

Pilgrims Hospices in East Kent

Pilgrims Hospice Thanet

Inspection report

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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

The inspection took place on 15, 16 and 17 June and was unannounced. Pilgrims Hospice Thanet is one of three hospice locations for the provider, Pilgrims 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 nurses, doctors, counsellors, social workers, occupational therapists, physiotherapists, spiritual leaders and a range of volunteers. The location has a day centre and capacity for 18 in-patients. At the time of our inspection up to 12 people were using the service as in patients. The community team provide 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 on the same day it is needed. Support groups for carers are available and there is a 24 hour advice. The service was providing services to 349 people in the community and in the hospice at the time of the inspection.

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.

Safe systems were in place for the ordering and administration of medicines. However, medicines which had passed their expiry date were stored with current medicines. This was not safe practice. Guidance was not in place for the use of prescribed creams nor if people were able to self-administer their medicines.

The service had not followed its policy in providing staff with regular supervision which offers staff support and learning to help with their development. Opportunities for staff to reflect on their practice and to learn what they were doing well and what they could improve in supporting people, had not been formalised throughout the service.

There had been a lack of consistency in leadership at the service and not all staff had not been protected from bullying and harassment. The staff team had not felt valued, listened to or supported for a number of years. Even though some staff morale was low, all staff continued to give a high standard of care for people who used the service. The new management team was aware of staff's feelings and that it took a long time to change the culture of a service. They had put in a range of initiatives to engage with staff.

Staff understood how to safeguard adults and children and this was central to the running of the service. Staff received training in safeguarding and demonstrated they knew how to recognise and report potential abuse.

Potential risks to people had been assessed and action and guidance was in place which identified how they could be minimised. Environmental and health and safety checks were carried out to ensure that the

environment was safe and that equipment was in good working order. There were systems in place to review accidents and incidents and to identify any patterns or trends. The service was clean and infection control guidance was followed to help minimise the spread of any infection if it should occur.

Checks were carried out on all staff at the service, to ensure that they were fit and suitable for their role. Staffing levels were flexible so staff could support people in the part of the service where there was the greatest need.

New staff received a comprehensive induction and were provided with the training necessary to their roles. This included specialist training in bereavement and end of life care to make sure that they had the right knowledge and skills to meet people's needs effectively.

People's health, medical, nutritional and hydration needs were assessed and closely monitored. Their changing needs were effectively communicated within the multi-disciplinary team and with other professionals so that everyone involved in their care was knowledgeable about their needs.

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). The service understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

The service provided a relaxed, comfortable and clean environment. There were a range of areas available for people and their visitors to sit and a large area for day patients to undertake activities.

Staff were kind, compassionate and caring and spent time listening and talking to people in a way that they understood. Supporting people's family members was key to the service and they received support before and after the death of their loved one through counselling, bereavement counselling and carers groups. People also benefitted from spiritual support and complimentary therapies being available.

People's individual wishes with regards to their care were recorded and the staff team advocated for people when necessary to ensure these were met. People and family members were involved in planning their care and treatment and care plans were personalised.

People's needs were thoroughly assessed before and at the time of being admitted to the service. The service could immediately respond to people's nursing and care needs to ensure they died in their preferred place.

People were supported to maintain their mobility and to manage their symptoms through exercise and breathlessness management. The day hospice offered a range of activities and information sessions and promoted conversation in a comfortable environment.

The service had built links with the local community through offering services and fundraising events. People were able to make their views known and knew how to make a complaint or raise a concern. When complaints had been received, these had been investigated so that lessons were learned to improve the service.

The service had a clear management structure and lines of accountability. There was a programme of clinical governance and audit to identify and take action to address any shortfalls. Research and education was undertaken to help improve the care offered for people at the end of their lives.

We found two breaches of the Health and Social Care Act 2008 (Regulated activities 2014). You can see what action we told the provider to take at the back of 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?

The service was not always safe.

The storage of medicines was not safe as some medicines were held past their expiry date and some dressings, prescribed to individual people, were for general use.

There were sufficient numbers of trained and experienced staff to meet people's needs. Checks were carried out on all staff who were employed by the service to ensure they were suitable.

Staff were trained in safeguarding adults and children and knew the action to take if they were concerned that abuse might be taking place.

Potential risks to people's well-being had been assessed and were regularly reviewed to ensure people's safety.

The service was clean and procedures were in place to promote good infection control.

Requires Improvement ●

Is the service effective?

The service was not always effective.

People were provided with care by a staff team that had not received the supervision they required to reflect on their practice and so improve people's care.

Staff were trained to ensure they had the skills and knowledge to care and support people with palliative care needs and understood their responsibilities in relation to the Mental Capacity Act 2005 and how to act in people's best interests.

People's nutritional needs were assessed and their dietary needs and preferences were taken into account when being provided with food and drink.

The service used a multi-disciplinary approach to meet people's health needs.

Requires Improvement ●

Is the service caring?

The service was caring.

Staff were friendly, kind, caring and passionate and supported people according to their individual needs.

People were treated with respect and dignity at all times and their privacy was respected.

