Gold Standards Framework in Care Homes Programme

Re Accreditation Round 11 (2016) Quality Hallmark Award Final Report

Care Home Details	
Name of Home & Coordinator	Derbyshire House
Care Home Registration Number	14
Address	Station Road, East Leake, Loughborough, Leics, LE12 6LQ
Telephone Number	
Facilitator	
GSF Visitor/Date	30/06/2016 L Hollowood
Final Score	
50/50	

Number of Excellents awarded	**E** **17**	

Panel Decision	**BEACON**
Comments	This home was a truly outstanding example of how to provide individual and high quality care for people nearing the end of life and for their residents with dementia it is a safe haven where they can thrive. Living well until you die is evident at every stage of the care process. The whole team approach to the implementation of GSF is what makes it such a success here – it is everybody's business and each staff member has an important role and demonstrate a quiet pride in delivering it. I spoke to residents and visitors to the home and the praise was of the very highest, particularly from an ex nurse who's mother had recently died in the home – her final words to me were 'this place is brilliant!' and I have to agree.
Areas of Strength	The leadership and administration support ensure that the framework is implemented smoothly. The home is a non-profit making charitable organisation and that ensures that the ethos is very much resident centered. The changes made in support of Dementia Care Matters are utterly conducive to support GSF philosophies. The home is moving forward and continuing to strive for better all of the time,
Areas For Development	To carry on with the good work

The 'must do standards' which are listed below and also highlighted need to achieve full marks not 'working towards'

Standard 1E
Standard 2B
Standard 3A
Standard 4A

Standard 1. Are we identifying the right residents and recognising them and their needs early enough?

a) Identifying residents. The team has a means of identifying the stage of every resident on a register. The register includes all residents in the home.	**Score**	**E**
All residents on a register. A 'quick view summary' template gives all relevant information regarding GSF including codes, DNACPR Status, OOHs forms, anticipatory medication, DoLs, dates of ACP and PPC discussions and date for review.	**2**	**E**
b) Needs Based Coding is used to help prioritise care e.g. traffic light system (RAG), A-D.		
Coding used as an effective care management and communication tool, all staff aware of coding.	**2**	
c) Meetings to discuss residents on the register are used effectively to prioritise and identify need, and provide better coordinated care from all MDT members.		
Monthly coding meetings which include GPs and Community Matron teams	**2**	**E**
d) There are identified GSF coordinators, but all staff in the home are involved appropriately and there is senior support to enable the coordinators and other staff to work effectively.		
GSF Coordinators and their support system is very clearly identifiable – please see standard 5 –c.	**2**	
e) The team are able to evidence that they work with the wider health teams in communicating and developing the coding, individual care plans and proactive identification of personal resident needs and choices with them.		
Wide engagement with coding review meetings, evidence of collaborative working seen with Macmillan nurses, mental health team and dementia outreach teams to support identification of deterioration, management of care and individualised care plans.	**2**	**E**

Standard 2. Do we really know the residents' and carers' needs wishes and preferences for care towards the end of their life?

a) Clinical needs are assessed and addressed routinely. The home uses symptom and holistic assessment tools for all residents, including behavioural assessment tools for those with cognitive impairment/communication difficulties.	**Score**	**E**
Comprehensive and individualised care planning seen with tools used effectively to assess residents needs. Care and attention paid to those with cognitive impairment and working with them closely to identify changes in behaviour, which may indicate change in needs. A community matron present at the visit told me about how the home were 'innovative in their approach to assessment' and had involved in her in training for the use of the Abbey Pain Score to improve on what they were already doing.	**2**	
b) Assessment of personal needs - Advance Care Planning or best interest discussions if there is a lack of capacity, offered to all residents as routine. A clear system is in place to document preferences including PPC, and to demonstrate % of residents with an ACP/PPC (target = >90%)		
100% of residents have an ACP in place, which is used as a 'live' document to reflect changes in [references or needs. PPC is clearly identified within this	**2**	**E**
c) Carer assessment and support: The needs of families and others identified as important to the resident are actively explored, respected and met as far as possible. Written information is available to signpost people to other support networks.		
Good documentation of family involvement in care planning process with their needs identified too. A daughter of a relative who had lived in the home for 18 months who visits daily stated that she experienced high levels of involvement in mum's care and was well informed. 'Mum feels safe here…..they have the patience of saints as mum suffers with anxiety and sometimes they have to sit with her all night…. Even the manager will sit with her all night' When asked about planning for future care I was told 'yes, we've been through all that, DNAR, living will and all that, they go through it all of the time…… Mum's on the 4 colours scheme, she's weeks at the moment but if she gets worse and goes to days they'll sit with her 24/7 if she needs it.' She also expressed how welcome she felt at the home, they always offer her a meal and she can walk in and out at will.	**2**	**E**
d) Dignity is an integral part of daily practice, residents are offered choice and privacy, and enabled to receive compassionate and dignified care and death.		
Everything about the environment, décor, atmosphere and care given that I witnessed was shrouded in dignity and respect for the individual. Each resident's room had a personalised frontage and address and individuality was reflected in each room. Meal times are flexible to meet individual's needs, staff always eat with residents, and no uniform is worn to maintain a homely atmosphere. Each resident has an active bucket list, within their life story, developed with them and their families culminating in a beach being brought to a a very frail lady, a man with advanced dementia and inability to communicate verbally going swimming a couple of weeks ago as he used to swim daily until he was 80 (very moving photo's seen) and other such examples. Life story work is on-going with each resident as the ethos is that life is continuing and does not stop with admission to this home. All profit from the home is reinvested to enhance care example - £30,000 profit made last year was invested in to a minibus to take residents out.	**2**	**E**
e) Dementia care: Activities and environment are conducive to the reduction of the impact of dementia, and other cognitive difficulties, on the person. There is specific, relevant training for all staff, and appropriate assessment tools are used. Life story work is in place		

