Katharine House Hospice Trust

The Katharine House 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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 19 and 20 June 2017 and was unannounced.

We had found three breaches of the regulations at our previous inspection in March 2016. Quality assurance systems in place were not effective in assessing, monitoring and improving the quality and safety of services provided. The registered person did not report notifiable safety incidents. Staff did not always receive supervision to enable them to carry out the duties they are employed to perform. At this inspection we looked to see what measures had been taken to improve the quality of the service and whether these had been effective. The provider told us that all the actions required to meet the regulations had been completed by the end of March 2017 as scheduled in the actions plans. During our inspection on 19 and 20 June 2017 we found that most of the required actions to improve the service had been completed.

Katharine House Hospice provides palliative and end-of-life care, advice and clinical support to adults with life-limiting illnesses, their families and carers. The hospice delivers physical, emotional and holistic care with the aid of teams of nurses, doctors, counsellors and other professionals including therapists. The hospice runs a 10-bed in-patient unit and accepts admissions for end of life care, symptom control and respite care. At the time of our inspection six people were in the unit. The hospice also provides community services designed to support people in their own homes. At the time of the inspection the hospice was providing support to 160 people in their own homes. The hospice's day service welcomes up to approximately 30 people per week and was being used by six people during our inspection.

There was a registered manager in post. 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.

The service did not have a business continuity plan. Although some emergency cases had been taken into account in different risk assessments, there were no contingency plans to address such issues as a data breach, adverse weather conditions or a pandemic. Staff we spoke with did not know who to contact in case of an emergency if the registered manager was not available.

A range of audits were in place to monitor the health, safety and welfare of people. However, relevant actions were not always taken to address the issues identified by the audits. Therefore, we were not confident that the quality monitoring system was effective and provider could act on the findings of the audits in a timely manner.

Staff told us they received regular supervision, but the supervision meetings were not recorded by the provider. As a result, we were not able to determine how effective the supervision meetings were. We couldn't find out whether appropriate action was taken to act on issues raised at the meetings either.

Medicines were safely stored and those requiring refrigeration were stored within their recommended temperature range. Nurses recorded the administration of medicines on medicine administration charts including prescribed creams applied by care workers. Staff had the skills needed to effectively manage people's medicines and ensure they were administered safely to people.

People said they felt safe receiving care provided by the hospice. Staff had been trained in safeguarding adults and received regular refresher courses. Staff gave clear explanations of the different types of abuse to be aware of and knew what steps to take in the event of any suspicion of abuse.

Risks to people's safety were assessed and managed appropriately. Assessments identified people's specific needs and showed explicitly how the risks could be minimised. The service carried out environmental and health and safety checks to ensure that the environment was safe and that the equipment was in good working order.

Accidents and incidents were recorded and monitored to identify how their recurrence could be prevented.

Staff and volunteers had been suitably recruited and there were sufficient staff with a variety of skills to meet people's individual needs and to respond flexibly to changes.

Staff received the training they needed and were highly motivated to undertake their roles and deliver sustained high quality care. People were extremely confident and positive about staff's abilities to meet their individual needs.

The service manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The service had made applications under DoLS to ensure that people were not deprived of their liberty unlawfully.

Staff provided meals that were in sufficient quantities and met people's needs and choices. People and their relatives praised the food they received and they enjoyed their meal times.

The hospice provided a relaxing, comfortable, clean and attractive environment. There was a quiet reflective area in the sanctuary and well-maintained gardens where people could spend their time.

Staff were aware of people's individual needs and the support they and their family members required. We saw that people were provided with care by staff who were kind and compassionate. People and their families spoke very highly about the service.

Staff were highly motivated and committed to providing people with the best possible palliative and end-of-life care. The service had received a large number of compliments concerning the kind, compassionate and caring manner of the staff team. People told us staff dedicated their time to listening to people and never rushed them.

The service had a holistic approach to caring for people at the end stages of life. Supporting the person and their family members was seen as key to their well-being. Family members received support after the death of their beloved ones and bereavement counselling was offered to them. People's spiritual needs were met and there was a range of different complementary therapies available to people.

People's needs were thoroughly assessed before and at the time of being admitted to the service. The staff team ensured that care and support were offered in a timely way, and services were offered as flexibly as

possible to suit people's needs.

Regular multi-disciplinary meetings were undertaken to review and respond accordingly to peoples' changing needs. The management and staff worked closely with other professionals and agencies to ensure peoples' various needs were fully met. Clear information about the service, the facilities, and the complaints procedure was made available to people and visitors. People told us they knew how to make a complaint if they had any concerns.