Staff knew people well and advocated on behalf of people to ensure their individual wishes were taken into account.

Providing support to people, and their family members, was key to the service. This included people's spiritual and emotional needs.

Good ●

Is the service responsive?

The service was responsive.

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

People were supported to maintain their independence, manage their symptoms, take part in activities and socialise with people in similar circumstances.

People at the end of life were supported to remain in their own homes.

People knew how to raise a concern or complaint and they were acted on.

Good ●

Is the service well-led?

There was low staff morale due to staff being bullied, not listened to and not effectively supported. A new management team was in place that had started to engage with staff.

The views of people who used the service were sought and acted on.

There were systems to maintain and monitor the quality of the service to ensure continuous improvement.

Requires 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 checked 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. At our last inspection in December 2013, we found the service was fully compliant with legal requirements.

This inspection took place on 15, 16 and 17 June and was unannounced. The inspection team consisted of two inspectors on all three days of the inspection and two pharmacists and a specialist nurse on the first day of the inspection.

Prior to the inspection we looked at previous inspection reports and notifications about important events that had taken place at the service. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also obtained feedback from the manager of one care home, who received support from the community team and a commissioner of the service.

We spoke with eleven people who used the service and two relatives. We also spoke with thirty six staff, including nurses, health care assistants, volunteers, catering, domestic and support staff, pharmacist, consultant, physiotherapist, social worker, chaplain, human resources manager and members of the management team. The registered manager for the service and was present during the inspection and we also spoke with the chief executive officer.

We spent time on the in-patient unit and in the day hospice where we shared lunch with people who used the service. We looked at six people's care notes and checked how their care was planned and delivered.

We viewed a number of records including eight staff recruitment records; the staff training programme; medicines; supervision policy; health and safety records; risk assessments; audits; staff meeting minutes; compliments and complaints logs and quality assurance questionnaires.

Is the service safe?

Our findings

People said that they felt safe whilst receiving care and treatment. One person said, "I feel very safe here. Staff are very sensitive". Another person stated in their feedback to the service, "The hospice I consider to be my home". People said there were enough staff available when they needed them, to help keep them safe. They also said that nursing and medical staff supported them with their medicines. "I have seen the nurse today and they have helped me to sort out my medicines".

Prescribing was undertaken by in-house doctors, consultants and a nurse prescriber. A pharmacist also visited at least weekly to advice 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 for the application of creams to people did not always have enough detail, such as the name of the cream applied to a person, or where it had been applied. Accurate records of this help care and clinical staff to monitor the condition of people's skin.

Staff said people could self-administer their medicines, but this rarely occurred. Staff demonstrated a good awareness of how to assess people to check if they were able to administer their own medicines, but this had not been formalised in a self-administration policy.

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.

Medicines which are at higher risk of misuse and therefore need closer monitoring were stored securely. Destruction of medicines requiring safer storage was undertaken in a timely manner and recorded appropriately. Staff conducted balance checks of these medicines. High strength preparations of medicines requiring safer storage were kept separately from other strengths to help prevent incorrect selection. Blank prescription forms 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. However, there was a considerable quantity of waste medicines still awaiting collection.

People's individual and stock medicines were kept securely. However, there was a range of stock medicines, including some for intravenous use and stock dressings, which were past their expiry date and therefore were not recommended by the manufacturer as safe to use. Emergency medicines and oxygen cylinders were available. However, one emergency medicine used for severe allergies was out of date. There were a range of dressings in the dressing stock cupboard which had belonged to people who had been previously treated at the hospice. These dressings had labels with people's names on from community pharmacies and

should not have been held as stock. It was not possible to guarantee the dressings were of suitable quality where they had been stored in people's homes before being brought into the service.

The storage of medicines which had passed their expiry date with medicines that were safe to use was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines requiring refrigeration were kept between the recommended level so they were safe to use. Nurses appropriately prepared syringe drivers for people (a system which allows medicine to be administered by slow release 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 safe use of syringe drivers. Staff clearly explained information people were given about 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. The service had undertaken audits on medicines requiring safer storage, inclusive of reviewing incidents and near misses. Staff had a good knowledge of how to report errors and were able to give examples of learning from previous events. The review process for errors was highly robust, with an independent peer review to ensure any incidents had been investigated fully. This review process resulted in changes to make practice safer; examples included amended prescription charts and initiation of transdermal patch records.

Ensuring that people were safeguarded from abuse was central to the service. The social work team understood the complexities of family life and how to recognise abuse which sometimes took place in complex home situations. The team supported people in these circumstances by developing an individual relationship with the person, gaining their trust and helping them to take control of their life.

All staff received information about how to safeguard children and adults through on-line training. This had been supplemented by a group presentation and discussion through Skype on the first day of our inspection. Staff knew how to recognise different types of abuse by looking out for physical, emotional and behavioural changes in people. They were confident that if they reported a concern to their manager that they would act on it in order to keep people safe. Staff were aware of the service's whistle blowing policy and were confident about the circumstances when they might "blow the whistle". This is where staff are protected if they report the poor practice of another person employed at the service, if they do so in good faith.