This home is working towards the 'Dementia Care Matters' award and the care and understanding of this condition is reflected in all that they do. Three different social areas are available to residents which cater for the changing nature of the disease, one was for people who were sociable and able and had an accessible garden attached, social group activities going on, another was for those who spend time in an alternative reality, had 2 vintage work stations for typing in an office environment and sewing with an old Singer sewing machine. It had a vintage bar and décor, a low, accessible kitchen, music and photos and a quieter area for people with more advanced dementia was full of individual reminiscence, and one to one care observed with staff going through photo albums or talking quietly and holding hands. Namaste care is used throughout the home with lots of resources such as lights, music, massage to support and so it can be given in resident's rooms. Most effective use of Life Story work that I have witnessed … 'the story goes on…' Home décor provides visual cues to orientate people with memory loss – Poppy Fields street, corridor decorated with poppies, etc. Sensory gardens and access from each bedroom and social area to secure and pleasant garden spaces. Pets in the home, dogs, cats, rabbits, tortoise's. Staff are well trained and confident in providing good care to people with dementia. Staff spoken to had participated in a week long face to face course in preparation for Dementia Care Matters.	**2**	**E**

Standard 3. Are we planning the provision of care across boundaries?

a) Integrated Cross Boundary care: There is an effective communication process to reduce avoidable crises, and inappropriate hospital admissions towards the end of life. Particular focus on enabling the person with dementia, and other cognitive difficulties, to remain in the home. There is an active and effective process in place to reduce length of hospital stay.	**Score**	**E**
GSF meetings are incorporated into monthly ward rounds with GP, Community matrons and DN teams. All residents transferred into hospital go with a 'snatch pack' – documentation pack which includes specific hospital avoidance documentation DNAR, ACP, PPC etc… They also use a Rapid discharge form and daily ward contact to facilitate early discharge once in hospital. DN team support with provision of equipment to support early discharge. Intervention from an Age UK 'Worry Catcher' – an independent advocate who visits the home and talks to residents who may have concerns, worries or distress every 2 months and reports back anything appropriate which feeds into care plans.	**2**	**E**
b) DNACPR policy, verification of death policy linked to CCG /Out of Hours provider policies. (N.B. this score is dependent on local policy to score 2) Awareness of DOLs legislation and rulings around dying under a DOLs		
All residents except 1 (by personal choice) have a DNACPR as it forms part of the initial admission assessment. DoLs training is part of mandatory training.	**2**	
c) Robust measures to improve the continuity of care out of hours e.g. handover form sent by home / GP practice provider for those most unwell (C+D).		
GP completes OOHs forms at C and D	**2**	
d) Anticipatory medication when coded 'C' is routine practice and PRN drugs to prevent crisis admissions considered.		
GP will prescribe anticipatory medication at time of coding, in attendance at GSF meetings. They will also visit if required if a resident deteriorates.	**2**	

