

Rennie Grove Hospice Care

Gillian King House

Inspection report

Hodgemoor View
Three Households
Chalfont St Giles
Buckinghamshire
HP8 4LS

Date of inspection visit:
17 February 2016
18 February 2016

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15 July 2016

Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

The inspection took place on 17 and 18 February 2016 and was announced.

Gillian King House provides Hospice at home care. The service provides 24 hour access to specialist nurses to deliver planned and responsive care in people's homes.

Gillian King House is the office base for the Hospice at Home nursing team for South Bucks and Wycombe.

There is a registered manager in place who has been in post for many years.

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 received care and support in a personalised way. Their complex medical needs were well managed and staff were trained to meet these needs. Risks were assessed and managed. Staff knew people and understood their complex needs.

Staff were caring and showed people kindness and compassion. Staff were motivated and demonstrated a commitment to providing the best quality care in a compassionate way. People told us they were cared for to a high standard and this included on-going bereavement support for families. Planning for end of life care and post death support was provided to families. Bereaved families told us that the support had been invaluable.

There was a holistic approach to people's care with the spiritual needs given equal importance. People received a responsive service with needs fully assessed, planned and met.

The service was aware of their responsibilities in regard to the Deprivation of Liberty Safeguards (DoLS). These safeguards aimed to protect people from being inappropriately deprived of their liberty.

The feedback we received from people was excellent. Those people who used the service expressed great satisfaction and spoke highly of the registered manager and staff. For example one person said "I wish there were more funds available for them to employ more excellent staff".

The safety of people who used the service was taken very seriously and the registered manager and staff were well aware of their responsibilities to protect people. There were systems in place to ensure that risks were identified and addressed.

The registered manager ensured that staff had a full understanding of people's care needs and had the skills and knowledge to meet them. People felt safe and secure when receiving care.

People had positive relationships with staff and were confident in the service. There was a strong emphasis

on key principles of care such as compassion, respect and dignity. People who used the service said they were treated with kindness and said their dignity was always respected. Changes to people's needs were quickly identified and amended.

The registered manager was committed to continuous improvement. Feedback from people was used as an opportunity for improvement. The registered manager demonstrated a good understanding of effective quality assurance systems.

There were processes in place to monitor quality and understand the experiences of people who used the service. The registered manager demonstrated strong values and a desire to learn about and implement best practice throughout the service.

Staff were highly motivated and proud of the service. They said they were fully supported by the registered manager and a programme of training and supervision that enabled them to provide high quality service to people.

Professionals gave positive feedback about the service commenting on qualities, skills and knowledge of the staff. Staff were recruited safely and received an induction and specialist training to ensure they had the skills and knowledge to meet people's needs.

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.

People were protected from harm.

People had confidence in the service and felt safe when receiving support.

Risks to people who used the service were addressed.

Staff had knowledge and skills to provide care for people in a safe and consistent manner. There were sufficient staff recruited to meet people's needs.

Medicines were managed safely.

Is the service effective?

Good ●

The service was effective.

Staff monitored people's dietary intake and any risks identified were closely monitored.

Staff were provided with effective training and support to ensure they had the necessary skills and knowledge to meet people's needs effectively.

The service was aware of the principles of the Mental Capacity Act (2005). This meant that people who lacked capacity received care and support that was judged to be in their best interest.

Is the service caring?

Good ●

The service was caring.

People valued the relationships they had with staff and expressed satisfaction with the support they received.

People said staff treated them with kindness and respect. The service supported people to express their views and be actively involved in making decisions about their care, treatment and support.

Is the service responsive?

Good ●

The service was responsive.

Changes to people's needs were quickly recognised and appropriate action was taken to include the involvement of

external professionals where necessary. People contributed to the assessment and planning of their care as much as they were able to.

People's feedback was valued and any issues were dealt with in an open and transparent way.

Is the service well-led?

Good ●

The service was well led.

People and those important to them had opportunities to feedback their views about the quality of the service they received.

Staff were proud to work for the service and were supported by the management.

The registered manager promoted strong values and a person centred culture.

There were robust systems in place to assure quality and identify any potential improvements to the service.

Gillian King 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.

This inspection took place on 17 and 18 February 2016 and was announced.

The provider was given 48 hours' notice to ensure the registered manager would be available to assist us with collecting information relating to the service.

