Pilgrims Hospices in East Kent

Pilgrims Hospice Thanet

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?	**Good** ●

Summary of findings

Overall summary

Pilgrim Hospice Thanet is one of three hospice locations for the provider, Pilgrim Hospices in East Kent. The hospice offers specialist palliative care, advice and clinical support for adults with life limiting illness and their families. They deliver physical, emotional and holistic care through a multi-disciplinary team of doctors, nurses, occupational therapists, physiotherapist, social workers, counsellors, spiritual leaders and a range of volunteers. The location has a day centre and capacity for 18 persons in their In-patient unit (IPU). At the time of our inspection, nine people were using the service as in-patients. The community team provides services for people in their own homes and at an outreach clinic in Deal. There is a rapid response service that provides personal care to people in the community and is available the same day it is needed. The Hospice at Home service supported people in the last days when they approached end of their life. Support groups for carers are available and advice is available 24hours a day. The service was providing services to approximately 400 people in the community and in the hospice at the time of our inspection.

There was a manager who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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 registered manager was also the director of nursing and care services.

At our last inspection on June 2016, we found that medicines were not properly and safely managed; staff had not received the appropriate supervision to enable them to carry out their roles; we issued two requirement notices in relation to these two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found that the service was not always effective in protecting staff from rude and bullying behaviour. The registered provider sent an action plan to us detailing the improvements they would make. They confirmed they would be meeting the requirements of the regulations by October 2016 and that new systems would be embedded and sustained over time. They kept us informed of their progress.

This inspection was carried out on 15 and 16 June 2017 to follow up on compliance with these notices and check whether new systems were embedded in practice. At this inspection we found that the registered provider had met the requirements detailed in the requirement notices and had made significant improvements to medicines management, the support provided to staff and the culture of the service.

Staff knew how to recognise signs of abuse and how to raise an alert if they had any concerns in regard to people's safety. Risk assessments were centred on the needs of the individual. Each risk assessment included clear measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm.

Improvements had been made in regard to the management of medicines. People received medicines that were stored, documented, administered and disposed of appropriately by competent staff.

People received care from staff who were appropriately supported, skilled and appropriately trained. All staff received regular one to one supervision sessions to support them in their role. There were members of staff who took the lead in a speciality, offering guidance to other staff so people could be confident about staff particular expertise. There were sufficient staff on duty to meet people's needs across the service. Robust recruitment systems ensured staff were suitable to work with people.

People were fully involved in the planning and review of their care, treatment and support while in the Inpatient Unit (IPU) and while receiving support in the community. Staff delivered care and support to people according to their individual plans.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS) which applies to hospices. A system was in place to submit appropriate applications to restrict people's freedom when necessary after the least restrictive options were considered, in accordance with the Mental Capacity Act 2005 requirements.

The staff provided meals that were in sufficient quantity and met people's needs and choices. People were very complimentary about the food provided and told us they enjoyed their meal times. Staff knew about and provided for people's dietary preferences, restrictions and reduced appetite.

Staff knew each person well and understood how people may feel when they were unwell or approached the end of their life. They responded to people's individual communication needs and treated them with genuine kindness and respect.

Staff were caring, empathetic and compassionate. Staff approach was kind and pro-active; they were skilled at giving people the information and explanations they needed in a sensitive manner.

Clear information about the service, the facilities, and how to complain was provided to people and visitors. People's privacy was respected and people were assisted in a way that respected their dignity. Staff sought and respected people's consent or refusal before they supported them.

People and relatives told us they were very satisfied about the staff approach and about how their care and treatment was delivered. People's feedback was sought, valued and acted on.

A robust quality assurance system was implemented and embedded in practice. A range of audits and checks were carried out throughout the service to identify how the service could improve and action was planned and taken as a result.

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.

Practices regarding the storage, administration and management of medicines were in accordance with current legal requirements.

Consistent and robust recruitment procedures were followed in practice.

Staff knew how to recognise signs of abuse and how to raise an alert with the local authority if they had any concerns in regard to people's safety.

Risk assessments were centred on the needs of the individuals and there were sufficient staff on duty to meet people's needs safely.

Is the service effective?

Good ●

The service was effective.

The system for the monitoring of staff training was effective. Essential mandatory training was provided consistently. All staff received one to one supervision to be supported in their role and were provided with opportunities to discuss issues and make suggestions about the service.

The service used a multi-disciplinary approach to meet people's health and psycho-social needs. Staff had a good knowledge of each person and of how to meet their specific support needs.

Staff were trained in the principles of the Mental Capacity Act (MCA) and the DoLS, and were knowledgeable about the requirements of the legislation.

People were supported to be able to eat and drink sufficient amounts to meet their needs and were complimentary about the quality of the food.

Is the service caring?

Good ●

The service continued to be caring.

Staff showed kindness, compassion and knew how to convey their empathy when people faced challenging situations. They were skilled at giving people the information and explanations they needed in a sensitive manner.

Staff communicated effectively with people and treated them with respect.

People and their families when appropriate were consulted about and fully involved in their care and treatment. People were enabled to experience a comfortable, dignified and pain-free death.

Is the service responsive?

Good ●

The service continued to be responsive to people's individual needs.

People were fully involved in the planning of their care, treatment and support, which reflected their choices and preferences.

People's needs were assessed before support was provided in the community and as soon as they came into the In-patient Unit (IPU). Care plans and risk assessments were reviewed and updated when needs changed. The delivery of care was in accordance with people's care plans and was very responsive to people's individual needs.

People's views were listened to, valued and acted on. People and relatives' comments were very positive about how staff responded to their needs.

Is the service well-led?

Good ●

The service was well-led.

New systems and projects had been implemented and embedded in practice to improve staff support and consultation. There was a culture that focused on people and people were placed at the heart of the service.

The staff told us they had confidence in the current management team and were very complimentary about the management team.

There were systems to maintain and monitor the quality of the

service to ensure continuous improvement.	

Pilgrims Hospice Thanet

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 carried out 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 was carried out on 15 and 16 June 2017 and was unannounced. The inspection team consisted of three inspectors, one pharmacist inspectors and an expert by experience. The expert by experience who supported this inspection had experience in palliative care.

The registered manager had completed a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. Before our inspection we looked at the information provided in the PIR; records that were sent to us by the provider, the registered manager and the local authority to inform us of significant changes and events; the provider's action plan; and our previous inspection reports.

We made a tour of the premises and equipment. We looked at twelve sets of records that related to people's care and examined people's medicines charts. This included people's assessments of needs and care plans, and observations to check that their care and treatment was delivered consistently with these records. We consulted documentation that related to staff recruitment, training and management, maintenance and safety of the premises, and records relevant to the storage, ordering and administration of medicines. We path-tracked a planned discharge which had involved all members of the multidisciplinary team, including doctors, nurses, a physiotherapist and social services. We looked at audits, checks and surveys concerning the monitoring of the safety and quality of the service. We observed a multi-disciplinary meeting and the administration of medicines. We sampled the services' policies and procedures.