There was an open culture at the hospice where people and their relatives were encouraged to share their experience of the service. Staff understood the ethos and values of the service and knew how to put these into practice. They felt valued, listened to and well supported. This resulted in the staff team being motivated to give a high standard of care to people.

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 knew how to protect people from abuse or poor practice. There were processes in place to recognise and address people's concerns.

People were protected against the risks associated with medicines. The provider had appropriate arrangements in place to manage people's medicines safely.

Robust recruitment processes for new staff ensured they were suitable to work with vulnerable people. These checks were also carried out for volunteers.

Is the service effective?

Good

The service was effective.

Staff of all levels had access to ongoing training to meet the diverse individual needs of people they supported. Staff members were suitably trained to provide the specialist care people required.

The manager's and staff had a good knowledge of the Mental Capacity Act (2005). Policies and procedures in relation to the MCA 2005 were in place and accessible to staff.

Staff encouraged and supported people to have a balanced diet that met their individual needs and professional advice was sought if people's eating and drinking abilities deteriorated. People were referred to healthcare professionals promptly when needed.

Is the service caring?

Good

The service was caring.

People and their relatives told us that staff treated them with exceptional kindness, care, dignity and respect at all times.

Positive, caring relationships had been developed between

people who received care and staff. Staff interacted with people positively, with patience, understanding and respect. They always showed kindness to people when facing challenging situations.

Staff supported the emotional well-being of people and their relatives with end-of-life care being provided with sensitivity and compassion. The care people received enabled them to experience a comfortable, dignified and pain-free death.

Is the service responsive?

Good

The service was responsive.

People and their families were fully involved in assessing and reviewing people's needs and planning how their care should be provided. This included their wishes and priorities regarding their end-of-life care.

The service used a range of tools to obtain feedback from people using the service, relatives and professionals. Such information was acted upon to ensure the care was person-centred and suited people's needs.

The provider had an effective complaints policy and procedure in place. People and their relatives knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A range of audits were in place to monitor the health, safety and welfare of people. However, actions were not always taken promptly to address areas for improvement identified by the audits.

The registered manager was praised both by people and staff. Staff told us they were able to approach the manager to raise their concerns and felt they were provided with good leadership.

Staff felt supported, valued and included in making decisions about how the service was run.

The Katharine House 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. The objective of the inspection was 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.

We inspected Katharine House Hospice on 19 and 20 June 2017. The inspection was unannounced.

The inspection team consisted of three inspectors, a pharmacist inspector, an expert-by-experience and a specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. A specialist advisor is someone who has up-to-date knowledge and experience of working in a specific field. The specialist advisor who participated in this inspection had an extensive knowledge and experience in palliative care. Palliative care is a holistic, multi-disciplinary approach to providing patients with relief from the symptoms of a life-limiting illness such as pain and stress.

Before the inspection, the provider had 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 reviewed the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider about significant issues such as safeguarding, deaths and serious injuries. The provider is legally obliged to send us this information within required timescales. The PIR was used as a prompt to follow up specific areas at the inspection and to support our findings.

During the inspection we observed how staff interacted with people using the service. We spoke with seven people who used the service. We talked to the registered manager, the chief executive officer, two doctors, and the pharmacist. We spoke with the in-patient unit staff, including the in-patient nurses' manager, three

nurses, three health care assistants and three volunteers.

We looked at the care files for six people who used the service. We also looked at the documentation concerning medicines handling, including medicines administration records for four people. We observed a handover meeting where medical and nursing staff shared information about the care and treatment of people using the service. We were present at two Multidisciplinary Team Meetings (MDT). An MDT is a meeting of a group of professionals from different clinical disciplines who together make decisions regarding the recommended treatment of people.

We looked at a selection of documentation relating to the management and running of the service. These included six staff recruitment files, training matrix, staff rotas, minutes of committee groups meetings, surveys, quality assurance audits and record relating to the maintenance of the equipment.

We completed a tour of the building to look at how hygiene and cleanliness were maintained.

Good

Is the service safe?

Our findings

People and their relatives told us that they felt safe at the hospice. One person said, "I'm free from any worries. Never thought I'd have the peace of mind like I've got here". One person's relative told us, "I'm very confident that [name] is safe. It's been such an improvement since he came in".

Staff and volunteers contributed to protecting people from abuse or breaches of their human rights as they were aware of and able to clearly explain their responsibilities with regard to keeping people safe. All clinical and care staff had received safeguarding training so they could recognise any signs of abuse and take effective actions. They were able to tell us what they would do if they had any safeguarding concerns. This included reporting issues to the appropriate authorities outside of the organisation, if necessary. One staff member told us, "I would report this matter to [the registered manager]". Another member of staff told us, "I would go to whoever is on duty at the time. This could be [the registered manager] or any other senior member of staff. I would also seek for advice externally".

