Katharine House Hospice Trust

The Katharine House Hospice

Inspection report

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Date of inspection visit:
09 March 2016
10 March 2016

Date of publication:
06 October 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
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 10 and 11 March 2016 and was unannounced. Katherine House Hospice provides specialist palliative care to people in North Oxfordshire, South Northamptonshire, and South Warwickshire. The hospice is set amongst fields with secluded areas for the enjoyment of people and their visitors.

They provide inpatient services, day hospice facilities, specialist community nursing and bereavement support. There were six people receiving care on the day of our visit. The inpatient service can accommodate up to 10 people. A registered manager was 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.

People and relatives were complimentary about the care provided. One person said "It's a wonderful place; my family member was cared for here and was treated with the utmost respect and dignity". Staff we spoke with had a good understanding of safeguarding. However, we found that appropriate referrals had not been made to the local safeguarding team as required.
Risks assessments had been completed to monitor people's health and safety, however, not all completed risk assessments reflected consistent information regarding risks to people.

Medicines were not always managed safely within the service. We were aware of several errors that took place prior to our visit related to nursing interventions with syringe pumps. There were also pharmacy errors within the service. The errors had been reported to the services accountable officer, but had not been reported to the local authority as a safeguarding incident.

There was safe recruitment of staff and all staff had Disclosure and Barring Service checks completed prior to commencing employment.

People receiving support told us that staff were kind and caring, treated them with respect and protected their dignity. Staff told us they always asked for people's consent before providing support and care, however discussions with people regarding consent to care and treatment were not documented in all people's records.

Staff were supported in their job role through induction, supervision and appraisal, as well as regular training to ensure they had the knowledge to meet people's needs. However, one member of staff who had worked at the service for over one year told us they had never had supervision.

Most care files we viewed were detailed and specific to the person, reflecting their wishes, choices and preferences. However, we found that not all care plans contained sufficient detail regarding people's needs.

Processes were in place to gather feedback from people and listen to their views. People had access to a complaints procedure which was provided to people when their support was arranged.

Feedback from staff regarding the management of the service was contradictory. Some felt supported with the management structure whilst others did not share this view.

Staff were aware of the company's whistle blowing policy and told us they would not hesitate to raise any issues they had.

The building had a history of movement and minor cracking. The engineers report stated that the building is structurally sound and does not represent a major cause for concern.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely within the service. People were at risk of receiving inadequate pain relief due to poor practices in relation to medicines.

People benefitted from having sufficient numbers of staff to meet people's needs.

Staff had a good understanding of safeguarding however; appropriate referrals had not been made.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff mostly sought people's consent regarding provision of care.

People were supported by staff and external health care professionals to maintain their health and well-being.

Staff were not always supported in their job role through supervisions.

Is the service caring?

Good

The service was caring.

People receiving care and support told us that staff were kind and caring treated them with respect and protected their dignity.

The service captured people's preferences in relation to end of life care

Is the service responsive?

Good

The service was responsive.

Plans were specific to the person and people were involved in the development of their support plans. However, not all

identified needs were reflected within the care plans.

Processes were in place to gather feedback from people and people had access to a complaints procedure.

Is the service well-led?

Requires Improvement

The service was not always well led.

Feedback regarding the management of the service was contradictory. Some staff did not feel listened to or supported.

The manager had not notified Care Quality Commission (CQC) of all reportable events and incidents that occurred in the service.

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. 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 10 and 11 March 2016 and was unannounced. The service was previously inspected on 3 June 2014 where care records, risk assessments and care plans were found to be incomplete. A responsive follow up inspection took place on 8 September 2014 to find out if improvements had been made. During the follow up inspection we found that improvements had been made.
Prior to the inspection we looked at all the information we had about the service and notifications we received. A notification is information about important events which the service is required to send us by law. A provider information return (PIR) was not requested prior to our visit. A PIR 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.
The inspection was undertaken by an inspector and two specialist advisors. Specialist advisors are people who have experience in a particular area. One of the specialist advisors was a qualified nurse who had experience in palliative care and the other advisor had experience in health and safety and older people's care.

During the inspection we spoke with the registered manager, the chief executive officer, six members of staff, two volunteers, four members of the fundraising team, reviewed a range of records, including three care plans, three medicine charts, policies and procedures and meeting minutes. In addition we had a tour of the building, spoke with three people who used the service, two relatives and took part in the day hospice activity session.