We spoke with the chief executive officer (CEO), the registered manager, the palliative specialist nurse community lead, the medical director (who is also the palliative care consultant), the hospice services manager, the director of HR and workforce development, and the director of income generation and marketing. We also spoke with the senior nurse manager, a team leader for the Hospice at Home service, the volunteer services manager, a community fundraising officer, the head chef, eight members of nursing and care staff and an occupational therapist assistant.

We consulted four people who stayed in the IPU, four of their relatives, four visitors and four volunteers. We also spoke with four people who attended the hospice day centre, and two relatives of people who had received support in their own home from the Hospice at Home team. We spoke with district nurses who provided care for people in the community alongside the hospice team, and two managers of nursing care homes that were supported by the hospice, to obtain their feedback.

Good ●

Is the service safe?

Our findings

People told us they felt safe living in the service. They said, "This place is the safest place to be", "Well, I have only been here a few days but I feel very safe. Truth be told I would like to stay here. Everyone is kind here they make you feel safe and if you have any problems you can ask", "The staff are fantastic, I cannot see how it could be improved, it is really first class and they make everyone feel safe and cared for." A relative told us, "I have seen so many examples of care and safeguarding; this is one of the best examples of safe care I have ever seen." A manager of a nursing home that was supported by the hospice team told us, "Their advice in invaluable to ensure safe practice in end of life care."

At our last inspection in June 2016, we issued a requirement notice in relation to a breach of the Regulation 12 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the management of medicines was unsafe as out of date medicines, including emergency medicines, were not disposed of in a timely manner and individual prescribed dressings were used for other people. In response to the last inspection, Pilgrims Hospices had commissioned a full external review of medicines management. The registered provider had sent a full action plan to us detailing the improvements they would make. They confirmed they would be meeting the requirements of the regulations by October 2016 and that new systems would be embedded and sustained over time. They kept us informed of their progress. At this inspection, we found that improvements had been implemented.

Prescribing was undertaken by in-house doctors, consultants and a nurse prescriber. A pharmacist and pharmacy technician also visited at least weekly to advise on prescribing and medicines management. Processes were in place to ensure that medicines for management of pain were administered in a safe and timely manner. Staff completed people's prescription and administration charts, including reasons for missed doses and allergy status. People's notes showed that staff regularly monitored and responded to their symptoms, including pain. The hospice had additional procedures in place to ensure patches for pain relief were used appropriately and safely. Records were also in place for the application of creams to people. The hospice had undertaken a risk assessment on a process for self-administration of medicines; however the medicines policy had not been updated to reflect this. We discussed this with the registered manager who scheduled a review of the policy on the day of our inspection.

The service had effective processes in place to allow people to take out medicines when on day leave. People were provided with oral syringes for use with liquid medicines when on leave. Staff gave people a take-home medicines reminder card when they were discharged. These were completed by nurses alongside people and their families prior to discharge to ensure they understood what their medicines were for and how to take them.

Controlled drugs (medicines which are at higher risk of misuse and therefore need closer monitoring) were stored securely. Destruction of controlled drugs was undertaken in a timely manner and recorded appropriately. Staff conducted daily balance checks of controlled drugs. High strength preparations of controlled drugs were kept separately from other strengths to help prevent incorrect selection. Blank prescription forms (FP10s) were stored securely and there were processes in place to track their use in the hospice. This is important in preventing misuse of prescriptions. Waste medicines were stored securely and disposed of appropriately.

People's individual and stock medicines were kept securely. Medicines and dressings were stored appropriately and were within their expiry dates. Emergency medicines and oxygen cylinders were available, accessible and within their expiry dates. Medicines requiring refrigeration were kept between the manufacturer's recommended range of 2oC and 8oC so they were safe to use.

Nurses appropriately prepared syringe drivers for people (a system which allows medicine to be administered by slowly over a period of 24 hours) during a medicines round. Staff had good access to up to date resources which they may need for medicines administration, including guidance on the use of syringe drivers. Staff clearly explained information when people were given unlicensed medicines or medicines which are used off-label (licensed medicines which are used outside their normal terms).

Staff had completed training in medicines management and their competency had been assessed to ensure they knew how to administer medicines safely, including via a syringe driver. Staff had good knowledge about the reporting of errors and were able to give examples of learning from previous events. The review process for errors was robust, with an independent peer review to ensure any incidents had been investigated fully. The hospice had also re-designed their electronic incident reporting system through a multi-professional working group. This had improved both reporting rates and the quality of information recorded. The level of incident reporting had risen by 80% since our last inspection.

The service used a specifically designed toolkit to continually monitor the quality of service provided in respect of medicines. The service had also commissioned an independent review of their medicines processes by a pharmacist from another hospice. This review process resulted in changes to make practice safer; examples included amended prescription charts and initiation of transdermal patch records.

There was a comprehensive safeguarding policy in place which included relevant guidance from the local authority multi-agency policy and protocol. Safeguarding training was mandatory for all staff and volunteers within the hospice and checks were maintained concerning the level of compliance for different staff groups. The safeguarding policy reflected relevant legislation and was summarised in a folder that outlined clearly the procedures for staff to follow, and quick reference guides for the protection of adults and children. Staff we spoke with were knowledgeable concerning how to identify abuse and potential abuse and were clear about the need to take steps to report any concerns they may have.

The senior social worker was a safeguarding lead whom staff could approach for advice in safeguarding matters. Staff were also aware of the whistle blowing procedures that were in place in case it was necessary to raise concerns about professional practice. Staff we spoke with were confident that concerns would be addressed by management. One staff member told us "Every one of us has a duty to report anything that is not right. Neither my colleagues nor I would hesitate to report if we have any concerns, the patients are our priority. The manager does listen and action will be taken for sure." Another said they would report any concerns "in a heart-beat." The senior social worker told us how emphasis was placed by the service on safeguarding and whistle blowing being "everyone's responsibility."

A system was in place to ensure that when staff were employed, all relevant checks were completed prior to them commencing work at the hospice. Staff had provided evidence that were eligible to work in the UK and a full employment history was provided as part of the application process. Staff completed Disclosure and Barring Service (DBS) checks before they started work at the hospice. These checks indicated whether staff had any criminal history. Checks were made concerning the current registration status of clinical staff. For example, systems were in place to ensure that nurses employed by the hospice were registered with the Nursing and Midwifery Council (NMC). Staff had completed questionnaires about their medical history that showed that they were fit to work and able to fulfil their roles.