People and staff said there were enough staff available to meet their needs. Staff commented that there were times when nursing staff were very busy such as when there were a number of people being admitted to the service or where a number of people required pain relief. During the inspection there were sufficient staff available on the in-patient unit and in the day hospice to respond to people's care and treatment needs. A ward nurse and senior nurse were responsible for the day to day running of the inpatient unit and they were supported by registered nurses and health care assistants. The staffing rota was consistent and reflected the staff on duty on the days of the inspection. The day hospice and community services were managed by a senior nurse who was supported by experienced trained nurses, health care assistants and volunteers. In order to ensure that there were sufficient nursing and health care staff in the community, in-patient unit and day hospice, some staff worked flexibility across all areas and other staff were specifically recruited as flexi workers. This meant that staff supported people in the setting where people had the greatest need. There was also a multi-disciplinary team of health and social care professionals who supported people and their families using all hospice services. Therefore, there was a range of skilled and experienced staff available for people to meet their needs.

There were robust recruitment procedures in place for staff and volunteers. These involved applicants completing an application form, attending an interview and gaining suitable character and/or work references as appropriate. Any gaps in staff's employment history were checked to ensure they were of good character. Disclosure and Barring Service (DBS) criminal checks were completed before staff started to support people. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Volunteers were shadowed until these checks were completed.

Potential risks to people such as in relation to their skin integrity, nutrition, levels of mobility and social isolation were assessed when the person was first known to the service. These risks were reviewed regularly for each person and daily for people who had been identified as at high risk. This included people living in the community who had been identified as vulnerable due to a range of factors as well as people on the in-patient unit. If a person had been assessed as having a specific risk, such as poor mobility, a flag was added to their electronic care notes. This meant that each time a staff member assessed their care notes they were alerted to the potential risk. Control measures were in place to minimise risks to people. This included the provision of specialist equipment such as airflow mattresses to help maintain skin integrity and the use of hoists and moving and handling equipment to support people to mobilise safely. Specific advice and guidance was also in place such as for people to call for assistance when mobilising to reduce the risk of them falling.

Regular environmental and health and safety checks were carried out to ensure that the environment was safe and that equipment was fit for use. There were checks to ensure that equipment was in good working order such as hoists, the nurse call system and medical equipment. Environmental risk assessments were in place to minimise the risks of people living and working at the hospice from potential hazards such as slips, trips and falls.

There was a clear procedure to record and respond to any accidents, incidents or near misses. Each event was reviewed by senior staff to ensure that it had been responded to in an appropriate and timely manner. All accidents, incidents and near misses were investigated to see if there were any patterns or root causes and discussed at the group health and safety committee. The service had a business continuity and seasonal pressure plan for emergency situations such as flooding, gas or electricity failure, bad weather and increased infections. This policy was tested through the use of scenarios to ensure that staff knew what action to take in any emergency.

The service was clean throughout on the two days of the inspection. Housekeeping staff understood their roles and responsibilities and followed schedules of cleaning to ensure all areas of the service were cleaned to the same standard. An infection control lead nurse had been assigned to ensure that the service's policies and procedures with regards to the control of infection were followed. Bathrooms, toilets and sluices contained all the items necessary to maintain good infection control practices, such as personal protective equipment. Infection control audits were regularly carried out to ensure all areas of the service were sufficiently clean and to reduce the risk of infection occurring.

Is the service effective?

Our findings

People said staff had the skills to give them the care, treatment and support they needed. They said staff gave them the specific support and advise they needed in relation to their health and that they regularly saw the consultant. Feedback received by the service supported this. One person commented, "The staff and volunteers are on the ball. The volunteers meet you and they know you so well. They can tell when you are ill and need the nurse. The nurse then comes out and makes sure you are ok". People were complimentary about the food and choices available. Comments included, "The food is very good. Also, they read all the menus out and ask if you want small, medium or large and they ask you if you want anything different or off the menu"; and "The food is nice although I can't eat a lot of it. You always get a choice. If it's not on the list they still do it for you."

Staff were not supported in their role by regular supervision. Health care assistants and nursing staff supporting people on the in-patient unit had not received clinical supervision for nearly a year. The service's policy stated that staff should receive, "Six supervision sessions (three for part time staff) for sixty minutes per session" per year. Supervision records showed that the last date one group had received supervision was on 10 July 2015. There were no processes in place for senior nursing staff to receive supervision. The service's policy stated that an external supervisor should be employed to carry out these supervisions and this had not occurred. Staff told us they had raised their lack of supervision at a Ward Sister's Meeting on 21st April 2016 and had been told that, "It was being looked into". One to one meetings were held with staff on occasions when there were issues with their practice or medication errors occurred. This meant that staff did not receive regular positive feedback about their performance and how they could be developed to improve care for people.

Staff had not received appropriate supervision to enable them to carry out their roles. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Health care professionals such as social workers and counsellors received supervision from an external supervisor. Health care assistants who worked in the Rapid Response team had requested group clinical supervision. This was provided one afternoon each month and included an hour of reflective supervision with a trained clinical supervisor. Annual appraisals had been arranged for all staff.