People's care was delivered as safely as possible. When a person was prone to health risks, relevant risk assessments were incorporated into their care plans. They described the risks and instructed staff how to support people safely. Identified areas of risk depended on the individual and included areas such as health needs, bathing and nutrition. Each person and, when appropriate, their families and carers, were consulted about their care. This contributed to promoting people's independence, choice and rights. Staff were knowledgeable about the care needs of people living at Katharine House Hospice, including associated risks and, if needed, any additional support people might require.
The service ensured they 'learned lessons' from any accidents and incidents that occurred. Accident, incident and near-miss reports recorded in detail the accident or incident, described what action had been taken and any further action or learning needed. If necessary, individual care plans were reviewed and amended. For example, when one person had developed a pattern of falls, they had been referred to a physiotherapist. Their care plan and risk assessment had been updated and the person had been advised to use a wheelchair for distances they might find difficult to walk. A quarterly report regarding incidents was made to the Health and Safety Committee in advance of the meeting to analyse and seek for incident patterns and a way to prevent them.
People were cared for in a safe environment. Regular environmental and health and safety checks were carried out to ensure that the environment was safe and the equipment was fit for use. For example, records showed and staff confirmed that fire alarm tests were carried out on a weekly basis. Checks were also conducted to ensure that the equipment such as hoists, the nurse call system and fire equipment was in good working order.

Effective systems were in place to ensure people received their medicines as prescribed. Staff checked what medicines people were taking when they came to the hospice to make sure they would continue to receive the correct medicines in the relevant dosage. The hospice had an arrangement with the local NHS hospital to provide a pharmacy service. Staff could order and receive medicines the same day, including weekends. Hospice staff were also able to use the hospital on-call pharmacy service, if needed. People were confident their medicines would be available for them.

A pharmacist from the hospital trust visited the hospice three days a week to check medicine administration records (MAR) charts and provide clinical pharmacist support. The pharmacist also attended the weekly multidisciplinary team meetings. Staff were also able to use the hospital trust medicines information service. The medicines information service is a centre where expert advice on medicines is given to other health care professionals (including doctors, nurses, GPs and community pharmacists).This helped to ensure that staff managed people's medicines safely.

We observed medicines being administered in a caring manner; nurses talked to people about their medicines and asked about their pain. Medicines administered were documented appropriately. People told us that their medicines were well managed. One person said, "They are very good with medication. When I came here, I was in a lot of pain. They changed my tablets and I hardly feel any pain now". Another person told us, "They talk me through any issues with medication".

Staff recorded the medicines they had given, or used a code to record the reason if they had failed to give a medicine. The charts included a list of medicines, agreed with the doctor, that staff were able to give to people to treat some common symptoms. This meant staff could respond to people's symptoms quickly. We looked at five people's medicines administration charts. Records showed that staff had given people their medicines as prescribed.

The medicines charts included medicines to be given by subcutaneous injection via a syringe driver. A subcutaneous injection is a method of administering medicines into the fat right under the skin. Staff made regular checks of the syringe drivers to make sure they were running correctly and documented these checks. Some people received pain relief via a skin patch. Separate record showed where these were applied and included the checks staff made to ensure they were still in place. These precautions helped to reduce the likelihood of medicines errors.

People were looked after by qualified nurses who administered medicines. People were able to self-administer their medicines if they wished so and staff had assessed people if they were able to do so safely. No-one was doing this at the time of our inspection.

Medicines were stored safely and securely within a secure treatment room. Records showed that this room, as well as the medicines refrigerator, were checked regularly and kept at a safe temperature for storing medicines. Staff told us they checked whether medicines were in date and suitable for use. Staff from the local hospital provided a weekly 'topping up' service to make sure medicines were available as needed.

Controlled drugs (CDs), were stored securely. Suitable records were in place for these medicines to show they were managed safely. The hospice had an Accountable Officer who investigated and reported any incidents involving controlled drugs. Quarterly occurrence reports of any incidents involving CDs were made to the local controlled drugs intelligence network to help monitor the management of CDs and prevent incidents.

The hospice had comprehensive medicines policies and procedures. Systems were in place to identify medicines errors and take relevant action to reduce the risk of recurrence of similar mistakes. Staff told us there was an open culture for reporting errors and they were able to learn from these and improve their practice.