Requires Improvement

Is the service safe?

Our findings

People we spoke with complimented the staff, one person commented, "They are truly wonderful here; all the staff and volunteers are brilliant". One relative told us "They all know the people and families very well and know what they need".

During our two day inspection we found medicines were managed appropriately and safely. However, when we inspected the services accident and incident reporting documentation. We found 20 drug incidents had occurred from the period of 4 May 2015 until 1 January 2016.
None of which had been reported to the relevant authority. The majority of the drug errors appeared to be in relation to syringe drivers. Syringe drivers also known as a syringe pump, is a small portable machine that is able to give medicines constantly (usually over 24 hours) via a small needle under the skin, so tablets do not have to be taken.

One example, of an incident was a person's syringe driver had not worked for 12 hours; the syringe had not been checked by the nursing staff at the 05.00 check or the 09.00 check. This meant the person had no pain relief for several hours and may have suffered pain and anxiety due to this occurrence.

This was one of the drug errors we were aware of and had not been reported to the safeguarding authority. We have reported our concerns to the local authority safeguarding team.

On one occasion controlled drugs delivered to the hospice were left in the inpatient unit by the external pharmacy provider, who did not obtain a signature for the delivery. This incident was not reported to the safeguarding authority, the reporting of this incident may have ensured this was was not repeated in other services.

We looked at how staff were recruited within the service. We looked at three personnel files and found the Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults.

The care files we looked at showed staff had completed risk assessments to monitor people's health and safety. However, not all provided accurate information. For instance, one person's daily notes stated 'obvious parkinsonism, why not treated' it was not clear from the care plan who was responsible for taking this further. We spoke with a member of staff about this and they said, "It just got missed in the community".

We spoke with staff about safeguarding. Records showed that staff had completed safeguarding training and staff we spoke with confirmed this. Staff had a good understanding of what constituted abuse and how to report any concerns. A policy was in place to guide staff on actions to take in the event of any concerns.

Staffing levels were appropriate within the service to meet people's needs. At the time of our inspection there were six people using the service with four staff to support them.

Where the service had identified staff had been responsible for unsafe practice the service did not follow disciplinary procedures.

The building had a history of movement and minor cracking that had appeared in 2006 and further cracks had appeared since then. Following a fully structural survey it was noted that some of the cracks had opened a further 2-3 cm in some areas. The internal and external cracking relates to foundation movement which is attributed to the removal of a large oak tree during the construction of the hospice. The engineers report stated that the building is structurally sound and the cracking does not represent a major cause for concern. A schedule of structural works and remedial repairs which include the use of steel ties to manage and monitor further movement had commenced. Appropriate checks of the building and the maintenance systems had been undertaken to ensure the safety of the building. This demonstrated that the provider had developed maintenance systems to protect people who use, work and visit the premises.

Requires Improvement

Is the service effective?

Our findings

People receiving support told us they were happy with the service and relatives we spoke with agreed. One relative commented "The staff are like family". One person said "It's a wonderful place". Staff told us they were kept updated on people's needs through handover and reading people's care plans. People told us staff knew their needs well.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). 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 make particular decisions, any made on their behalf must be in the person's best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). No-one receiving care was subject to an authorisation under the Act.

We were aware one person's care plan had no consent to care and most of the care plan was not completed. We spoke with a member of staff about this and they told us the person had recently been admitted. We noted the admission date to be 8/3/2016 which was two days prior to the inspection visit

People were supported by external health care professionals when required to ensure their health and well-being was maintained. The care files we looked at showed people received advice, care and treatment from relevant healthcare professionals, such as consultants in palliative medicine and specialist nurses.

We looked at staff personnel files to establish how staff were inducted into their job role. Staff confirmed they received an induction where they completed mandatory training, followed by a three month probationary period. New staff were appointed a mentor during their probationary period. Training is by way of in house training where palliative training is mandatory.

Staff had mixed views regarding support they received from the management structure. Some felt supported and said they were able to raise any issues with the registered manager. Whilst others had a different view and said they were unable to raise any comments or concerns with the management. Most staff confirmed they received regular supervisions whilst one member of staff said they had never had supervision. We did not see any documented evidence that supervisions had taken place. We spoke to the registered manager about this and they confirmed they will ensure evidence is documented in relation to future supervisions.