The inspection team consisted of one inspector. A Provider Information Return was not requested prior to our visit (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 planned to make. The purpose of the information is to highlight risk and provide a summary of the service, people's views and experiences.

We spoke with five people who received a service from Gillian King House. When visiting the office we spoke with the registered manager, three members of the nursing team, three care staff, two members of the HR team and two volunteers.

We reviewed a range of records about people's care, including staff recruitment files, staff training records, quality assurance records, minutes of meetings with staff and incident reports. We also viewed policies and procedures, staff rotas and sample care plans.

The previous inspection was carried out in January 2014 and was found to be fully compliant at that time.

Is the service safe?

Our findings

Everyone we spoke with said they felt safe and supported by the staff who worked at Gillian King House. One person said "They make me comfortable and I feel safe knowing they are around". Another person said "If I am worried I know I can talk to the staff".

A safeguarding policy was available and staff completed safeguarding training as part of their induction. Staff were knowledgeable in recognising signs of potential abuse and the correct reporting procedures. One member of staff said "I would report any concerns even if it was about a member of the team". The registered manager informed us that any concerns regarding the safety of a person would be discussed with the local authority and referrals made when necessary.

Assessments were undertaken to assess any risks to people who received care and support. This included any risks such as malnutrition due to deteriorating health. For example, due to the nature of the support provided this would be individual to each person receiving care. Risk assessments included information about action to be taken to minimise the chance of harm occurring. Some people had reduced mobility and were at risk of falls information was provided to staff on how to support them when moving around their home and transferring from bed to chair.

Staffing levels were determined by the number of people using the service. In addition the service considered potential absence due to staff sickness; this was taken into consideration when calculating how many staff were needed to ensure safe staffing levels. There were sufficient staff deployed with appropriate skills and experience to support people safely.

The service followed safe recruitment practices. Staff told us they received a comprehensive induction and mentorship program. Staff files we looked at confirmed that checks had been undertaken with regard to criminal records, obtaining references and proof of ID. Volunteers also undergo the same rigorous recruitment checks.

Medicines were administered safely by registered nurses who had completed training in administration of complex medicines specifically relating to the people receiving end of life care. There were up to date policies and procedures in place to ensure that medicines were managed in accordance with current regulations and guidance.

This was carried out during the regular meetings with senior staff and clinicians. Training records and discussions with staff evidenced that training had been completed in the administration of medicines and their competency assessed. Medicines were stored in people's homes.

Accidents and incidents monitored were thorough, questioning and objective. Action plans were developed and monitored to make sure they were delivered.

Is the service effective?

Our findings

Everyone we spoke with said staff were competent in their work. One person said "I cannot believe the weight lifted off me the moment they came into the house and I was also contacted by telephone to see how I was after [person's name] died."

The service offered complimentary therapies, one person commented "Through my treatment the reflexology was like a tonic to me". In addition a family support counsellor and volunteers provided support to people's carers (family members and close friends) from diagnosis during treatment and bereavement. Another person who received the support of the service said "During the time that [name of person] suffered we were both supported by the service and had a 24/7 contact number which was a great comfort, I used this on several occasions when I felt unable to cope. I was touched that a member of staff attended [name of person] funeral. I am currently attending the monthly bereavement meetings that the service runs."

Family support listening volunteers were also part of the support that the service offered. The volunteers provided support to people carers' family members and close friends. This may involve one to one support, attendance at regular social support groups or telephone contact. One person we spoke with said "the service is like a lifeline to me since the loss of my family member".

People were supported by staff that had the knowledge and skills to meet their needs. Gillian King House had Health Care Assistants (HCAs) to support the clinical team. Plans were in place to develop HCA competencies in line with Knowledge and Skills Framework (KSF). The KSF is a competence framework to support personal development and career progression within the National Health Service (NHS) in the United Kingdom. One member of staff we spoke with said "It's brilliant, you get a month induction and have a mentor, I feel that I can work to my potential".

Another member of staff said "I am pleasantly shocked by the amount of training and support you get". With regard to visits, staff told us, "There is no specific time during visits; you get the time to ensure people's needs are met". This meant that people's care was not rushed and staff were able to spend enough time to deliver support and care.