Appropriate staff and volunteers recruitment processes helped to protect people from staff that may be unsuitable. All the recruitment files inspected showed that appropriate checks had been carried out before staff or volunteers were recruited. Clearance from the Disclosure and Barring Service (DBS) had been

requested. A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they were suitable to work with vulnerable adults and children. References had been sought from previous employers and employment histories had been requested. Reasons for any gaps in the employment histories of prospective employees and volunteers had been explained at job interviews and appropriately recorded. Relevant checks were carried out to confirm the professional registration status of doctors and nurses.

There were enough staff on duty to care for people in the way and at times they preferred. We observed staff were available to help people at various times, depending on people's needs and wishes. The staff team were supported by a range of additional staff, senior managers and the registered manager. There was also a range of staff employed by the service, including doctors, nurses, physiotherapists, a chaplain, maintenance personnel, catering staff, domestic workers and volunteers. In addition, a family support team consisting of social worker and bereavement counsellors was also available. Rotas for the previous month showed that the staffing levels had been maintained according to the provider's stated staffing levels.

The service had a bank of staff to use for short notice absences and to cover holidays. We saw there were on-call arrangements for senior nursing staff, medical staff and the hospice management.

People were protected from the risk of infection. The premises and the equipment were clean and staff told us about the procedures they followed to prevent and manage potential outbreaks of infection. We saw that protective equipment such as aprons and gloves were readily available and utilised by staff and volunteers. Bathrooms, toilets and sluices contained all the items necessary to maintain good infection control practices. There was hand gel at various points in the building for staff and visitors use to help protect people from infection.

The kitchen staff ensured the kitchen remained clean and free from potential cross infection. They adhered to food safety standards and ensured the food was prepared safely. They wore appropriate protective clothing and food was kept at appropriate temperatures. Other staff had limited access to the kitchen.

Some areas of the hospice, such as the laundry and the clinical store room posed a potential risk to people as harmful chemicals were stored there. Those areas were protected with a keypad lock so that people were not exposed to danger. Up-to-date maintenance certificates such as gas safety electrical installations and portable electrical appliance testing were readily available at the service.

Care staff and nurses wore protective disposable gloves and aprons when delivering personal care so as to reduce the risks of cross contamination. One of the domestic staff told us, "We use a colour coded system and things like aprons and gloves are never taken outside of a room. They are disposed of then and there." As a result, the spread of a potential infection was reduced. We observed that staff washed their hands and used hand cleansing products before performing various tasks.

An external company was contracted to help manage risks in relation to Legionella. Legionella is a respiratory disease caused by Legionella bacteria. There were appropriate waste management arrangements in place. Sharps were stored in sharp containers which were used and emptied as per provider's policy. Sharps are any needles, scalpels or other articles that could cause wounds, cuts or punctures to a person handling them. Care equipment, such as stethoscopes, syringe drivers, and thermometers was stored appropriately following use. This minimised the possibility of damage or contamination of the care equipment.

Good

Is the service effective?

Our findings

At our previous comprehensive inspection in March 2016 we had identified a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff had not always received supervision to enable them to carry out the duties they had been employed to perform.

At our recent inspection in June 2017 we found the provider had taken action to implement the required improvements. Staff told us they received support from their colleagues and the registered manager. Support was achieved through regular individual supervision sessions and an annual appraisal. A member of staff described why they felt supported by the service, "I have always been supported in regard to work and family life. Not necessarily management, I can go to anyone here. Normally I go to [the support service manager]. We have our one-to-one meetings but not a regular one. Once a quarter we meet and discuss staffing levels, equipment, etc. The support service manager asks if there is something we need. I can ask for a supervision meeting anytime and this would be arranged". The bereavement service manager told us, "I have my supervision provided every six weeks by an external psychologist that comes in. I find those meetings really useful".

People and their relatives told us they received care from highly skilled staff. One person said, "They are definitely very knowledgeable and well trained." A person's relative told us, "Staff are very kind, they answer any questions openly, nothing is any trouble. Lovely volunteers, can't fault it here."

New staff underwent a comprehensive induction programme designed for their specific role. Each staff member was assigned a mentor whom they shadowed until they could demonstrate they had attained the level of competency required for their role. Staff confirmed they had received an induction where they had completed mandatory training, followed by a three month probationary period. Palliative care training is mandatory for all staff and had been completed. People were cared for by staff who were appropriately trained to meet their needs. Staff were trained in the areas relevant to their role and to the specific care needs of individuals. Staff told us they received all the training they needed to work effectively and provide the best quality of care. A wide range of training was on offer for all staff including volunteers, such as fire safety awareness, cardiopulmonary resuscitation (CPR), anaphylaxis, safeguarding adults, child protection, and infection control.