There was a detailed disciplinary process in place that clearly outlined the steps that would need to be taken if it was necessary to address staff performance issues. Appropriate steps had been taken by the provider to keep people safe and ensure good standards of practice were maintained. This ensured people and their relatives could be confident that staff were of good character and fit to carry out their duties.

There were sufficient numbers of staff deployed to ensure that people's needs were met. People and relatives told us that there were enough staff around to meet their or their relatives' needs "day and night." In the IPU, during early staff shifts, there were three registered nurses and three care workers; during late shifts, two nurses and three care workers; and at night time, two nurses and two care workers. Comments included, "There is always plenty of staff around, we can always find someone, plenty of nurses and workers" and, "The staff check on me every fifteen minutes but not in an obtrusive way, discreetly and they are quick to come when I call." Three palliative care consultants worked across the three Pilgrim hospices providing medical guidance and treatment. In the community, approximately 300 people were supported with symptom management, advice and support by four clinical nurse specialists led by a palliative specialist nurse community lead. The Hospice at Home team included seven senior care workers and two care workers, providing personal care for people when they approached the end of their life.

There was a helpline that operated 24hours a day through a hub call centre. This ensured people and families could access nurse specialist advice in and out of hours in the community. When people were in pain, home visits by the hospice palliative specialist nurses, district nurses or GP were arranged without delay. Approximately 1700 volunteers supported the three Pilgrim hospices in East Kent including 300 in the Pilgrim Hospice Thanet location.

Individual risk assessments were carried out for people in the community and in the IPU to identify how risks could be minimised. They included clear control measures for staff to follow in practice. Staff were aware of the risks that related to each person. For example, assessments were carried out for people who needed manual handling procedures, who were at risk of falls or skin damage, or may have communication difficulties. Control measures to minimise risks were implemented, such as the provision of pressure relieving equipment. Staff ensured that people had their call bells within easy reach so that staff could respond when they needed help.

There was an effective system in place for reporting, monitoring and analysing accidents and incidents. This ensured that where preventative measures were identified, these were implemented. A new reporting system, within the IT system, had been introduced to improve the way staff reported and logged accidents and incidents. All departments had been involved in its development. The registered manager showed us how the system triggered successive relevant questions, following events such as a fall or skin damage. As the questions were answered, the system automatically created an email that was sent to staff with relevant responsibility, the nurses and the registered manager. For example, a person had a pressure wound upon admission to the hospice. The system had requested an input of equipment and nursing practices to be put into place, and checks that the next of kin had been made aware. A review was automatically scheduled. The system was interrogated for reports and patterns to identify how future risks could be minimised.

Environmental safety was assured by the hospice services manager to keep people safe. A range of maintenance contracts ensured that equipment in the hospice was safe and well maintained. Contracts were in place for the regular servicing of equipment such as passenger lifts, hoists and kitchen appliances.

Repairs were logged and information was appropriately recorded showing how and when issues had been resolved. Issues were addressed promptly. There were 24 hours on call arrangements for maintenance cover. The infection control lead had identified an unsafe practice regarding the disposal of clinical waste. This had been rectified and discussed at a health and safety meeting

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A detailed infection control policy was in place that provided detailed guidance to staff including routine checks and precautions against Legionella, mattress care management, waste management, protective personal equipment requirements, hand hygiene, and potential hygiene risks posed by any animal visitors. Eye protection kits, spillage and body fluids kits were available. Audits on infection control were regularly carried out and used to identify good practice as well as any areas that were in need of improvement. A lead nurse and two nurses were responsible for monthly infection control audits, involving care workers in the process. A recent audit had led to a decision to change sharps containers. Some shortfalls that had been identified had led to staff being re-trained. A nurse told us, "These audits are nipping things in the bud." Infection control assessments were carried out on each person at admission, with weekly reassessment, or sooner, in response to changes in risk, for example for catheterisation of the use of syringe drivers.

The hospice services manager ensured that high standards of cleanliness were maintained throughout the premises and it was evident that the housekeeping team took pride in their work. Staff had completed infection control training and they knew who the infection control lead was in case they needed further guidance. There was a plentiful supply of personal protective equipment available within the premises and staff were observed using this equipment appropriately throughout the inspection. Cleaning inspections were undertaken monthly, allocated tasks were shared by care workers and housekeeping staff.

There was a comprehensive current fire risk assessment in place and actions had been completed as a result, such as the replacement of hinges, intumescent strips and glass which was not fire resistant. Fire protection equipment was serviced regularly. Staff evacuation training was held quarterly. The hospice services manager was running a programme of evening 'catch-up training' for night staff, with evacuation practice, as part of a health and safety action plan. 'Grab bags' were located at strategic locations, which contained items to use by fire marshals in case of emergencies. The nurses who were trained as fire marshals assessed people's mobility needs and ability in the IPU daily, in case of a possible evacuation. The outcomes of these assessments were noted in staff handovers. We discussed with the registered manager how these personal evacuation plans could be made more easily accessible to emergency services. Action was taken on the day of our inspection to print off this specific information on a daily basis. Fire escape signage was noticeable throughout the premises and fire instructions were displayed for people and visitors to read. There was a detailed business continuity plan and an emergency response plan in place that provided comprehensive guidance concerning how the hospice would operate in case of disruption to services or evacuation. The premises were secure and visitors signed in on entry to ensure that only people who were authorised to be within the hospice were allowed into the building.

Good ●

Is the service effective?

Our findings

People told us the staff gave them the care they needed. People who stayed in the IPU said, "They cannot do enough to help here, I came along to have some help with my breathing then had [complications], that was difficult but the doctor and everyone talked together to talk about the best care for me; they soon got things going and here I am", "They are trying to sort my pain relief to get it more effective and we are getting there" and, "Doctors are extremely helpful; they are sorting my pain management and they are listening to me." Relatives told us, "They are great at communicating with you; they have a way to get [X] motivated again to be as well as possible and be involved with her treatment" and, "All the staff are so professional, they are obviously well trained, and the best thing is how well they work together, and with the patients and with the families." A district nurse who worked alongside hospice staff in the community told us, "They [staff] are very efficient, and great at communicating."

At our last inspection in June 2016, we issued a requirement notice in relation to a breach of the Regulation 18 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not received the appropriate supervision to enable them to carry out their roles and help them improve care for people. The registered provider had sent an action plan to us detailing the improvements they would make. They confirmed they would be meeting the requirements of the regulations by October 2016 and that new systems would be embedded and sustained over time. They kept us informed of their progress. At this inspection, we found that improvements had been implemented.