Reflective practice was not offered on a regular formal basis but staff could request it and had done so when there had been issues that needed to be discussed. Reflective practice is where staff personally and critically reflect on their work, on what they are doing well and what they need to do better, to ensure continuous learning. Staff said they had suggested at a ward meeting that they could talk about how a shift had gone at the end of each shift. They said this would be useful to discuss what had gone well as well as what had not gone so well. Another staff member told us they had recently taken part in a trial session reflecting on the emotional aspect of working in care. They had found this extremely useful and thought provoking and believed it would be very beneficial for the whole staff team. The registered manager told us the service was considering introducing these sessions on a regular basis.

New staff received a corporate induction and individual programme specific to their role. The induction contained essential training such as moving and handling, hand washing and infection control. The 'Care Certificate' had been introduced for all new staff. This certificate was launched in April 2015 and is designed for new and existing staff, setting out the learning outcomes, competencies and standard of care that care homes and hospices are expected to uphold. Staff also had the opportunity to shadow more experienced staff members to learn what they needed to do. New staff said the induction gave them the skills, knowledge and experience that they needed for their role.

Staff said they had received the training they needed to enable them to carry out their roles. They had undertaken regular training to ensure their knowledge was up to date and they had the skills needed to carry out their role. Training covered essential topics such as safeguarding, moving and handling, health and safety and fire safety. Mandatory training was completed electronically but staff had received face to face training in end of life care. Staff had received specialist training in palliative/end of life care and bereavement. Staff and volunteers could also access training in Sage and Thyme. This course trains staff how to effectively communicate and respond to people who are distressed or concerned by actively listening and prompting the person to consider their own solutions. Nurses undertook specialist training specific to the care of people with life limiting illness. Planning was in place to make sure that nurses were able to revalidate their registration with the Nursing and Midwifery Council. This process ensures that registered nurses can demonstrate that they can practice safely and effectively.

Once a month a virtual training session was held giving staff across all three hospices, operated by the provider, an opportunity to learn about a particular subject area. Recent topics had included 'A good death: what do we mean by that?' and 'Total Pain: report from Rediscovering Holism.' The registered manager had recently asked all managers to complete a training plan for their departments. Managers had identified a range of courses which would be beneficial to staff such as tissue viability and hand and foot massage. Therefore, staff received regular training in a variety of areas to help keep them up to date with their practice.

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 the best interests and as least restrictive as possible. All staff had received training in the MCA. Whether a person had the capacity to make individual decisions was central to the operation of the service and was considered at every stage of a person's care and treatment. Staff clearly understood that when people had the capacity to consent, they had the freedom to make their own decisions. When a person had been assessed as lacking capacity to make a specific decision their next of kin, and relevant staff and professionals came together to make a decision on their behalf, and in their best interests.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The service understood their duty to make such applications in a timely manner.

Whether people wished to be resuscitated as part of their care and treatment, was introduced as a topic with people as soon as it was appropriate so that this decision could be made when the person had the capacity to do so. A hospice doctor discussed this decision with the person and their relatives, so that everyone was aware of the person's wishes.

Health care for people was provided by a multi-disciplinary team made up of consultants, doctors, clinical nurse specialists, nurses, health care assistants, occupational therapists and physiotherapists. Each person on the in-patient unit had a named nurse with special responsibilities for making sure their individual needs were met and to provide continuity of care. People's care records showed in detail how they were supported with their medical and health care. There was guidance about each person's condition, extensive information about any specialist conditions and the pathway and progression of the person's illness was clearly tracked. Staff recognised that people's healthcare needs could change quickly. There were effective handovers between each team of nurses in which information about people's medical and health needs were discussed and communicated. Therefore, people could be assured that all professionals understood their individual and changing health needs.

People were supported at the end of their life to have a comfortable and pain-free death. The clinical team used a range of tools such as the 'Symptom Control Checklist' and 'Palliative Care Outcome Scale', (IPOS) to measure the effectiveness of symptom control. IPOS captures information in relation to people's symptoms and also practical concerns, anxiety or low mood, family anxieties and overall feeling of being at peace.

The service had a Hospice at Home team comprising of a team of community nurses whose role was to visit people in the community who had palliative care needs. This included people in nursing and residential homes. These people remained under the care of their named GP and the service worked closely with them to support the person to remain in their own home. Positive feedback had been received from the manager of a residential care home whose residents had been supported by the Hospice at Home team. They said that staff were very knowledgeable about palliative care and gave excellent advice and support to the residential home staff team.

Pilgrims Hospices East Kent ran a 24 hour, seven days per week telephone service where people in the community and carers could phone at any time for support or advice. The telephone operator was able to answer general queries, book appointments and to refer people to the most suitable professional. If people required urgent advice about their symptoms they were put through to the specialist on call nurse. This gave people the assurance that they or their family members could seek the appropriate support or advice at any time and enabled people to remain at home, according to their wishes.

