Gold Standards Framework in Care Homes Programme

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

Care Home Details	
Name of Home & Coordinator	St Dominics
Care Home Registration Number	39
Address	London Road, Kelvedon, Essex, CO5 9AP
Telephone Number	
Facilitator	
GSF Visitor/Date	D Douglas
Final Score	
49/50	

Number of Excellents awarded	E 4	
Panel Decision		
Comments	This is the first time for Re Accreditation and the home has maintained the process and principles of GSF over the last three years. It has been particularly challenging for them as they have prepared for re accreditation, and the portfolio statements did not adequately tell the story for each of the standards. This has been due to the Manager being off for some time. However, the visit, and the evidence seen in the home has demonstrated how embedded GSF is.	
Areas of Strength	Supportive Management Strong leadership. Commitment to training and continually improving. Very good relationships with GP, DN and Palliative Care Nurses from the hospice. Good relationship with the local hospital to facilitate rapid discharge of residents. Good reputation for end of life care.	
Areas For Development	St 2c -Update information folder and GSF leaflet	

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 10**	**E**
The home has a coding register for all residents	**2**	
b) Needs Based Coding is used to help prioritise care e.g. traffic light system (RAG), A-D.		
The home uses a Traffic light system Blue, green, amber, red	**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 review meeting held at the home, GP, DN & SPCN from the local Hospice attend. DNACPR and ACP are also discussed at this meeting. Daily 11am meeting of ALL heads of departments, including catering and housekeeping to discuss residents and handover sheet with coding and DNACPR status on. The information is then disseminated to each of their teams.	**2**	**E**
d) There are identified GSF coordinators, but all staff in the home is involved appropriately and there is senior support to enable the coordinators and other staff to work effectively.		
The main coordinator is the Manager, who has been off for some time and therefore the Assistant Manager, Admin & Clinical Lead has continued on. However, all staff is involved with good support from the senior management.	**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.		
The monthly MDT review meeting is held at the home which includes the GP, DN and SPCN. The home is a Residential Home with excellent daily support from the DN who visits daily. The GP visits routinely every fortnight and when necessary. The home has a very good relationship with the GP.	**2**	

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 10**	**E**
Waterlow, Abbey pain assessment, Body maps, Dolplus 2.	**2**	
b) Assessment of personal needs - Advance Care Planning discussions 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%)		
Preferred Priorities for Care/`I AM' are offered to all Residents with capacity. Those who have cognitive impairment, information are recorded. Leaflets informing residents of ACP discussions are given/available.	**2**	
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.		
At Pre admission & admission residents and relatives receive an information pack. If the resident is for palliative care, the staff will discuss with them end of life care which will be provided. The home has a variety of written information which is given/available for relatives/families including Bereavement information.	**2**	
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.		
Dignity is `part of the home'. Residents are offered choice in numerous ways, i.e. time they get up & go to bed, menus, and activities. Everyone appeared to be well cared for and happy and spoken to in a respectful way. One man who was dying & swallowing difficult, stated he would have loved a whiskey. The staff put a small amount on a tea spoon for him to taste, which he loved.	**2**	
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		
The home has an Activities Coordinator and Assistants who wear Yellow Tunics, so stand out and are easily recognisable which can help people with cognitive impairment. There is a daily programme of activities which is on a weekly rota. However, this is very flexible according to the resident's needs and sometimes the weather! They have a men's club and Ladies club on a Wednesday. Men play dominos, cards and have a beer. The Ladies do crafts. Residents who are in their room or bedbound they give one to one attention. Hand massage, reading, nails. They have recently bought a number of new Dementia `toys' from a donation. The home is very attentive to people's individual needs. One lady they noticed kept pulling the hem of her skirt up. They discovered she used to be a seamstress and so gave her some material with a zip, and some threads to occupy her. Some residents have `jobs', i.e. Folding the napkins for meals, collecting the cups. Two Pat dogs come in each week for residents both in the communal areas and those in their rooms. Some of the residents have dog biscuits that they can give to the dogs. The resident's rooms have different picture on for each person. One resident had their photograph on so she would recognise her room. Some of the signage is currently being changed on the bathrooms and toilet's to be more Dementia friendly	**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 9**	**E**
Monthly Coding review meeting. Fortnightly GP visit and more regularly as needed. Good processes in place, i.e. DNACPR, Anticipatory meds at green/amber including antibiotics. DN visits daily and is very supportive. Rapid Assessment Unit used to prevent hospitalisation. If resident is admitted to hospital, carer escorts and stays with them until in a bed. Transfer letter with all details including ACP goes with the Resident. Manager visits daily to speed discharge when appropriate. Manager is well known at the hospital and has developed a good relationship for rapid discharge. The Key outcome ratios support this with only 2 of 11 deaths in hospital and one of those was at the person's request.	**3**	**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		
DNACPR, Verification & Certification of the dying person policy in place. Aware of DOLS regulations. The home has no application for DOLS at this current time. The home has leaflets on DNACPR which are given to residents and relatives which explains what it is and the process.	**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).		
Home informs the OOHs, via 111 themselves. Also the DN when residents are deteriorating.	**2**	
d) Anticipatory medication when coded 'C' is routine practice and PRN drugs to prevent crisis admissions considered.		
Anticipatory meds are routinely prescribed and obtained when a resident is deteriorating and coded green/amber. This includes antibiotics, diuretics, and epilepsy meds.	**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 10**	**E**
The DN provides a formal individualised end of life care plan. The home also uses an individual Palliative Care Form check list used as a guide when a resident is coded Red.	**2**	
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		
Relatives are supported well with clear communication and written information of what to expect when their loved one is dying. Relatives have use of a room or a bed is put up in the person's room if they wish. Family are well cared for by staff.	**2**	
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.		
Holistic, compassionate and dignified care is given by all staff, including the non- clinical. There are structures in place to ensure no person dies alone, unless that is there choice, this includes staff from all areas. Hospice at Home and Marie Curie also provide support and care if needed.	**2**	
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.		
The staff are very supportive to relatives. Written information is given in a leaflet. Staff are encouraged to attend the funeral. A condolence card is sent. The home has a Memorial service for an individual soon after they have died and invite the family. Relatives are invited back to attend events at the homes. Some have returned and are now volunteers. New staff are supported, especially with `last offices'. Hospice at home staff provide counselling support for residents, relatives and staff.	**2**	**E**
e) Significant Event Analysis (SEA) after a death to develop the means to improve professional practice and staff support.		
Significant event analysis occurs after every death and is recorded.	**2**	

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 8**	**E**
GSF is well integrated into the home, with all staff being aware and involved in the processes.	**2**	
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		
There is a training matrix which includes end of life care. All staff have regular supervision. New staff induction, GSF is included as part of End of life care. The home is currently developing a training programme for all the staff to expand upon eol care, MCA, Dementia, DOLS. Many of the staff has undertaken the online ABC of End of life care.	**2**	
c) Explain any significant developments / initiatives / changes the home has made to improve the care of the person at the end of life.		
One development has been the colour change of the yellow tunic for the activity coordinators. An information folder and resource for staff which includes end of life care, ACP, spirituality. Changing of notices on doors to be more Dementia friendly.	**2**	
d) The home demonstrates that they are involved with local forums and meetings and/or influence local provision & policy.		
The home manager attends the local Care Home Forums and also the My Home Life meetings.	**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**
The case study demonstrates effective, compassionate and dignified care from admission to death and ongoing supportive bereavement care of the wife. It does not explicitly refer to the 7 C's or coding.	**2**	