The service's clinical supervision policy had been amended to ensure it clearly showed the range of supervision that was available for staff and the update had been communicated to all staff in the hospice. Staff we spoke with confirmed that they received the support and guidance they needed, through formal supervision meetings with their line manager. They also were enabled to access informal supervision when they required it. Staff in all services received regular supervision sessions every six to eight weeks and were scheduled for an annual appraisal of their performance. The rate of staff appraisal had increased to 95% since our last inspection. All staff took part in a 'personal best development' programme that included an annual review where additional training needs and individual goals were discussed. Social workers received reflective clinical supervision externally every six weeks. Every six weeks staff got together for 'peer reflection sessions', to exchange views and discuss how they may have found events in the hospice particularly challenging. These meetings were facilitated in rotation by social workers, the chaplain, a counsellor, a doctor and nurses. All staff were invited to attend across the hospice, including staff not directly involved in people's care. A member of staff told us, "This is a time where we can talk about how we are affected, and gain strength from each other; this makes us even more solid as a unit." A meeting was held monthly in each ward, local management team and departmental meetings titled 'Claims, concerns and issues'. This gave staff an opportunity to celebrate their work, raise any concerns, and for line managers and team leaders to write action plans to ensure any issues were addressed and monitored until completion. The service's education and training department, that was based in a sister hospice, supported staff with academic studies, such as a foundation degree in health and social care.

Staff told us they felt well supported in their role. Staff completed a detailed and comprehensive induction process when they began working at the hospice. This included orientation and relevant information they needed to be effective in their roles. Staff were signposted to key policies that they needed to be aware of such as whistle blowing and confidentiality. Staff told us, "Morale is on the up, definitely. We can discuss any problem we have and it will be properly addressed, there is a lot of support available."

Volunteers also received induction training and orientation when they started at the hospice. One volunteer we spoke with told us they had been given opportunities for shadowing and that they were well supported by colleagues and their manager. They told us, "We get the same support as if we were permanent staff." The volunteer services manager had developed a problem-solving policy for volunteers. They told us of their plan to develop the role of volunteers and acknowledged how volunteer support was crucial and extremely valued by all in the service. There were quarterly forums held for volunteers, who participated in a seasonal volunteer newsletter.

The director of human resources and workforce development told us how the personal best programme had been improved as a result of the last CQC visit and of recent staff surveys. Initiatives had been created to support staff, such as health and wellbeing workshops that addressed how staff could stay healthy, 'feel their best', and 'achieve their best'. Staff and volunteers had been invited to apply and be trained to become coaches and deliver the workshops. Three coaching sessions had been held over four months and ten coaches had been trained. The outcome had been very positive as 25 staff had participated in the programme and another cohort of 25 staff was waiting to get on the next programme in October. The staff handbook had been revised to be clearer and easier to navigate. It included a new charter and new topics such as, 'values and behaviour', 'our vision and strategy', and 'our responsibilities'. A newsletter 'Staff matters' included stories from staff across the three Pilgrim hospices, which was provided to staff with their payslip to ensure effective delivery.

There was a wide range of statutory and mandatory training provided to staff, that was selected per department. Training records indicated that staff were up to date with their training programme, having achieved their target or being scheduled shortly to do so. Non clinical staff received training that included fire safety, health and safety, moving and handling, safeguarding adults, equality and diversity and 'Sage and Thyme' communication (techniques to discuss end of life concerns with people and their families). Clinical staff received the same training and in addition were trained in emergency first aid, bereavement risk assessment, clinical record keeping, advance care planning, dementia awareness, principles of end of life care and compassion awareness. Further training included venepuncture, cannulation, and catheterisation. There were members of staff who took the lead in a speciality such as tissue viability, infection control, falls and manual handling with link workers on site. These members of staff could offer specialist guidance to other staff. This meant that people could be confident that staff had access to expertise that could enhance their knowledge and delivery of care. Quarterly mandatory clinical update sessions were run for senior clinical staff to ensure that staff were up to date with clinical developments. These presentations were then cascaded to ward staff.

Monthly 'Act together' sessions were provided for staff, which were presentations and discussions which raised awareness on different topics that may affect the provision of palliative care and support in the service and in the community. For example, in February the Act together session had addressed inequalities and disparities in outcomes and provision of care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) community.

An effective system of referrals was in place to ensure people's needs were effectively met. Daily meetings and weekly multi-disciplinary meetings were held to review each person's care and treatment in the IPU to ensure it remained appropriate, and discuss how to support people in the community who might be admitted to the hospice. The palliative care consultant told us, "I 'follow' people wherever they are: at home, in the hospice, in the IPU, there are no artificial boundaries, but good continuity of care." When appropriate, people were referred internally to the hospice counsellors, social workers, physiotherapists, occupational therapist and the day therapy centre where they could access a wide range of activities and complementary therapies, such as massage, Reiki, and aroma therapy. External referrals were carried out to healthcare professionals such as NHS Continuing Healthcare, GPs, district nurses, social services and intermediate care teams.

There was effective communication with people. Staff ensured they obtained permission from people in order to share data with other professionals when needed. Prior to a person's discharge from the hospice, a summary had been completed by the nursing staff, which included nursing treatment, condition of pressure areas, and activities of daily living, for example their ability to manage stairs. A copy of the summary had been given to the person and another copy sent to their GP. In addition, people were provided with a bespoke 'how to take your medicines' summary, which included which medicines they were prescribed, their dosage and frequency. Nursing staff went through theses summaries with people, and their relatives or carers before discharge from the hospice. A relative told us, "They are very efficient with communication, we are told everything we need to know and very clearly." There was a system of frequent and scheduled staff handovers throughout the day to ensure continuity of care between staff shifts. Staff in the community used portable electronic devices to access and input people's data without delay. People's electronic records were in the process of being re-designed in order to make the inputting of data more effective.

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 this in care homes, hospitals and hospices are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had completed training on the Mental Capacity Act (2005) including the Deprivation of Liberty Safeguards and had acquired appropriate knowledge about DoLS and of the relevant processes. No one was subject to DoLS at the time of our inspection. Staff we spoke with were aware of the need to assess people's capacity in relation to decisions and involve families and also other professionals when necessary to help make decisions in the person's best interests. This was carried out in practice, as assessments of people's mental capacity, relevant meetings and their outcome were appropriately documented. For example, a mental capacity assessment had been carried out regarding a person's ability to consent to their discharge to a nursing home. Meetings were held to reach a decision in people's best interests when they were assessed as not having the relevant mental capacity.

People told us they were very satisfied with the quality of the food and of the way chefs consulted them. Their comments included, " The chefs are so helpful and knowledgeable about food and how to get you to eat; they puree carrots and puddings for me; they just ask all the time what I want. They know what they are doing", "The chef is extraordinary, he comes and ask what I fancy and it is nicely presented" and, "[X] was losing two to three kilos a week but since he has been here only just a half a kilo, I cannot believe it; that chef is a miracle worker." The head chef oversaw three chefs and four kitchen assistants. The kitchen never closed and people could eat at any time of day and night. Hot and cold refreshments were offered throughout the day. The evening staff took people's orders about their preferred meals and breakfasts. The head chef told us, "Whatever they want, we try to accommodate as much as possible. We do a menu with meat and a vegetarian option, soup and dessert, but often they don't want it so we do whatever they fancy." People were offered homemade cakes, hot and cold refreshments, jellies, ice cream and 'ice lollies' as this relieved oral discomfort. Special diets were provided for, such as soft diet, vegetarian, pureed, diabetic or liquidised. Kitchen staff were made aware of people's allergies, intolerance and preferences.