People had a nutritional assessment when they were first known to the service and care plans included people's nutritional and hydration needs. The catering team provided meals to people on the in-patient unit, in the day hospice and to relatives. They had received a compliment about the service they provided. "The food and catering are excellent with healthy choices catering for individual tastes". There was a varied menu which had a number of options including a meat, vegetarian, soup and salad. People's health and dietary needs were catered for as well as people's preferences for a small or large meal portion. Staff understood that for people at end of life care it was important to ensure they were offered food that they felt like eating and alternatives were provided when requested. The acting head chef was passionate about their role and they or a member of their team spoke to each person on the in-patient unit each day to get to know them and their likes and preferences. They understood the important of presenting food to people in an attractive manner and this was successfully achieved on the days of our inspection. People were regularly offered drinks or if they had difficulties swallowing, ice that they could suck for refreshment.

For people using the day hospice, the lunchtime meal was an important focal point where people come together to socialise and staff ensured that it was a special occasion. People and staff sat around the same table so people could have individual or group conversations. Specialist equipment was available such as adapted cutlery and plates, so that people were able to eat independently. For people who required staff to support them to eat, this support was given whilst engaging with the person in the task or in general

conversation. People in the community with more complex nutritional needs were referred to speech and language therapist who advised on the consistency of a person's diet and fluids, to aid swallowing. Therefore, people had access to well-presented nutritious food and any support they required to ensure they had adequate nutrition.

Visitors to the service benefitted from a main reception area which was manned by volunteers all day and early evening. There was a café where they could purchase food and drinks and a quiet area which could be used for private conversations with friends and relatives. The reception area had recently been refurbished. Accommodation for people on the in-patient unit consisted of bays with a number of beds, with privacy curtains or single en-suite rooms. Bathrooms were fitted with equipment which enabled people with mobility problems to have a bath. There were a number of reclining chairs and sofa beds so that people could stay overnight with their loved ones. All rooms had direct access to the garden, as did the communal lounge. The garden was beautifully tended by a group of volunteers. The day service had a separate entrance and consisted of a large area separated into a dining and seating area. There were a number of clinical rooms, a therapy room, a family counselling room and hairdressing room with a sink that could be lowered and raised so it could be used for people with limited mobility. There was also an on-site gym to promote people's health and well-being, so that they could remain mobile and active. Therefore, people's needs were met by the design and layout of the service.

Is the service caring?

Our findings

People and visitors were full of praise for the staff team and the kind, caring and compassionate atmosphere that was present at the service. They said that this was created by all staff who gave them direct care and also other support staff. One person told us, "The staff are absolutely marvellous from the ladies who volunteer to the nurses and the doctors. They listen to you". Other comments included, "I am treated as though I am precious. Staff cannot do enough for me". I can choose when to get up and ask for a drink. I am treated with the upmost respect"; and "It's nice, really, really nice. It's relaxing and friendly and the staff really help you". The service had also received feedback about the caring nature of the service via its website. One person commented, "The staff are unbelievable! They care about the wellbeing of every single person that walks through their doors, not just the patients. They are kind, caring, dedicated, thorough and friendly. My mum stayed at the hospice and was treated with respect and dignity"; and "Everyone is so caring and understanding. I have felt surrounded by love".

People were involved in decisions and planning their care. People's care plans contained detailed information about their care wishes, including their preferred place of care, preferred place of death and preferences regarding decision making and information giving. Staff had a clear understanding of people's preferences, especially around end of life care and decisions. One person feedback to the service the following comment, "Every step of Mum's care has been explained to us and Mum has been consulted on every decision. As a family we can't believe the lengths Pilgrim's staff have gone to, to ensure her happiness. We are truly amazed."

People told us that they had benefitted from counselling support. This support was provided to people and/or family members. Individual counselling was provided on a one to one basis before or after a death. Group bereavement support was offered to family members three months after bereavement for a six week period. In these groups people were encouraged to take ownership of the group and talk about their loved one in a safe place where people had a shared experience. Support was also provided for children. This was either direct therapeutic work such as through memory boxes or creative art; family counselling or referral to external children's counselling service.

A monthly carers group was held for people who cared for a person with palliative care needs. The aim was to provide social, practical and emotional support for carers. The topics discussed were evidenced based and were used to initiate discussion amongst the group. The last session involved talking about people's five sense. This included people's sense of purpose and achievement and feelings about their caring role.

A chaplain had been appointed within the last month and was the spiritual care lead for the service. Their role was to offer spiritual support and guidance to people, carers and staff. They explained their role was to be available to listen to people when they felt the time was right for them to talk. "I've sat in silence for half an hour and someone has just spoken to me", they told us. As the spiritual lead, the chaplain had links with other faiths and so was able to ensure people had access to the spiritual support they required.

The service had its own mortuary and chapel/private area, so family members could spend time with their

loved one after they had died, if they so wished. People found it comforting to know that they could continue to spend time at the service with their loved one after they had died as they were familiar with the environment and staff team.

There was a relaxed and homely feel throughout the service and people were encouraged to chat if they wished, and they were listened to. It was a credit to the staff that despite some feelings of low morale, staff were positive and cheerful in their engagement with people. They said that their role was rewarding and that if they had made a person laugh or smile, they left the service feeling their day was worthwhile.