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not supported and encouraged to question practice. Furthermore, staff who had been involved in medicine errors had a duty of care to ensure the people in their care were safe. The Nursing and Midwifery Council (NMC) code of practice states that nurses should escalate concerns at the level of care people are receiving in the workplace.

Staff supported people with diet and nutrition. We saw the chefs sourced fresh produce and provided good quality food and catered for people's individual preferences. This included people's specific health and dietary requirements. Staff told us "We plan meals and the menus, this change to meet individual choices and we ensure people eat what they enjoy most". The catering team recognised that changes to health and diet can affect people people's overall well-being. A member of staff told us "We do everything to enable people who have lost their appetite through illness or treatment to enjoy food once more".

As well as producing food for people the service offered home cooked meals for family members who were visiting.

Good

Is the service caring?

Our findings

People who use the service, those that matter to them and other people who have contact with the service were positive about the caring attitude of staff.

People receiving support told us that staff were kind and caring and treated them with respect. People told us "They are willing and always have a smile". One visitor told us "They are truly wonderful here and the atmosphere is one of peace and tranquillity". This means that people, their families and carers experience care that is empowering and provided by staff who treat people with dignity, respect and compassion.

People receive care and support from staff who know and understand their history, likes preferences needs hopes and goals. The relationships between staff and people receiving support demonstrated dignity and respect.

During discussions, staff spoke about people in a warm and caring manner. Staff described the ways they respected people's privacy and maintained their dignity. Examples included, knocking on people's door before entering and not discussing people's care needs in front of other people receiving support. One person told us "They leave me if I'm not ready and come back later".

We found through discussion, that staff knew the people they were caring for well, including their needs and preferences. Staff were attentive to people's needs including their emotional state. Staff were also kind and caring towards people's families and friends. This was demonstrated when relatives became upset due to their family member being admitted for pain management. A member of staff supported the family and offered them a quiet place to sit and 'collect their thoughts'. This meant that staff showed kindness and knew how to show empathy when faced with challenging situations. The relatives we spoke with told us staff were understanding and were aware of how they were feeling.

Staff knew people's individual communication skills, abilities and preferences. There was a range of ways used to make sure people were able to say how they felt in relation to the caring approach of the service and whether they matter and belong. Staff knew that they needed to spend time with people to be caring and have concern for their wellbeing. Staff were given enough time to get to know the person who was new to the service, and read through their care plan and risk assessments.

People who use the service knew about support they may require for example, the service employed clinical nurse specialists to focus on people's pain control and in addition supported the social, emotional and spiritual needs of people and their families. A clinical nurse specialist provides expert knowledge and care in a specific field of nursing.

People were involved in the planning of their care, including symptom management and preferences at the end of life. The plans gave people and their families an opportunity to express their views and wishes with regard to care and treatment. This included any spiritual choices and religious beliefs. Any resuscitation wishes were appropriately recorded in the person's care plan.

People's records included information about their personal circumstances and how they wished to be supported. People were given the information and explanations they need at the time they needed them. This was demonstrated on the second day of our inspection when relatives became visibly upset at the deterioration of their family member. A member of staff made arrangements for the family to take some time away from the unit to come to terms with information they had received. This was done in a professional and dignified way by the member of staff.

People were given support to make decisions about their preferences for end of life care. When necessary, people and staff were supported by palliative care specialists. Staff arranged for equipment to be provided, including liaison with other services, as and when needed when this was part of their role.

The service ensured that people had emotional spiritual and bereavement support before during and after death. This was demonstrated during our visit when we observed staff spending meaningful time with people and their relatives. Staff knew, understood and responded to each person's diverse culture, gender and spiritual needs in a caring and compassionate way.

Good

Is the service responsive?

Our findings

We looked at how people were involved in their care planning. Most people we spoke with told us they had been involved in the development of their care plan. One person said "Staff always talk to me about my care plan and check if I agree with it". Records we viewed confirmed that people had been involved in their plan of care. This meant that people received the care they needed, were listened to and had their rights and diverse circumstances respected.

Staff we spoke with told us they were informed of any changes to people's care during daily handover reports and by viewing people's files. Relatives told us they were updated with any changes to the care of their family member either by phone or during their visit. One relative said the care needs change frequently due to their family member's condition. The service had regular clinical meetings to discuss people's ongoing care and support needs.