The premises were well designed and suitable for purpose, including a number of comfortable private spaces where people and their friends and families could spend time. On the upper floor, the main reception area included a visitors' dining area, a chapel and a private homely lounge. In the IPU, people were accommodated in two wards, each including a 4-bed bay with curtain screening. Each bay had assisted bathroom and separate toilet. Additionally, there were eight side rooms, all with en-suite bathrooms. People using two side rooms have been relocated temporarily due to contractor noise while a roof garden was being constructed, which will give the rooms an improved outlook. Other rooms looked out over the gardens. The lounge was roomy and homely, with direct access to a terrace overlooking immaculate gardens. There were games and computer consoles for visiting children to use. Two further comfortable, quiet sitting areas welcomed people and visitors. A separate smoking room had been created. There were plans to develop a further visitors' area, where they will be able to make drinks without needing to ask. On the lower floor, the Day hospice offered a room dedicated to group activities, a kitchenette, therapy rooms, an occupational therapy room, a gymnasium and three consultant clinical rooms. Staff were proud to show visitors around and were able to point out areas that were next in line for redecoration under the service rolling programme.

Good ●

Is the service caring?

Our findings

All the people we spoke with, their relatives, visitors and healthcare professionals told us how they positively appreciated the service that was provided and the manner in which it was delivered. They told us, "The care is second to none", "Smashing staff, absolute stars." Relatives told us, "All the staff are ever so kind", "I was so scared, [X] had a fall at home and didn't want to go into hospital; I was so scared of the word hospice, but they are like angels here. I could not fault anyone from the management down, so good, nothing is too much." An outpatient visitor told us, "It is nice and quiet here you can sit outside and have a sleep, I don't feel too clever today but I can just sit here and hear the birds: beautiful. The staff are lovely here, they give me real dignity." Another outpatient visitor told us, "I just started to come here but it's lovely, everyone is very friendly and caring."

In a 'Friends and Families Test' online satisfaction survey, people had commented, Respect and dignity towards patients and family is caring and sincere, I cannot fault any staff or any part of the service received", "Good about care; smiling faces and always a little chat. Always 'is there anything else I can do for you'. Willing to do anything to help. General chat about family and other things and also do a really good job" and, "I can't speak highly enough of the treatment I have received and kindness of all the staff." The service kept copies of compliments that people and relatives had sent to the hospice over the last twelve months. Comments included, "The whole staff team are a credit, nothing was ever too much trouble", "Doctors, nurses, carers, cooks and volunteers, what amazing care and dedication", "You showed [X] such dignity and respect not only to [X[but to us all as a family." A person had written, "I came in to the hospice in a bad way, and you have helped me get back to being me."

There was a homely atmosphere throughout the service and a social atmosphere where people were encouraged to chat if they wished, and were listened to. Staff were smiling and engaging; they looked neither rushed nor under pressure and took time to sit and chat with people and their families appropriately. People and visitors were greeted and conversed with by staff in the corridors as they passed. Staff engaged in conversations with apparent genuine interest. Their approach was kind, patient and respectful. There were frequent friendly and appropriately humorous interactions between staff and people who staff addressed respectfully by their preferred names. One member of staff told us, "Sometimes even if you feel really poorly it is good to laugh or have a chuckle." Families were welcome at any time in the hospice and were able to stay overnight with their loved ones. People's pets were welcome to visit. Children and grandchildren were visiting during our inspection and appeared at ease in the environment. Staff talked with them warmly about the game they were playing. Their parent told us, "They never mind coming here, actually they look forward to it, everyone is so nice here."

Relatives were able to share a meal with their loved ones. The head chef told us, "Sometimes families want to talk to me because I am not clinical and I often stop, sit with patients and talk with them". A person who lived with dementia and visual impairment had been provided with coloured plates, bowls and cutlery that had been specifically adapted so they could eat independently. The person had commented, "This is wonderful." Special occasions such as birthdays and anniversaries were marked with a cake made by the catering team. They had also provided catering for special events held at the hospice such as memorials, weddings and christenings.

Attention was paid to diversity and equality throughout the service. An informative board dedicated to equality, diversity and inclusion was displayed in the service for staff, people and visitors to read. There were comprehensive policies in place relating to diversity, equality and dignity at work. A person in the community held a particular religious faith and as a consequence had chosen to decline intervention involving blood products. The community staff had advocated their wishes at multidisciplinary meetings. The palliative specialist nurse community lead told us how they used telephone interpreters when necessary to communicate with people whose English was not their first language. They told us, "For [a particular culture] for example, the way they discuss their illness may be different, they prefer not to talk about that sort of things so we make sure we are very respectful and understanding of this trait."

Staff respected people's dignity during personal care. A relative of a person who was supported in the community told us, "They [staff] shut the door for the wash, and cover him with a towel; they make sure he doesn't get embarrassed as he is a very private man."

The staff responded quickly to people's changing needs or wishes. For example, whenever people changed their mind about any aspect of their care and treatment, this was respected and staff communicated the updates during handovers. People and their relatives told us that the staff were very polite and respected their or their family's need for privacy and dignity. A mixture of single side rooms and bays allowed staff to present people with choice of accommodation. Staff always knocked on the doors before they entered, were discreet and always entered with a cheery greeting directed at the person and then to their family members. A person who experienced difficulties with their continence had been referred to a district nurse for an alternative to continence pads that offered more discretion. Family members were allowed quiet time on their own and could sit in any of the lounges without being disturbed.

Staff had exceptional communication skills. They knew how to communicate with each person, pre-empted their mood and understood their individual needs. Relatives told us of the staff willingness to engage with them. They told us, "They [staff] make time for us; we feel we are on a journey together and that they are guiding us." Staff were transparent with people and did not shy away from difficult conversations. People were given support when making decisions about their care and treatment and were fully involved with all relevant planning, from symptom and pain management to their end of life care. The handovers we looked at contained information about people's or their relatives' emotional state when people's health declined.

A senior nurse had taken the lead in a 'Compassion Project' across the three Pilgrim hospices which aimed to promote a culture of compassion within the acute hospital setting. This project proposed wards and departments across East Kent hospitals to use and display an end of life symbol (such as Pilgrims Hospice hands) when a person was expected to die in the next few hours, or when they had died. This symbol was proposed to be displayed on doors, curtains, ward boards and bags containing people's belongings that were returned to families. On seeing the symbol, all staff should be considerate in their activities and any encounters they have with people who may be grieving or distressed. The project entailed training, training material and products that were to be provided by Pilgrim hospices.