Staff took time to sit with people, engaging them in conversation and listening with genuine interest. There was a lot of laughter in the day service as staff and people joked with one another. One person was supported with their mobility. The staff member asked them to slow down as they could not keep up with them. This was said in a light hearted and humorous way that was appropriate to the situation. Staff knew people well, understood their likes and dislikes and how to communicate with them. When supporting someone to eat, staff explained to them what they were going to do and gained their consent so they were fully involved in the process.

Staff valued people's contributions. One person had limited verbal skills. When a staff member could not understand what they were trying to say, they smiled and reassured the person. They then touched their arm and asked them if they would mind if they got someone who knew them better. This person smiled when the other staff member came and communicated they wanted a blanket as they were feeling cold. The staff member gave them their blanket and apologised for not having understood what they were initially saying. The person was visibly happy and relaxed having been given their blanket and smiled broadly.

The service understood the importance of advocating for people who did not find it easy to speak up for themselves. Some people had complex family relationships in which the wishes and choices of the person were not always the same as each family member. In these situations the social work team played a key role in ensuring that the person's wishes were sought and realised at the end of their life.

People were supported from the local community if they had palliative care needs, whatever their age, disability, religion or race and this included offering care and treatment to people who were refugees. Interpreters were accessed for people and their family member whose first language was not English. This meant that people were able to communicate their needs to the staff team in times of distress.

People had privacy curtains around their bed and these were used to give people privacy when being assisted with personal care. Bays had a single sex policy and people and their visitors had access to quiet private areas. Staff used signage on doors to indicate when rooms were in use, such as for private meetings, counselling and therapies, so that people were not disturbed. People's relatives and visitors were able to visit at any time and this included overnight stays. Therefore, people could be continually supported by people who were important to them.

Is the service responsive?

Our findings

People and their visitors said that the service responded to their needs as staff were highly attentive. One person told us, "It is very good here. Staff get you anything you need". Another person said, "The staff are very good here. They always seem very concerned about you if you need assistance they're only too happy to help." Very positive feedback was received from the manager of a residential care home whom the service supported. They said that when they contacted palliative care nurses for advise and support they responded immediately and there was very good communication between both services.

The service promoted people's physical well-being and independence. The physiotherapy and occupational therapy (OT) team supported people in the hospice and community to access the relevant mobility equipment and to maintain their mobility for as long as possible. One person told us, "Staff have come to my home to sort out the equipment I need to help me move around by myself. The service had responded to this growing need for these professionals by assigning an assistant to the OT and one to the physiotherapist. Compliments had been received about the support the teams provided. "The physio and OT were confidence builders, patient, caring, and understanding. Everyone seems genuinely kind and caring"; and, "The care was non-intrusive and yet pushed boundaries of one's self-imposed restriction and capabilities. Since starting to come to the hospice I have found my confidence in my ability to grow through the exercise and physio.'

The physiotherapy team ran 'Breathlessness management' programmes and exercise programmes. Breathlessness programmes were for people in the community whose illness caused breathless periods or anxiety attacks due to their illness or medication. During three hourly sessions people benefitted from understanding they physiology of how they breathed, and ways of managing their breathing through the use of equipment, inhaling techniques and comfortable positions. The aim was to help reduce the need for people to be admitted to hospital due to anxiety. Programmes included, "Ooops a daisy", an educational and exercise group for people at risk of falling; "Sit down, get fit have fun", a seated exercise programme and "maintenance gym group", which took place in the therapy gym."

People were complimentary about the day service which was run by a team of nursing staff, health care assistants and volunteers. "I get here and we get settled and then we all have a chat and we might do some exercises or a quiz", one person told us. Another person said, "I like it here as we do games and exercises. I am looking forward to having a massage this afternoon, like that lady is now". People were given lunch and offered a range of activities including bowling, games, quizzes, walks in the garden, aromatherapy and talks. One talk had been given by the physiotherapist and on the day of the inspection an external provider spoke about 'Imaginary Me', where people could input their memories and pictures on a specialist computer programme.

People said the day service offered them a regular opportunity for companionship. One person said that they had been referred to the service to prevent them becoming isolated and lonely. Another person told us, "I enjoy coming to the day service. It is the only time I get out. The staff are great. I cannot do the exercises, but I enjoy being able to talk to people".

People were referred to the hospice by their doctor or a local hospital. On admission to the service people were seen by the doctor and an assessment was made of their medical and treatment needs. Assessments of people's needs were comprehensive and detailed and included falls and mobility assessments and the use of nationally recognised tools to identify people's functional impairment and prognosis, risk of pressure ulcers and level of ability in achieving every daily living task such as dressing, eating and continence. These assessments were accurate and reflective of people's needs and abilities.