Standard 4. Are we enabling care aligned to resident preferences in the final days?
Planning Care in the final days

a) Care in the final days – Consistent use of individualised end of life care plans in line with the 5 priorities for care. (Refer to page 7 of 'One chance to get it right' – Leadership Alliance for the care of dying people. June 2014)	**Score**	**E**
End of Life care plans seen, consistent with 5 priorities and evidence of individual care planning. Plans in place for those expected to deteriorate.	**2**	**E**
b) Support for the relatives, close friends of residents and awareness of their practical and emotional needs. Written information for relatives about what to expect when someone is dying		
Information available to support those who have relatives dying 'What to expect…' and a personal bereavement pack is provided, that includes appropriate signposting. A recently bereaved relative visited the home and told me that when her mother was dying 'every time I walked in day or night someone was sat with Mum….. not only did they look after her but they looked after me and they are still doing so'	**2**	**E**
c) Ensuring that holistic, dignified and compassionate care of residents is part of the policies and practices of the home, particularly related to care in the dying phase including provision to ensure that no one dies alone unless that is their recorded wish.		
When a resident is coded 'D' an extra member of staff is put on to rota to solely meet theirs and their families needs, as evidenced by rotas and relatives testimony's.	**2**	**E**
d) Following the death of a resident, there is good care and support for relatives, staff and other residents, including written information and signposting for bereavement care.		
Memorial services held at the home and provision for wakes if required. Lots of staff attend funerals. Memory garden with wall mounted plaques for each resident, and staff that have died at the home, and a named rose is planted for each resident and a certificate presented to family. Structured bereavement support in place. Staff are involved in reflective practice and a junior member of staff described very good team support provided to her when experiencing her first deaths.	**2**	**E**
e) Significant Event Analysis (SEA) after a death to develop the means to improve professional practice and staff support.		
SEA's completed at GSF meetings so are multidisciplinary. They also always complete a case history, as shown in their portfolio, for every death to highlight to staff how they are meeting the 7 C's. Evidence of whole staff involvement in SEA process and of reflection.	**2**	**E**

Standard 5. How will we sustain and build on these improvements, to ensure we provide consistent high quality care for every one of our residents nearing the end of life?

a Full integration of GSF within the Care Home with all staff aware & involved in the processes	**Score**	**E**
Whole team approach to GSF with domiciliary staff and administrative staff having key roles. Example - The chef was recently asked to read a poem when someone died by the daughter, so she visited the deceased in her room and did so. The home have an innovative staffing structure to support the use and integration of GSF – The Tree of Life – which is depicted in the little conservatory at the homes entrance as a pictorial tree with photos of staff who support GSF. The 'roots' is Sharon, home manager and coordinator who leads by example and supports the development of GSF, The 'trunks' are non clinical staff including an administrator whose passion for GSF and attention to detail ensure that the homes policies, that incorporate the framework, are adhered to, the 'branches' are senior carers and ensure any relevant information is branched out through the home and the petals are the rest of the team members who are described as the 'most important people for providing emotional support to people in their final days'. All residents have a named petal that will incorporate life story and Namaste care into their final days.	**2**	**E**
b) There is a plan for staff education and ongoing training with, induction training of new staff to include palliative care, GSFCH and communication skills. Reflective practice and learning support for all staff, including competency assessments, supervisions and training records		
Comprehensive and up to date training matrix, updated monthly by administrator. Lots of evidence of detailed reflective practice seen.	**2**	**E**
c) Explain any significant developments / initiatives / changes the home have made to improve the care of the person at the end of life.		
• Tree of Life staffing structure • New wing built to increase capacity from 27 -31, but also provides additional social area, hair salon, conservatory and office space • Progression towards 'Dementia Care Matters' • Staff levels have increased so there are 7 care staff on duty at all times. • Wi-Fi throughout home used to enhance residents lives and also facilitate better multidisciplinary working • Bucket List • They offer wakes with complimentary food, order of services and provision of a commemorative CD with life photos • Roses added to memorial garden • Documentation updated to meet 5 priorities of care • Reduced hospital admissions • Minibus purchased • All staff complete Care Certificate a part of induction • Worry Catcher – advocacy service from Age UK	**2**	**E**
d) The home demonstrates that they are involved with local forums and meetings and/or influence local provision & policy.		
The manager attends local home managers meetings and is a representative on a joint homes board. She is proactive in sharing best practice and the local authority have visited the home in recent times for examples of best practice to take to other homes.	**2**	

Inclusion of case history to demonstrate continued practice development and embedding GSF. The case study must relate to the seven 'C's and include reflection on the individuals care.	Score	E
A well written case study which demonstrates the provision of individualised care whilst maintaining the highest level of autonomy for the resident and showing how the 7 C's are incorporated into EOL care here.	**2**	**E**