Clear and comprehensive information about the service and its facilities was provided to people, relatives and visitors. A 'welcome pack' included a guide to Pilgrims therapy centres, how to contact the hospice advice line that was available 24 hours a day, and a wide range of booklets and leaflets designed and written by the service that were clear to understand. These included 'caring with confidence', 'skin awareness', 'facing change – living with a serious illness', 'breathlessness management' and information sheets about practical arrangements when death occurred. People nearing the final stages of life were provided with an informative and sensitive guide about end of life care and about how to consider what was important to them and express these wishes; carers were provided with a similar guide that addressed planning ahead and accessing the support available to them. The complaint procedure and the Pilgrims newsletter, 'Pilgrims matters' were displayed in the foyer.

Family support was recognised by staff as vital to people's wellbeing and staff strived to meet the emotional needs of people's relatives and families, before, during and after the death of their loved ones. One to one specialist counselling support for adults and children was available and offered when needed. Social work support was provided, that included psycho-social support, advocacy, fast track applications for care packages in the community, benefits applications and signposting for practical matters such as relevant to debt management, tenancy and making a will. One person's carer told us, "I didn't know where to start, and the social worker came to do an assessment and showed me all the options that were there for me, I could not have coped without this help." When a person had decided to stop taking all their medicines, the social workers had engaged with the person to find out how much support they needed, and had advocated for him once they had appraised the reasons behind the decision. Subsequently, the person had been admitted to the hospice and had participated fully with a pain management programme.

Spiritual care played a vital part in the holistic care that was offered to people and their families. All clinical staff received spiritual care training. A remembrance path had been built into the gardens that commemorated people who had passed away. A volunteer told us, "A lot of relatives like to come and sit in the chapel and reflect, and we have a memorial book which is made of beautiful parchment type paper with a very attractive font, this was made by a very thoughtful member of staff." The chapel was adorned with a copper memory tree where named leaves bore people's names. A visitor pointed towards it and told us, "Nice touch, very comforting."

People were supported at the end of their life to have a comfortable, dignified and pain-free death and their wishes were at the centre of the service. The doctors and clinical nurses followed a process based on the 'Gold Standards Framework' for their assessments. The Gold Standards Framework is a systematic, evidence based approach, developed to improve quality of care for patients with a life-limiting illness, adopted by all organisations providing end of life care. When people had expressed their wish about resuscitation, this was appropriately recorded and staff were made aware of people's wishes. Each person in the IPU had a pain management programme. Symptoms control and pain management were discussed with people before any new medicines were administered. Staff stayed with people when they approached the end of their life when they did not have families present. A member of staff told us, "It's not about managing death but also managing life. We stay with the patients until the end; no patients is left alone, unless this is their wish of course." With such caring approach from staff, people could be confident that staff spent time with them when needed and had genuine concern for their wellbeing.

Good ●

Is the service responsive?

Our findings

People and their relatives told us that staff responded well to their needs. They told us that staff respected their preferred routine and decisions about any aspect of their care. A relative told us, "Every day I have spoken to the doctor, every nurse listens, you can tell them things you cannot tell anyone; I am scared about what will happen after dad dies, but they have got the social worker to chat to me and already I feel a bit better. They are helping me with what I have to do to make him feel comfortable, and myself at the same time." A person who was staying in the IPU told us, "They are very attentive, come and listen and have a chat, ask you all the time 'are you OK; anything I want, they do it for me, I could ask almost anything."

Staff actively sought people's views about where and how they preferred their care to be delivered. People completed a 'Patient preference questionnaire' and were assisted to compile an advance care plan. These plans give people the opportunity to let their family, friends and professionals know what was important for them for a time in the future where they may be unable to do so. These plans included how they might want any religious or spiritual beliefs they held to be reflected in their care; their choice about where they would prefer to be cared for; which treatment they felt may be appropriate or choose to decline; and who they had wished to be their legal representative. Advance care plans meetings were held were people, their family, the medical team and the care workers who were caring for the person could discuss together how best to manage people's hopes, wishes, and preferences about their end of life care. Families had access to training sessions about advance care planning within the Therapy centre. A relative told us, "The staff helped us get a plan together, we had really frank and honest discussions about all this, and the plan is very tailor-made."

People's views were sought, valued and acted on. Feedback was obtained through several methods, such as a 'The Friends and Family test' survey, a 'Help the Hospices' survey, comments boxes in the service, an online survey 'I want great care' and questionnaires featuring in the newsletter 'Pilgrims Matters'. 500 people had responded to these questionnaires, and their responses indicated that people saw the service as "vital" and described the staff as "caring." Additionally, every person who received care in the IPU, in the therapy centre or in the community was provided with a short questionnaire titled 'Did you get great care today?'. This included questions such as 'what was good about your care and what could be improved'; about dignity and respect, involvement in decisions, the information provided, the staff approach and whether they had confidence and trust in the staff. The results of this survey were included in a report that the registered manager presented to the Quality and Governance committee. There had been no negative comments in the last twelve months. In the day hospice service, a review of current activities provided had been carried out, that included gathering people's feedback, consulting staff and looking at group attendance. As a result, the day hospice service was due to launch a new activities programme in September 2017.

A Department of Health 'Patient-led Assessment of the care environment' had been carried out to determine how to enhance people's experience in the hospice. As a result, hearing loops had been installed in designated rooms to help people with hearing impairment; a range of adapted crockery to help people with mental or physical impairments such as dementia or Alzheimer's disease eat and drink had been provided; magnifying glasses had been made available to help people with visual impairment.

People knew about the complaint procedures which were displayed in the service. People and visitors told us they had nothing but praise for the service and did not have any concerns or complaints, but felt they would be able to approach any members of staff if they had an issue. Complaints were logged appropriately, fully addressed in line with the service's policy, and analysed to see if lessons could be learned.

Staff took account of- and responded to- people's individual needs and requests and special wishes were facilitated whenever possible. For example, when a person had said they "really fancied" lobster for lunch, the head chef had gone to buy one and cooked it for the person. When several persons had wished to go on a holiday before they approached the end of their lives, staff had helped with applications for funding from a charity group. One person who lived on a first floor with steep stairs had been assisted by staff to successfully apply for an external stair lift. Staff had used social media to find tickets for a football game, so a football fan could attend a special game which had been sold out. Another person whose house had burned down had been helped by staff to obtain furniture and equipment that could be adapted to their relative's home, including a hospital bed through the district nurses. At the multi-disciplinary meeting, a person's wish to move into a nursing home had been discussed and considered. There was 'open access' to the IPU in cases of emergencies, when beds were available. A person who had experienced an 'awful night' in the community had been invited to come in and was offered a bed while staff could look how to alleviate their breathlessness.