New staff completed an induction programme at the start of their employment which followed nationally recognised standards; end of life training was part of the induction. Staff told us the induction helped them with the knowledge to support people in their own homes. During the induction staff read the service's policies and procedures. They confirmed the induction process included shadowing other more experienced staff and spending time with people before working independently. Training was provided during the induction and on an on-going basis thereafter. A training programme was in place that included courses that were relevant to the needs of the people who received care from the service. Staff had received training in areas that included consent and capacity, equality, dignity and diversity, safeguarding, moving and handling, information governance, infection control, fire safety. Future training had been arranged in areas that included dementia care, end of life, advance care planning and DNACPR (do not attempt cardio-pulmonary resuscitation). This meant that people could be confident their care was carried out by staff who were confident and knowledgeable in their role.

There was a non-medical prescriber at the service. Non-medical prescribing was undertaken by a health professional who was not a doctor but had received appropriate and on-going training to be as competent to prescribe as a doctor. This benefitted people during 'out of hours 'and if deterioration occurred rapidly. It provided extra support for end of life care and supported the GP.

Nutritional care plans were in place in people's homes, if there is a specific issue, liaison with external health care professionals took place as necessary. Staff had completed training in nutrition and assessment of malnutrition.

The service ensures that all care and treatment provided is carried out with the consent of the person receiving care. People receive a letter from the director of nursing in their information pack prior to commencing care and treatment. The letter requests that a consent form is signed where possible. Where a person is unable to give consent, care and treatment will continue to be provided which is judged to be in the best interest of the person.

Staff received regular supervisions and appraisals in line with the services policy and procedure. Staff we spoke with confirmed this.

On going multi-professional approach ensured streamlined, integrated approach to service provision. The on-going evaluation of care was via monitoring of electronic documentation and care planning in the home. The service plans to further develop the health care team two health care assistants are being employed permanently. Mobile laptops/tablets are being piloted by all teams to improve connectivity when working away from the home base.

Is the service caring?

Our findings

People spoke highly of the kind and considerate care they received from staff. Positive comments included "My wife benefited from the care she received, it is a wonderful service".

The registered manager was motivated and passionate about making sure people had excellent palliative and end of life care based around themselves and their families both day and night. This enthusiasm was also shared with the staff we spoke with.

Staff were respectful of people's privacy and maintained their dignity. They told us whilst carrying out personal care it was important that doors were closed as a sign of respect and to keep the person covered as much as possible. Staff received training in relation to dignity and respect. Their practice was then monitored when they were observed in people's homes. One of the people we spoke with said "They always make sure my hair looks nice and that makes me feel better".

Staff understood the importance of promoting independence as much as possible. People who received care from the service were often frail due to their illness, however, staff told us they 'support' rather than take over. This was confirmed by people we spoke with; they told us "They assist when I ask them to".

People were supported to express their views and to be involved in making decisions about their care. Care plans were specific to the client group. For example, in addition to the person's main care plan was a document 'getting it right for me' which was a person centred assessment record that accompanied the care plan and progress notes. This document involved the person in the process of planning and delivering care. It invited the person to complete sections of the plan where possible and invited them to sign the document to show they have been involved in the care plan. People we spoke with commented that the plan helped them discuss aspects of their illness in a more constructive way, identifying issues they felt were important but did not know how to 'open the conversation'. One of the questions in the document asked 'Is there anything else you are concerned about at this time'. The person's initial response may be 'no' but as the illness progressed the answer may change. Staff confirmed this was often the case.

Advanced communication training for staff ensured effective management of difficult and emotive situations. Regular assessments of needs and holistic care plans were documented and monitored against people's needs. Spiritual care needs were assessed and documented in people's care plans.

Complementary therapy was offered to people family and carers to improve well-being. Counselling and listening support was also offered to provide support when reaching the end of life.

Carers support and bereavement counselling was also offered as part of the service. This enables families to understand the end of life process. Telephone support was also available 24 hours a day.

Is the service responsive?

Our findings

People and their relatives were involved in developing their care, support and treatment plans. Care plans were personalised and detailed daily routines specific to each person. Staff confirmed each person's care plan contained information specific to their needs and any changes in delivery of support was documented and discussed with the person receiving care. People told us "They always ask me if anything has changed and if I am happy with the care provided".

Care, treatment and support plans were personalised. The examples seen were thorough and reflected people's needs and choices. An example of this was the document 'Getting it right for me'. The record incorporated vital information that the person may take with them if they moved to another service. The information included the person's care needs and wishes at the end of life.