Other training provided included safeguarding of vulnerable adults, documentation, record keeping, management of medicines and blood transfusion. People were supported by staff who had been appropriately trained. Training was up-to-date and staff had received additional training specific to the needs of people they supported, for example diabetes or dementia. The service supported staff through Nursing and Midwifery Council (NMC) revalidation process. Revalidation is the process that allows nurses to maintain their registration with the NMC and demonstrates their continued ability to practise safely and effectively. All nursing staff were required to complete the revalidation process every three years in order to maintain their registration.

Volunteers helped to deliver care to people at the service. They acted as companions, sitters and transport

escorts. All volunteers were provided with relevant training, for example with food hygiene.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental 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 these in hospices 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 all people using the service had capacity and did not require any DoLS. However, staff understood the principles of the MCA and the need to act in a person's best interests if the person they cared for had difficulty making a decision. Staff explained that such decisions may regard, for example, people's treatment or their wishes as they approached the end of their life. A member of staff told us, "The MCA is about assessing the person if they are able to make a decision about their care. If they are unable and no member of family has got a lasting power of attorney, we have to organise the best interests meeting".

People's care records included clear instructions regarding people's resuscitation status and there was evidence to show this had been discussed with people and relatives. Where people had made advanced decisions in relation to their care and treatment, this was appropriately documented.

People told us they enjoyed the food provided to them at the hospice. We observed the lunchtime meal and saw that the food looked appetising. We observed that staff gently encouraged people to eat dishes of their choice. Where people required assistance with eating, staff spent sufficient time to ensure they ate enough food.

Kitchen staff told us in detail about people's individual requirements regarding their diets. For example, the kitchen staff told us which people were on a special diet and which foods people preferred. The hospice's chef told us, "We have a good two-way conversation here. We spend time communicating with people to find out what they like or don't like. There was one lady with communication difficulties. We left a note for the nurse and she came back to us so we knew what the person liked". Where people found it difficult to eat due to loss of appetite, staff encouraged people to eat an alternative meal or suggested they could try to eat later. We also saw people were frequently being offered refreshments throughout the day by staff and volunteers. People told us they enjoyed their food. One person said, "They offer lovely meals, good choice of ice creams. Nice tasty food and you can have what you really like". Another person told us, "We have a choice of menu. Five different choices, nothing is too much trouble for them".

People's health needs were met by a range of health professionals during their stay in the in-patient unit and when people were supported in the day hospice and at home. Professionals included: palliative care doctors, GP's, occupational therapists, physiotherapists, a diabetic nurse and community nurse specialists. A specialist lymphoedema clinic, run by a specialist practitioner, was available to people and could help alleviate symptoms caused by a compromised lymph system. There was good communication among the various health professionals which ensured people received seamless care when accessing the various services provided. Staff were aware of how people's conditions could possibly affect their mental health and well-being. Services were offered to people to help reduce the risk of depression, anxiety and social isolation. There was also a chaplaincy service available to offer support if required. It aimed to meet multi-denominational spiritual needs of people and their family members.

The hospice was spacious and accommodated the equipment required to provide effective care. Overnight facilities were available to people's relatives if required. This enabled relatives to stay with people and be fully involved in their end-of-life care. People could access the areas of the hospice freely, which included the hospice grounds. There was a garden which was well tended by a volunteer gardener. The art and craft room was equipped with a sink that could be lowered and raised so it could be used by people with limited mobility. The equipment and facilities were suited to meet the needs of people who were receiving end of life care.

The multi-faith room within the hospice provided a warm welcome and was a place of sanctuary for people and their relatives of all faith backgrounds. It was also visited by those who didn't hold any religious beliefs. The multi-faith room created space to think, rest, contemplate, connect, reflect or pray. These contributed to promoting well-being as well as equality and diversity within the hospice. The hospice provided a private space for families to find quiet time and reflection, helping them to manage the stress and grief brought about by the challenges of life limiting illness.

Good

Is the service caring?

Our findings

We received numerous positive views about the care the service provides. One person said, "When I came in, I was at a real low point and felt terrible. After being here, I felt content for some reason. I sat back feeling really content. My mood has changed and I feel completely relaxed". Another person told us, "Got a way with them of easing your problems without you realising it. Feeling more positive about things than when I came in". One person's relative remarked, "He is so much better since he has been here".

People were supported by a kind, caring and committed staff team. There was a warm and homely feel to the service in the in-patient unit and at the hospice day service. There was a social atmosphere where people were cordially encouraged to chat with staff and volunteers if they wished. Staff were calm, smiling and engaging. We observed them listening to people and responding to them in an attentive manner. Their approach was kind, patient and respectful.
During the day we observed a number of interactions between in-patients, day centre users and care staff, volunteers and nurses. We observed staff interacting kindly and positively with people. All staff, including volunteers, carried out tasks with a good deal of humour and there was always unaffected laughter around.