Staff understood and strived to alleviate people's possible anxieties about coming into the hospice. A person told us, "You would think a hospice is sad and so scary but nothing is further from the truth; there is not one miserable person in here." The medical director told us how a person had been particularly anxious and had focused on the fact that the hospice did not have a juicer, and how they had been encouraged and supported with raising funds for this purchase. This project was understood by staff to be a positive distraction that helped this person overcome her fears. Another person came to the hospice with their own handwritten list of problems. Staff had sat with the person at length, listened, addressed and summarise each point to demonstrate they had genuinely understood the person's perspective. Staff had given the person a copy of the relevant notes they had taken at the multi-disciplinary meeting, and reported back to the person the plan that had been agreed while considering each point that the person had made. The medical director told us, "It's all about team work." The senior nurse for community services told us, "Staff stay and chat if it is needed, we extend our calls if necessary, we adapt to people's needs at the time." This was confirmed by a relative whose loved one received support from the hospice staff in the community, who told us, "Nothing is too much trouble; they stay as long as we need them to stay; they provide reassurance and sometimes much needed laughter."

People's needs were assessed before support was provided to ensure their particular needs were met. People completed a symptom and concerns checklist that recorded levels of pain, tiredness, breathlessness, changes of appetite and mood, sickness and particular physical problems. This checklist was revisited when changes occurred to measure how people fared and adjust people's support. People's initial assessments of needs were comprehensive, including risk assessments, a medical history, personal and family relationships with a genogram (a graphic representation of a family tree), the person's spiritual and religious needs, individual preferences, care wishes, housing and living arrangements. Staff used the 'Karnofsky Performance Scale Index' that classified people as to their functional impairment. This was used to compare effectiveness of different therapies and to assess the prognosis in individuals. Staff also used an 'Integrated Palliative care Outcome Scale (IPOS) assessment which informed them of the person's individual perspective when they approached the end of their lives. This highlighted people's main concerns and enabled staff to write individualised plans for people.

The day hospice was located on the lower ground floor, had a separate entrance and was accessible to people with a physical disability. There was ramped access to the day hospice service and we saw wheelchair accessible toilets, with handrails to provide stability. The day services were provided in clinic rooms, a complementary therapy room, large lounge area and a gym. The service provided included a range of activities and therapies, in response to people's needs. When people came into the hospice with fatigue and/or breathlessness, they were offered with the option of joining the day hospice to join 'fatigue management group' and/or the 'breathlessness management group', both led by the hospice physiotherapists. There were 'anxiety management and relaxation group', a 'energise exercise group', a 'stop that fall group', a 'maintenance Gym group' and a 'have fun exercise group'. One person had experienced extreme fatigue and isolation; as a result of attending the management group, this person had been able to regain confidence and attend the day hospice where he had socialised with others. The day hospice provided activities for people from the community, from the IPU, and for any visitors who wished to join. People could enjoy pets at a weekly pet therapy session. Activities were decided with people and options were offered, such as music and singing, art and crafts, and games. Themed activities and events included a summer party with home-made cakes stalls, pumpkin carving contests, a poetry writing day, a pirates' day, and a baking day. After a game of skittles, a person told us, "Oh it's such fun, I just started here but it is lovely, very friendly and caring."

Care plans were developed and personalised, including details of what was important to them, such as the extent of information they wanted disclosed to them about their diagnosis and prognosis. When people had wished to be positioned in bed in a certain way, or when they preferred visits at specific times in the community, this was recorded and acted on. The information was centralised and accessible through a secure NHS system, which meant that staff in the community and in the hospice were able to access data from hospitals, and update the same set of care plans. This system ensured that any updates reflected people's changing needs effectively without duplication or delay. This also meant that people could be confident that they would not have to repeat themselves and that vital information about their care and wishes could be shared amongst staff across the hospice and hospital services.

Staff handovers were comprehensive and contained people's past or present occupation, their wishes about their preferred place of death, about resuscitation, the progress of their medical conditions and their state of mind. A nurse told us, "That way we get a good profile and know instantly what has changed since the last handover and we can make any adjustments to meet any changes of needs."

The service provided support for carers and families, delivering a series of 'wellbeing and social programmes'. This aimed to provide carers with a safe environment where they could share the impact of their role with others. This entailed four sessions lasting two hours every alternate week, chaired by social workers, where a group of carers explored issues of identity and changing roles; their emotions and moods; the importance of self-care; normalisation and how to reduce the sense of isolation they may experience. Feedback about these sessions was very positive and comments included, "A very open-minded group meeting", "Very interesting; other carers' comments were helpful" and, "Always good to listen to other people's experiences; easy to identify with other people and relate to my own situation." Carers were able to attend these sessions and/or attend counselling beyond the death of their loved ones. Additionally, carers and families could attend a bereavement support group, chaired by counsellors and a chaplain, which was a six weeks programme. The lead social worker told us, "Carers can stay on our books as long as they need the support; we also refer to [a charity that specialises in bereavement counselling]; the counsellors and social workers also work with children, helping them understand illness and death.

Good ●

Is the service well-led?

Our findings

People, their relatives, visitors and staff's feedback about the way the service was currently led was very positive. Their comments included, "The place is definitely well managed, there is a great atmosphere here" and, "The hospice is very well organised and works like clock-work." Staff told us, "We get more consulted and we are listened to", "We get good support and we are a great team" and, "There have been some changes and the atmosphere has improved, we are a united team." A senior member of staff told us, "I have never felt so well supported; [the registered manager] allows me to work autonomously, she values my professional input and trusts my judgement." A member of the management team told us, "The culture here is very good, I have worked here 17 years; everyone is pulling together in the same direction." A 'Friends and Families Test' online satisfaction survey indicated that 92.3% of people would recommend the Thanet community service and 100% would recommend the IPU.

At our last inspection in February 2016, we found that the service was not always effective in protecting staff from rude and bullying behaviour. When staff had raised their concerns with management, these had not been acted on. At this inspection, we found that improvements had been implemented consistently across the service.
A range of initiatives had been implemented to forge improved communication across the hospice teams. These included, a 'Board to Ward' forum which invited teams to share ideas and updates with the trustees; 'Act together' workshops to share best practice across the three Pilgrim sites; regular leadership training days and more detailed staff and volunteer inductions. This, together with daily ward reviews and debriefing sessions for all care staff, was intended to give everyone an opportunity to express and discuss any concerns. Reflection sessions and face to face management time for all staff ensured staff were supported and able to express their feelings.