People's care and support was planned in partnership with them and their relatives. They were asked about their needs and preferences and these were recorded in their plans of care to guide staff. Nursing staff communicated people's information with appropriate members of the multi-disciplinary team. Staff had a high level of awareness of each person's condition and if there were any changes or deterioration in their needs. The service had introduced a system of nursing called, "Intentional rounding". This is a structured process where nurses carried out regular, structured checks with each person at set intervals, often hourly. It helped the staff team to organise their workload and ensure all people received attention on a regular basis and consistency in their care and treatment. Information about people's care and treatment was detailed and contemporaneous. This ensured that people were supported at the end of their life by staff who understood how to support them to have a comfortable, dignified and pain-free death.

A rapid response team was available that helped support people in achieving their preferred place of death by offering planned twenty four hour support with personal care. This service could be mobilised within twenty four hours of referral. For example, one person returned home from hospital and were able to spend their last days there which was their wish. There was a note in this person's record that their relative was very grateful for staff that had helped them assist the person to their bed and make them comfortable, when the hospital transport service had not been able to do so. Another person who lived alone was supported by the team at home, until a bed was available in the nursing home of their choice. Therefore, the team ensured people's preferences of place of death were enabled and prevented unnecessary hospital admissions.

The service involved in building links with the community which had a positive impact on people's quality of life. They had joint worked with Macmillan and Crossroads on a volunteer befriending scheme that people living in the community could access to help with day to day chores. Information about people who use the service was shared, via secure computer network, with the local ambulance service. This meant that the service was alerted if a person known to them was admitted to hospital, so they could take appropriate action. In addition, paramedics knew if the person they attended wished to be resuscitated or they had chosen not to which meant that people did not go to hospital unnecessarily.

In order to continue to respond to people's needs the service had a fundraising team as the majority of funding for the service was from charitable donations. A number of fundraising events had been planned throughout the year. There was a 'Colour Run' which involved people and families running or walking through brightly coloured paint clouds as they passed a number of colour stations and a 'Starlight Stroll' with music and food and the opportunity to walk in memory of a loved one. The service also operated a number of local retail shops and people had the ability to shop on-line via the service's website.

People said they did not have any concerns or complaints about the service but that they could talk to any member of staff if they were unhappy with any aspect of their care. Staff were knowledgeable about the complaints procedure and knew what they should do if a person using the service or their relative, raised a complaint or concern. There was a clear complaints policy and procedure in place outlining how complaints from people or their families would be dealt with. This was available on the service's website. A complaint was defined as, 'Any expression of dissatisfaction.' Each complaint raised was logged and the relevant head

of service or hospice manager was informed within twenty four hours. Complaints were investigated and appropriate action was taken as a result. Any learning identified from a complaint was shared throughout the organisation.

Is the service well-led?

Our findings

People and visitors said the service was well managed as they had positive day to day experiences of staff and senior staff. Feedback from a commissioner of the service was that there were good working relationships with the management team; they were open and honest, keen to work with them, and to develop the service for the benefit of the people who used it. However, staff responded that the last three years had been very unsettling due to changes in management, in the Board of Trustees, in the direction of the service and ways of working, and the lack of consultation in these changes which had resulted in low staff morale.

The service was not always effective in protecting staff from rude and bullying behaviour. In the 2015 staff survey 26% of staff felt it was safe to challenge the way things were done at the service. 65 % of staff said they had not been bullied at work in the last year, which indicated that 35% had not been protected. Disciplinary procedures were in place which set out the expected standards, performance and behaviours of staff and what staff conduct may lead to disciplinary action. However, the service had not been consistently effective when staff were not acting in accordance with the expected standards, performance and behaviours. Staff told us that one member of staff was rude and exhibited bullying behaviour and this affected their well-being. They said that although they had raised their concerns with management, they had not been acted on.

In the staff survey of 2015 only 5% of staff responded that they agreed that staff morale in the service was high and 12% that they had confidence in the trustee board. At this time the chief executive and registered manager were both new in post and they told us that staff felt, "exhausted by change." There was a new trustee board in place following the staff survey and other senior members of staff had also changed. Staff described the effect of these changes in management and ways of working as making them feel, "ground down" and "undervalued". One staff member told us, "This is the best place I have worked, but I do not have that happy feeling anymore when I come to work".

The senior management team acknowledged that staff had not been listened to and recognised the way they felt. They had put in place a range of initiatives to help address these issues. The chief executive had sent up an email address so people could email them directly with any concerns or feedback. A "Staff Matters" publication had been sent to all staff in May 2016 to highlight staff achievements. Staff and volunteer consultation groups had been introduced which consisted of elected representatives and senior members of staff. "Board to Ward" had started whereby members of the Board of Trustees, executive directors and senior management met with staff to look at what staff had done well and achieved and what key things could improve care for people. These meetings were planned to extend to volunteers and people who used the service. The poor staff survey results of 2015 were discussed regularly and they were used as a way of sharing information.

Staff said that some things were improving but there was still a disconnect between front line staff and some members of the management team. Comments included, "Morale is alright at the moment. Morale did go really low and people were talking about leaving and that was sad, as we're like a little family here"; "With

the management, you don't really see them to be honest. When I was off sick I had good support from the ward sister but the higher management you don't really see. I think if they popped in and introduced themselves that would be good as you'd know who they are"; and "There has been a tremendous amount of change over the past three years. The management team has been replaced, trustees have left. The staff survey was negative and I think nothing will be done about it".