The service had policies in place to maintain and promote people's privacy and dignity. We observed that care was delivered in an individual manner and centred on each person. Staff had a good understanding of people's needs and provided care with kindness and compassion. They knew how to provide care with respect and how to maintain people's dignity. A member of staff told us, "It's very important to ask for permission before carrying out any task. We respect privacy and dignity while providing personal care. We keep the flannel over people so they are not exposed and we draw the curtains down if we do any personal care".

Staff knew people's individual communication skills, abilities and preferences. They were aware they needed to spend a lot of time with people to make them feel cared for and safe. Staff always had people's well-being on their mind. Staff members told us they were given enough time to get to know a person who was new to the service, and read through their care plan and risk assessments.

We saw that a volunteer spent a great deal of time with a person who had some difficulty in communicating. The volunteer displayed a caring and considerate attitude: she established eye contact, gave the person time to explain what the person wanted. Then the person's wishes were passed on to a care assistant. We observed that a person with limited verbal communication skills was asked if they would like to go to the dining room. Staff members and a volunteer responded to the nod of his head, and staff spoke to the person throughout the journey.

We saw that a trained member of staff was using a basic aromatherapy technique to massage a person's feet and legs. The person told us how much they enjoyed the sessions and how they took pleasure in the conversations they had with the staff member.

People's care records provided us with evidence that people were involved with and were at the centre of

developing their own care plans. This demonstrated people were encouraged to express their views about how their care and support was delivered. Relatives and staff told us that people were given information and explanations about their condition and life expectancy if they needed it. They said it was carried out by the most appropriate staff and in a sensitive manner.

People were given choices and supported to make decisions concerning various aspects of their daily routines. These included choosing meals, clothing and places where they wanted to spend their time. 'Do not attempt resuscitation' orders and advanced care plans (records of people's end-of-life care preferences and choices) also showed that people and their families had been involved in making crucial care decisions. Before staff undertook any actions, they explained to people what they were going to do and why they asked for their permission.

We attended two multidisciplinary team (MDT) meetings where staff discussed people's treatment plans and progress. The MDT meeting helped to assess and evaluate people's physical, psychological, social, spiritual and information needs. Where appropriate, the MDT meeting also focused on the assessment of the needs of families and friends of people, and the support they might need.

The hospice paid attention to people's spiritual needs and chaplaincy support was available to people 'of all faith and no faith', which meant it was accessible to any person provided with care by the service. There was a quiet sanctuary room where people could go to be alone or to be with others in order to meet their spiritual needs. The hospice has arrangements to remember people who have used the service. Names of the deceased were written in a memory book and their relatives were free to come on the anniversary of their death to pray and remember their loved ones.

Bereavement support was available to people and their families or friends. The support and bereavement service provided by the hospice was comprehensive and flexible which ensured the individual needs of people and their families were met. People were able to access support from a family support team and a spiritual care lead. People were supported to work through relationship issues, grief and loss and to adopt coping strategies. Relatives were extremely positive about the support they received both during a person's illness and after their death. A person's relative using bereavement support told us, "From the first contact they were extremely supportive and encouraged me to be supported in this way. I have never had counselling before and my counsellor has been absolutely fantastic. I think I would have suffered some sort of breakdown without it as I was also processing a lot of shock and had physical stress symptoms which have pretty much gone now. It's also hugely comforting to know I can ring if I feel I really needed extra support".

The hospice was proactive in looking for an innovative way of supporting children and teenagers through the bereavement process. 'The special gang' activity book was introduced to support children up till the age of 10. The activity books were used together with colouring books, pencils, worry dolls, stress balls and activity boxes. This aimed to reduce stress and help children and teenagers to put their minds at ease. Portable toy boxes were in the service so a child was able to move a box to the bed space to play with a patient. There was an information pack for teenagers that explained the phenomenon of grief and the ways to ease emotional feelings in a way that was comprehensible to teenagers. A picture of a tree with blob characters in it was available for children of all age. The blob characters displayed different emotional states: some of them were playing, some were sad and others were angry. Picking one of the blob characters, teenagers and younger children explained what made them feel that way. Then they received individualised emotional support from one of the bereavement consultants. The consultants comforted and assured them it was normal to feel whatever they were feeling and that it was normal to feel different every day.

Good

Is the service responsive?

Our findings

People and their relatives told us staff were responsive to their individual needs. One person said, "If things changed, they bent over backwards to provide whatever we wanted". One person's relative told us, "Can't do more for [name]. They get to him quickly when he needs something and have made such a difference to him".