An external counsellor had been commissioned to support employees in confidentiality. Appropriate disciplinary action had been taken to ensure staff acted in accordance with the expected standards, performance and behaviours. A staff survey was in progress, and all the staff we spoke with spoke positively of the culture in the hospice and of the support that was offered. The chief executive officer had set up an email address so that staff and volunteers could email them directly with any concerns or feedback about the way the service was run. The registered manager had implemented a system to ensure meetings amongst staff took place each month, to discuss 'claims, concerns and issues'. Any concerns were reported to the registered manager, who told us, "It took a while to embed but is now firmly in place and appreciated by staff; it has facilitated a much more open culture on discussing problems."

All the staff we spoke with confirmed that the management team operated an open door policy and that they were welcome to 'pop into the office' and have a chat. They told us they had "total confidence" in the registered manager and appreciated their leadership and style of management. The registered manager was visible in the service and knew each member of staff by name.

The provider had been transparent with the Care Quality Commission and the public about their action plan and proposed improvements. The action plan and regular updates of the progress in its implementation had been posted on the service website and displayed on a dedicated board for people and visitors to read. There was a board displayed with, 'What does safe, effective, caring, responsive and well-led look like?' with a poster explaining how standards of care in each domain could be seen in practice.

The service continued to have a clear management structure and lines of accountability. The service had a structure in place to monitor the quality of its service delivery. There was a governance framework which included clear lines of accountability for clinical care and leadership, clinical practice based on evidence, people's experiences, risk management and an audit programme. The system of audits and quality assurance checks that were embedded in practice and effective. A quality governance board was chaired by the registered manager, where the risk register, reports from the IPU, accidents and incidents, complaints and feedback were discussed. The quality governance committee met monthly, attended by the registered manager, the audit lead, key staff across all departments of the service and the leads for the three Pilgrim hospices in manual handling, falls, tissue viability, and infection control. These leads crossed over the three sites to do peer reviews and share best practice. The committee met again quarterly and was then joined by the social worker lead to discuss safeguarding and DoLS. Each committee discussed reports of audits that had been carried out, to identify where improvements could be made.

The service was part of a national study utilising people and carers' feedback to effectively manage their needs and review outcomes. To this end, Pilgrim Thanet Hospice used a set of outcome measures, 'IPOS', that allowed staff to evaluate people's experiences at various phases of their illness. The registered manager informed us, "The use of IPOS demonstrates the impact we have on patient needs and enables us to benchmark this against other hospices. By monitoring phase of illness we can quickly identify unstable patients with the greatest needs and target team resources effectively."

Monthly audits included medicines, hand hygiene, mattress audits, pressure ulcer, falls, manual handling, and core data. At each committee, actions were determined to drive improvements across the service. As a result of audits discussed at committee meetings, all policies and procedures surrounding medicines management had been reviewed; a new bed rail policy had been ratified; falls and manual handling assessments had been improved so that 100% of people admitted to the hospice had a fall assessment completed within six hours; new mobile hoists and slings had been purchased; additional staff had been recruited; two IT projects had been implemented to improve the management of staff leave, education and appraisals; training for staff was scheduled in regard to new Data Protection legislation. The service had a clear vision and a five year strategy plan. Strategic plans were cascaded through every discipline to ensure that all staff could see how their objectives linked with the organisation's strategy.

A full year end review of quality and governance was presented to staff and Trustees with clear actions planned for the forthcoming year to greater improve performance. This addressed every aspect of the hospice and included reports from each department on issues such as incidents, staffing, medicines management, referrals, outpatient clinics, Hospice at Home, social work, manual handling, falls prevention, tissue viability and health and safety. Emphasis was placed on key achievements over the year, and areas for focus in the forthcoming year with future plans.

The hospice worked in partnership with external partners such as other NHS centres and local NHS Trust hospital and community partners. This ensured the hospice worked collaboratively in order to meet the needs of the local population. For example, the senior nurse for the day service told us they regularly attended a 'quality improvement hub' at the local NHS Trust to raise the profile of the hospice and highlight the services provided. A leaflet had been developed specifically for healthcare professionals, highlighting the therapeutic programmes provided by the hospice, along with the eligibility and referral process. This leaflet was handed out to attendees at the 'hub'. Additionally, they had worked with consultants, or specialist nurses who cared for people with life limiting conditions such as kidney failure.

The service continued to be involved in delivering the End of Life Pathway for East Kent which is a multi-agency partnership agreement between commissioners and providers of health and social care to ensure effective pathways for people who require end of life care. The service delivered Gold Standard Framework (GSF) training to local nursing homes. GSF is a systematic, evidence based approach to optimise care for people approaching the end of their life.

Pilgrims hospices ran an award scheme that encouraged nursing or allied healthcare professionals to submit a detailed plan of a project, or model of care, that they may wish to explore to improve End of Life Care in a variety of settings. This acknowledged how findings could potentially benefit patient care as well as influence nursing or allied healthcare professional communities.

The service promoted awareness of end of life care in relation to specific clinical studies and participated in a wide range of presentations, events and research. Over the last six months, Pilgrims Hospice staff members, including staff from the Thanet location, had participated in 18 national conference presentations; five of their own research projects; and five research projects as part of a national portfolio research. Additionally, the service participated in a Kent and Medway Palliative Care Research group, which brought together academics and clinicians and aimed to support and develop palliative care research in the local region. This group met quarterly. The Pilgrims Hospices research facilitator had contributed to the design of a workshop series run by the University of Kent, which aimed to provide an overview of the landscape of health research. The Pilgrims team from Thanet had attended the Queen's Nursing Institute 2016 Spring Awards ceremony and had been presented with their certificate in recognition of the successful completion of their Pressure Ulcer Prevention project. This project was also the Pressure Care award winner at the Journal of Wounds Care awards 2016, and this work was being cascaded throughout East Kent.

Numerous events throughout Dying Matters week and Hospice Care week were organised and advertised across East Kent and were co-ordinated by the Registered Manager. The lead consultant had led a communication evening that had been attended by GPs and Consultants from the Thanet area. This event focused on how to best initiate difficult conversations about death and dying in an accessible and lively way. A film night and post movie discussions had been facilitated by a consultant from the Thanet location, focusing on social exclusion and old age.

Links with the community continued to be actively sought and maintained through a series of fundraising events and challenges. The community fund raising officer and the director of income generation and marketing fundraised by involving as many people in the community as possible. Sponsored challenges included events such as trekking, walking, running, cycling tree recycling, themed 'get together', fire-walking and skydiving, anniversary balls and 'It's a knockout' team games. Special memorial events were also held such as 'sunflower memories' and 'trees of love' where dedications were written on a sunflower plaque and planted in the hospice grounds, and on illuminated trees at Christmas time.

All records relevant to people's care were well organised, fit for purpose and kept securely and confidentially. Archived records were kept for the appropriate period of time in accordance with legal requirements and disposed of safely.