Complaints and concerns were responded to appropriately and used as an opportunity to improve the service. All complaints were logged, any clinical complaints were discussed at Clinical Governance Committee meetings where actions and any additional training requirements were identified. There had been no complaints in the 12 months prior to our visit.

The service valued feedback from people and their relatives and used this as an important way in which staff can identify issues, resolve problems and improve the quality of the care provided. We saw the patient and carer feedback survey dated from 1st April 2015 to 30th September 2015. The survey contained mainly positive feedback and where any negative comments or suggestions were raised these were responded to and resolved. The health care professionals with whom the service worked were also sent biannual surveys. This last survey had been completed in April 2015 and included hospitals, GP practices, district nurses and specialist services such as Macmillan. Feedback from this survey in 2015 had helped improve communication and helped the organisation identify areas for development including the identification of Skills Needs Assessment (across the spectrum of nurses) from healthcare assistants (HCAs) to community nurse specialists (CNS). Skills needs assessments were to identify the required essential skills to carry out the safe assessment planning and delivery of specialist palliative care for people being nursed in their own home. Benefits to people who used the service were having care needs assessed and planned by staff who had been specifically trained in this area.

The service worked in collaboration with other health and social care providers to ensure the provision of high quality care through a comprehensive clinical governance structure and the education and training of staff. All the organisations referrals were received from a single point of access then triaged and prioritised by the nursing teams. Multi-disciplinary meetings took place on a weekly basis to prioritise referrals. This meant that people who required urgent support were referred to the service in a timely way.

Gillian King House supported people to meet any spiritual or religious needs. Staff had training in spirituality and had explored what spirituality was and how they could identify signs of 'spiritual pain'. Staff told us, "Spiritual pain may be recognised as distress and anxiety even when the person does not have physical pain". This meant that people could feel supported in a psychological and emotional way as well as receiving support with their physical pain.

People's care plans were used to make sure that they received care that was centred on them as an individual and the planned care was provided to them when and where they needed it. This included individual preferences interests and aspirations and made sure they had as much choice and control as possible.

People's needs were reviewed regularly and as required. The service ensured people's unpredictable condition was identified and had access to support and equipment. For example, the service had non-medical prescribers who could administer controlled drugs and medicine as necessary. This meant that people received pain relief in a timely manner.

Is the service well-led?

Our findings

The registered manager was committed to continuous learning for herself and for her staff. They had developed and sustained a positive culture within the service.

The service had a board of trustees consisting of multi-professionals who work on a voluntary basis to lead and monitor the organisation. The boards meet bi-monthly. There is collaboration externally with other health care providers to benchmark activities and service developments.

We received positive feedback from an external professional who was very complimentary about the service and the staff. The Health Care Professionals Survey carried out during May 2015 received feedback such as 'I have a good working relationship with the teams' and 'The involvement of the hospice service promotes patient choice'.

The positive and sustained culture that was open, inclusive and empowering ensured staff were motivated. Staff told us they felt fully supported by the manager and senior staff and that they received regular support by face to face meetings and formal supervisions.

The service's vision to provide specialist palliative care to support people and their families at end of life, making the choice to be at home to die a reality was supported by the people and families we spoke with. Comments such as "The wonderful care enabled [name of person] to remain at home." Similarly "We only needed the service at the very end [name of person] did not want to go to hospital and thanks to the service they did not have to". This was reinforced by the Health Care Professionals Survey when comments such as 'The additional resources the service brings can help a patient stay at home' were received.

The services' Quality Assurance Programme included clinical and non-clinical audits. Progress on the action plans following audits undertaken was monitored through the Clinical Audit Group and reported to the Clinical Governance Committee and Trustees. This ensured that quality assurance systems were in place to monitor the quality of care and support that people received. Staff surveys were used to identify issues for staff across the service, this information was used to guide the organisation in developing systems and processes to ensure the highest standards of care were provided.

People and staff had confidence the registered manager would listen to their concerns and would be received openly and dealt with appropriately. People benefited from staff who understood and were confident about using the whistleblowing procedure. We saw the services' whistleblowing policy which stated 'we are committed to a culture where it is safe and acceptable for all staff to raise concerns and we encourage staff to report suspected wrongdoing as soon as possible'. This was reinforced when we spoke to staff who told us they would have no hesitation in reporting any concerns they may have. Complaints policy and procedures were used to identify and monitor trends and formulate action plans when required.