The procedure of admission to the in-patient unit ensured people received a management plan in relation to their symptoms, emotional and spiritual support, pain relief and specialist care. Initial assessments had been undertaken to identify people's support needs and care plans had been developed outlining how these needs were to be met. People's wishes were at the centre of their care planning. Staff were aware of people's care plans and were mindful of people's likes, dislikes and preferences. For example, the support service manager told us, "[Name] has a small appetite and needs six small meals a day – high fibre, low sugar. Know she enjoys beans on toast, porridge and specially prepared scones".

People's care was planned with people's participation to meet their health, social, emotional and spiritual needs. Staff from all disciplines worked together to ensure people's needs were met holistically. Multidisciplinary meetings were held weekly and were attended by staff from the in-patient unit, the community service and the day hospice. Each person's needs and wishes were taken into consideration so that a comprehensive care plan could be developed. Such a plan reflected what the person wanted to happen and how staff would help the person achieve their goals. Care plans detailed how people's needs were supposed to be met. There was clear evidence that the care plans were reviewed daily or even more often if a person's condition changed. Staff maintained accurate records of what had been achieved and noted any variations to the person's agreed care plan.

The day hospice service offered people opportunity to enjoy the company of others or to spend time in the peaceful grounds. People staying in the in-patient unit were supported and encouraged to attend the day service activities where appropriate. When people did not wish to join activities and they preferred to read, watch television or listen to music, their choice was respected. There was a range of activities offered for different tastes. Most of the activities were offered by volunteers from the local community who had been carefully selected for their skills in particular fields. The activities included art, music, flower arranging, gardening, complementary therapies such as massage, music therapy and aromatherapy. The art therapy sessions enabled people with a previous interest in painting, craft or 3D modelling to continue their interest at Katharine House Hospice. What is more, the sessions also encouraged people to try these activities for the first time. Referring to the fact they had missed several art sessions due to the recent Bank Holiday Mondays, one person told us, "If it was down to me, I'd cancel bank holidays because I like doing this so much". Peoples' art work was displayed throughout Katharine House and had recently been shown at an exhibition in the Oxford Art Week.

People had the opportunity to spend time outside in their bedrooms if they wished so. The beautifully trimmed gardens provided people and their relatives with a quiet space where they could calm down and relax. People told us they took delight in spending time in the garden.

People told us they enjoyed the recently installed, fully accessible spa style bath. One person told us, "I had a gorgeous bubble bath with wine today. I say I do look forward to the day sessions".

Staff and volunteers helped people maintain their social life and contacts with their families. There were facilities available that allowed family members to stay overnight at the hospice. Staff told us that people's relationships with their loved ones were an integral part of the delivered care.

People, relatives and staff were encouraged to comment on the way care was being provided. There was a robust complaints procedure in place. Staff, people and their relatives told us they would feel comfortable to complain and would do so if necessary.

We looked at the processes in place to gather feedback from people and listen to their views. Most people we spoke with told us that they were regularly asked if they were happy with the support they received. The service put people at the heart of all discussions, and it was people that were the priority in making any decisions about the service. The service's philosophy of openness and honesty was promoted and ensured through continually reviewing the delivery of care. People and their relatives were encouraged to provide feedback on the care delivery and the management of the service. Feedback boxes were placed in different communal areas of the hospice.

The complaints procedure was prominently displayed on an information board in the communal area. The information was also presented in an accessible format to make sure that people with a disability, impairment or sensory loss were provided with information on how to raise a complaint. The registered manager provided us with detailed information about three complaints that had been made since the last inspection. They had been thoroughly and appropriately investigated and dealt with. It was clear that the complaints had been analysed, investigated and conclusions had been drawn from them. Consequently, relevant action had been taken to ensure that improvements, where required, had been implemented. The service had received numerous compliments and cards with very positive feedback and these were displayed on the notice board in the communal areas. There was a clear audit process to ensure that the registered manager undertook a comprehensive review of the complaints and compliments recording systems.

Requires Improvement

Is the service well-led?

Our findings

At our previous comprehensive inspection in March 2016 we had identified a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Quality assurance systems in place had not been effective in assessing, monitoring and improving the quality and safety of services provided.