The service understood that it would take a long time to change the culture of an organisation and continued to seek staff's views. Quarterly employee engagement questionnaires had been sent to staff and the February 2016 results showed improvements in staff feeling listened to and valued with 73% of staff feeling listened to and valued. In the June 2016 quarterly survey twelve comments were received of which five were negative and two were positive". Negative comments included, "Staff morale is very low. Not praised for good nursing but picked up by others; and "I rarely get the opportunity to meet with my line managers". Positive comments were "The organisation and appears to have stronger foundations to meet the challenges of caring for individuals and their families"; and "The organisation now has a clearer sense of purpose". A new staff and volunteer survey had been sent out in June which was a national survey supported by Hospice UK. The results were due to be received in August.

It had been acknowledged that leadership throughout the service needed to be strengthened and managers were being given extra training to support them to lead their teams. A leadership day had been held in December 2015 with a follow up half day in March 2016. This focused on the skills needed to be a good manager such as leading a team, coaching staff and communication. A senior nursing post had been introduced to provide extra support and supervision for staff on the ward.

Information about the service and its facilities was available on the service's website. However, some of this information was misleading. It stated there was an outreach clinic at Deal, offering, "Counselling, hand and foot massage, relaxation and breathing techniques and some gentle exercises". However, only clinical appointments were available at this site. The admissions criteria for the in-patient unit were on the website. The registered manager told us the eligibility criteria for accessing community and day services were under review. The public were not aware of this as this was not mentioned on the service's website and this had led to confusion about who was eligible to receive support from the service. Printed information and public awareness sessions had been arranged in the next few months, to ensure that the public and professionals knew about the changes.

The service had clear organisational objectives which set out how staff objectives fitted into the wider organisation". The hospice's vision was, "To provide specialist palliative care to the people of East Kent". Their values included, "Keeping people at the centre of all we do". This was seen throughout the hospice, where staff provided compassionate, person-centred care. A commissioner commented that the service had a clear direction.

Changes had taken place in the management of the service in 2015 with a new chief executive, director of nursing and care services, medical director and registered manager. In addition with the head of human resources and estates, this team oversaw the management of the three Pilgrims Hospices in East Kent and therefore spent time at all three locations. The registered manager demonstrated they were passionate about providing services for people with palliative care needs. Senior nursing staff were based at the location but the post of service manager was vacant and was being overseen by a service manager from another location. There were clear lines of accountability to the Board of Trustees.

The views of people and their carers and family members were sought through the Friends and Family Test. This is where people are asked if they would recommend the service to others and can comment how it met

or did not meet their needs. The results of the test were displayed in the in-patient unit together with the action that the service had undertaken to address any areas for improvement that had been identified. The Friends and Family Test was being extended to seek feedback from people who used community and day services, in addition to people using the in-patient unit. Patient-led assessments of the care environment (PLACE) had also been carried out. This is an initiative of the NHS whereby people and staff assess if people are cared for with compassion and dignity in a clean and safe environment.

The service had a structure in place to monitor the quality of its service delivery. There was a governance framework in place 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. Audits included hand hygiene, manual handling, medicines management and adverse events. This showed that there were processes for an on-going assessment and improvement of the service at all times. The 2014 to 2015 quality account for the service was published on the provider's website and identified areas of good practice and improvement. The Clinical Commissioning Group (CCG) commented that although the report was written in a way the public could understand, it did not provide clarity regarding which priorities had been delivered.

The service had identified a number of areas of improvement. For example, in order to strengthen clinical practice, additional senior nursing staff had been appointed and a lead nurse had been assigned to specific areas such as infection control and tissue viability. The service had reviewed its day services and a new model of care had been planned and was due to be launched. To support people in the community the physiotherapist and occupational therapist had been assigned an assistant and further exercise programmes and gym classes were due to be rolled out in the next few months. Additional programmes for carers were planned which included informal drop-in sessions.

The service had been very involved in developing 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 was proactive in providing education and undertaking research to identify and share best practice. The service delivered Gold Standard Framework (GSF) Training to local nursing homes. GSF is a systematic, evidence based approach to optimising care for all people approaching the end of life. delivered by generalist frontline care providers. Research included a hydration study led by the University of Guilford and National research in understanding the complexity of care needs. The provider had published research and made a presentation on the accuracy of prognosis in palliative care at the European Association for Palliative Care and a poster presentation at Hospice UK conference 2015. The provider had also made a financial award available to nurses and allied health care professionals to enable them to implement a project to improve end of life care for people. This helped to ensure that people received support from a service that continuously learnt through experience and research, the most effective ways of meeting their palliative care needs.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The management of medicines was unsafe as out of date medicines, including emergency medicines, were not disposed of in a timely manner and individually prescribed dressings were used for other people, which was neither safe nor hygienic.</p> <p>Regulation 12 (g)</p>
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>Staff had not received the appropriate supervision to enable them to carry out their roles and help them improve care for people.</p> <p>18 (2) (a)</p>