The day hospice service offered people the opportunity to spend a day in the company of others or to spend time in the peaceful grounds. There were 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. These included art, music, flower arranging, gardening, complementary therapies such as massage, reflexology and aromatherapy. There was also a special bath for people to use whilst attending the day hospice if they were having difficulties with bathing in their own home.

Much of the inpatient care was for general assessment, symptom management or short term respite stays. The vast majority of people admitted for these purposes were discharged home again in line with their wishes. Appropriate arrangements were made for the transfer and /or discharge of people to other health or social care provider.

The service offered a Bereavement Support Service and was available to anyone who had lost someone special to them through death, whilst under the care of the Katherine House Hospice.
There is also a Katherine House Memorial Book for families who would like the name of their loved one written in the book.

People and their families were encouraged to treat the hospice as an extension of their home. The hospice team endeavoured to work closely alongside people's families so a constant sharing of information with people's agreement can take place.

Visitors were welcome at any time and were invited to stay for as long as they wished. There were facilities for relatives to remain overnight if necessary. There was a children's room full of toys on the in-patient unit for visiting children. Pets were also welcome.

The hospice is set amongst fields with secluded areas for the enjoyment of people and their visitors.

We looked at 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. They told us they were the centre of their care and appreciated the unrushed approach in peaceful surroundings. The service ensured comfort, quality of life and the preservation of dignity. The service put people at the heart of all discussions and decisions regarding their management.

The services philosophy of openness and honesty was encouraged through continually reviewing delivery of care. In order to do this, feedback and comments were valued. In the event of people wanting to make a complaint they were encouraged to speak to the senior nurse based at the hospice. People we spoke with told us they would raise any concerns with the senior member of staff and felt they would be listened to, but had not had cause to make any complaints.

Requires Improvement

Is the service well-led?

Our findings

The manager had not notified the Care Quality Commission (CQC) of all reportable events such as medicine errors relating to people receiving adequate symptom and pain control. This may have caused prolonged pain and suffering. Whilst it is acknowledged the service was transparent in their recording of medicine errors within the service. The registered manager had misinterpreted the guidance in relation to notifications that should be made to CQC. This meant that CQC were not able to accurately monitor information and risks regarding the service.

This was a breach of Regulation 20 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

Information from investigations was not used effectively to drive improvements across the service. For example, actions to prevent further medicine errors were not robust. The manager had not ensured that staff who had made errors in the administration of medicine had further training. This meant that people were potentially at continued risk of receiving unsafe care and treatment.

Ketone monitoring sticks were used by nursing staff on one occasion instead of glucose monitoring sticks to check a person's blood sugars. The action report following this incident was to immediately remove the sticks as they were stored on the same shelf as the glucose sticks and had similar packaging which created opportunities for confusion. There was then a risk assessment as to whether the ketone sticks were required as a stock item at the hospice and they have since been stored in a different location.

A robust system of quality assurance was not in place at the service. We asked to see evidence of quality audits and any associated action plans used to improve care. There were limited examples of how quality had been assessed or used to ensure incidents were thoroughly investigated and action plans put in place to reduce future incidents. For example, in relation to syringe driver errors we could not see a rigorous plan in place to ensure staff had received further training or that disciplinary procedures had taken place.

This was a breach of Regulation 17 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

Feedback from other health and social professionals was negative. The management and leadership did not encourage an open fair and transparent culture at all levels. For example, we had conflicting information from staff with regard to the way the service was run. Some staff said the manager was supportive whilst others did not share this view and told us their opinions and views were discounted. This meant the service did not operate in a supportive inclusive way to all staff.

Staff were aware of the whistle blowing policy and told us they would not hesitate to raise any issue they had. However, some staff told us they feared recrimination if they reported any concerns. Staff told us and records confirmed that staff worked in partnership with other health care professionals, such as specialist palliative nurses and consultants in palliative medicine.

Staff had access to general operating policies and procedures such as safeguarding and whistleblowing. These provided staff with up to date guidance. However, we found that appropriate safeguarding referrals had not been made to the relevant organisations. For example, incidents regarding medicine errors.

Katherine House Hospice had a statement about the vision and values it promoted. It included values such as choice, privacy and social interaction.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems in place were not effective in assessing, monitoring and improving the quality and safety of services provided Regulation 17 (2) (a)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA RA Regulations 2014 Duty of candour The registered person did not report notifiable safety incidents 20 (1) (2) (9) (iv)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive supervision to enable them to carry out the duties they are employed to perform Regulation 18 (1) (a)