At our recent inspection in June 2017 we found the provider had made some improvements, however, further progress was needed in the areas of quality assurance systems and record keeping. Audits were carried out on regular basis in such areas as, for example, infection control, pressure ulcers or satisfaction surveys. The controlled drug and the accountable officer audits took place annually, however, the general medicines audit had not been conducted since 2015. Where the findings of audits had identified areas for improvements, like the lack of a policy and procedure for pressure ulcer prevention or the lack of a separate pain assessment tool, these had not been acted on immediately. The hospice's governance arrangements required that the audits' results were to be discussed and actions approved at one of the quarterly committee meetings. This meant that if an audit had been carried out in January, the service might not take any action to make improvements until the next committee meeting in March. The registered manager told us, they were going to change the system so the urgent actions identified by the audits would be acted on immediately without a need of waiting for the next committee meeting.

Although supervision meetings were carried out and staff felt supported, minutes of the meetings were not always recorded. The minutes of the quarterly committee meeting from April were not ready for perusal on the day of the inspection. However, the registered manager told us the minutes would be prepared and completed by the next committee meeting in July. We found that the lack of the committee meeting minutes had no direct impact on people who use the service.

There were various risk assessments in place, including an environmental risk assessment, a fire risk assessment and a strategic risk register. There were also documents relating to the maintenance of the service. This documentation covered some instances of untoward events, however, there was no business continuity plan in place. This meant that there were no procedures for acting in case of a pandemic, a data loss, a financial loss or weather emergencies. We raised our concerns with the service manager who immediately took action to draw up the business continuity plan.

At our previous comprehensive inspection in March 2016 we had identified a breach in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The registered person had not reported notifiable safety incidents.

At our recent inspection in June 2017 we found the provider had taken actions to implement the required improvements. The registered manager was aware of their responsibilities for reporting any significant events that affected the service to the Care Quality Commission. All notifiable incidents had been reported to us in a timely manner.

There was a registered manager in place. A registered manager is a person who has registered with the Care

Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. We found the registered manager to be very knowledgeable about the service. We observed how enthusiastically they spoke about the hospice and people who use it. All of the managers and staff we spoke with at the hospice were very dedicated to providing care to people. We found that they believed in the philosophy and values of the hospice, which were promoted and displayed prominently for all to see. Throughout our inspection we saw many examples of staff practising these values for the benefit of people using the service and their family members.

The hospice had clear visions of the service explained to staff and volunteers through their induction programme and training. There was a positive culture at the hospice where people felt included and consulted. People and their family members told us they felt staff not only offered to care for the person receiving treatment but also for family members. We found the culture of compassion, caring and kindness to be embedded within all staff and volunteers working for the hospice.

People and their families were all very positive about the care provided and the management of the hospice services. One person told us, "I believe that the place is well managed. We have a very good atmosphere here. Staff get on and it's a very happy place". People told us that all staff, regardless of their role, were friendly, kind and supportive which created an atmosphere of calmness at the service. We noted that staff working in all the areas of the service were motivated, enthusiastic and committed to providing a high quality service to people and their families.

All the staff we spoke with told us they felt supported and enjoyed their work. One staff member remarked, "I think they are doing really good job down there. I just think it's a wonderful place to work". Another member of staff said, "I feel very supported. We work well as a team. I can approach [the registered manager] or [the support service manager. Their doors are always open".

Volunteers formed an important part of the service and provided support in a variety of ways. Those volunteers who were suitably trained provided support to people and to their families. Others helped with daily tasks in the in-patient service, arranging flowers around the hospice, serving tea and coffee to people and visitors and greeting visitors in reception. One of the volunteers told us, "The hospice employs highly professional staff. I have never heard a cross word in 15 years".

Staff were aware of the whistleblowing policy and told us they would not hesitate to raise any issue they had. Staff told us and records confirmed that staff worked in partnership with other health care professionals, such as GPs and district nurses.

The hospice had strong links with the local community, which were maintained through fundraising and social events. There was a range of information for the public which was available in the reception area as well as other local facilities such as the Katherine House Hospice charity shops. The hospice recognised its responsibility to ensure that its services met the needs of all sections of the local community.

The registered manager and the support service manager were committed to sharing good practice and learning from national developments in order to drive improvement in palliative and end of life care across the sector. There were many examples of the hospice accessing development opportunities for staff within the service and encouraging membership of both local and national forums. For example, there was evidence of the hospice having being involved in research on the management of seizures in palliative setting. The research was presented at the Association of Palliative Medicine (APM) national conference in Belfast in March 2017. It was published in BMJ Supportive and Palliative Care in July 2017.

The service was proactive in providing education and undertaking research to identify and share best practice. The hospice had been involved in a research programme on a modified cardiac rehabilitation programme (palliative care of heart failure). The research had suggested that the palliative care and hospice have the potential to improve quality of life for heart failure patients, family members, and care providers. There was a strong evidence of the impact of the research on the practice within the hospice.