's wonderful here. I feel as though I've been rescued." They went on to say the staff would do anything for them but they wanted to do what they could for themselves and staff understood this.

People were encouraged to maintain relationships with family and friends. There was a small lounge where people and visitors could go. This had a selection of drinks for people to help themselves to. People were able to have visitors whenever they wanted. One relative told us, "We have family here from abroad and it is never a problem that we all turn up. In fact the staff know our names and even offer us tea and cake." The acting manager told us that although they did not have a specific room, they had a sofa bed and put up beds for relatives to use if they wanted to stay overnight to be close to their family member.

Good

Is the service responsive?

Our findings

The service had specific staff who carried out pre assessments and gathered all required information regarding each person before their admission. We spoke with one of these staff members who explained their role and took us through the procedure they followed. The people who use the service were asked for consent for staff to access and share all of their electronic records with other healthcare professionals. If this was given the service and other agencies would be able to access up to date information on a daily basis to enable them to respond consistently and effectively to any changes in people's needs.

Care plans were recorded using an electronic system. People's care was captured within individualised person - centred care plans. The persons specific individual care needs were identified at the front of the electronic records. Staff we spoke with told us they referred to people's electronic care plans prior to delivering care and this information was also shared at 'handover'. There was a laptop computer on a wheeled stand to enable people and their families with permission, to view their records. Care plans were subject to daily reviews or sooner if a person's health changed. They were updated when any review took place.

Some people had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) in place. Documentation was found to be transferable when people moved between the community, hospice and local hospital. Peoples DNACPR status was discussed at the clinical handover and this was always recorded on staffs clinical handover forms. These clinical handover forms were shredded at the end of each shift to avoid any confidential information being taken outside of the hospice.

People were encouraged to follow their interests where possible. One person said, "A nurse came into my room and played the guitar on Saturday and a nurse came in and played a euphonium yesterday, and I have physiotherapy. I used to come to the day centre and that's where I want to go."

Staff were responsive to people's emotional and practical needs. One person said, "I have used the counselling service." Another told us they knew about the counselling service but preferred to speak with their family. We spoke with a family support counsellor. They explained there was a team of counsellors, welfare benefits worker, social workers and a team coordinator, supported by volunteers. They told us they provided practical support and financial advice as well as talking and listening to people who use the service and their families. The service also had a bereavement team who all worked out in the community as well as in the service. For example, they visited people in their own homes or in the local hospital.

We saw that the service had a complaints policy and procedure. Information on how to make a complaint was displayed on the notice board within the hospice and was available in the information booklet given to people when they started to use the service. One person said, "No, never made a complaint. Never needed too." We found there had been some complaints. We saw that all the complaints had been promptly responded to in writing by the manager, who outlined a plan of action to deal with the specific complaint. We saw that each complaint had been resolved to the satisfaction of the person making it, and no further action was required.

Every person who used the service was given an opportunity to complete a questionnaire; this could be whist using the service or taking it home on discharge and returning it at a later date. Results from the questionnaires were analysed annually. We looked at the analysis for the year ending March 2016. The majority of results were very good, some comments included; 'There is not one fault, I would not change anything.' 'The staff are very friendly and accept and accommodate people's finicky ways.' And 'I love the fact that nurses and doctors have time to talk.'

Good

Is the service well-led?

Our findings

There was an open culture within the service. Staff and volunteers knew who the management team were and they were all seen conversing throughout our visit. It was obvious that everyone felt comfortable chatting with each other. Staff told us all management were approachable. Staff we spoke with told us they felt able to question practice if necessary and that they would be encouraged and supported to do so.

The CEO spoke of the vision for the hospice. They were in the process of developing their own in house run hospice at home service along with building a new purpose built hospice to replace the buildings they were in. They told us there had been a lot of consultation with people and staff with regards to these decisions. Staff confirmed they had been consulted and were excited about the new build.

Staff we spoke with told us they were involved in the development of the service. One staff member said, "We had someone bring us actual floor size plans of the rooms for the new build. It was really good as we could actually see if we could move the equipment around and make suggestions at this stage."

We observed staff to be kind and compassionate. All the staff we spoke with stated they loved working at the service as it felt like 'one big family'. One member of staff said that they understood and supported each other, and recognised if a colleague was emotionally struggling with a person who was being cared for. They recalled an incident when they felt sad that a person who they were caring for died, their colleagues recognised the impact this had on them and they gave them some time out to reflect and be in a quiet place to cry. The service also had support in place through one to one meetings with their line managers or the service's own counsellors to ensure staff were emotionally supported. There was also a staff confidential support line on the staff notice board. This showed staff could get support in a number of different ways. During our inspection we noted that the interaction between staff within the service was friendly, respectful and supportive. They were aware of each other's roles but they worked as a team.

There was a registered manager in post. At the time of our inspection they were on long term leave. A manager was in post who was being supported by the CEO and the management team. They were in the process of applying for their registration with CQC. Registration requirements were being met.

Information held by CQC showed that we had received all required notifications. A notification is information about important events which the service is required to send us by law in a timely way.

The manager was aware of the day to day activities within the service; they were on site daily and available on call out of hours. Staff told us they were very supportive and available at all times. We observed that staff on the unit had good leadership and although there was a hierarchical structure in place they all felt valued in what they did. Staff mentioned that managers and leads were always visible around the hospice and they knew who they were. Recently the CEO shadowed one of the housekeepers to see what their role was and this was seen as an extremely valuable exercise. Staff we spoke with felt that despite the number of changes that had taken place within the management structure they still felt supported and the managers were approachable and supportive. They felt that the changes had been positive and the managers were still

listening to their concerns.

The unit held monthly team meetings where staff told us they were encouraged to bring any issues that were affecting their work. An example was given about how staff were unhappy about constantly having to work longer than their allocated hours. A solution was found and staff felt this was a positive outcome and that as a team there was equal participation and ownership in resolving issues.

The provider had a board of trustees. Staff told us they quite often met trustees within the service and they were always present at any events they had. We met with two trustees who explained their roles. They told us there were at least two trustee members on each of the governance committees to enable them to discuss any issues before they went to the board for approval. An annual skills matrix was completed to ensure any skills they had were used effectively and new trustees were sought if they felt there was a need in a specific area.

The provider carried out a variety of quality assurance audits to ensure high standards of care was maintained. These included clinical incidents, carer's audit and health and safety. Each audit was evaluated and an action plan developed if required. This was followed up at the next audit to ensure all actions had been completed. There was an action plan in place to look at different ways to gather people's feedback. This had been planned as a discussion at the next user group meeting.

Recording systems were robust. Each staff member had individual log on for the electronic records and the provider's intranet. Paper copies of records were kept when required and confidential records were kept locked. The CEO told us they worked closely with other hospices within the country and Hospice UK. They used Hospice UK's benchmarks to develop themselves as a provider and a service. This ensured people who used the service were receiving care and treatment in line with national guidelines.

The service had achieved the Queens Golden Jubilee Award for Volunteering and Investment in Volunteers. Both of these were in recognition of their work with volunteers.