

Central London Community Healthcare NHS Trust

RYX

Community end of life care

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RYXY2	Pembridge Palliative Care Unit	Pembridge Palliative Care Unit	W10 6DZ







This report describes our judgement of the quality of care provided within this core service by Central London Community Healthcare NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Central London Community Healthcare NHS Trust and these are brought together to inform our overall judgement of Central London Community Healthcare NHS Trust

Summary of findings

Ratings

Overall rating for the service	Requires improvement	
Are services safe?	Requires improvement	
Are services effective?	Requires improvement	
Are services caring?	Good	
Are services responsive?	Good	
Are services well-led?	Requires improvement	

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	5
Background to the service	6
Our inspection team	6
Why we carried out this inspection	6
How we carried out this inspection	7
What people who use the provider say	7
Areas for improvement	7

Detailed findings from this inspection

Findings by our five questions	9
Action we have told the provider to take	24

Summary of findings

Overall summary

Overall rating for this core service **Requires improvement**

End of life care services were caring and responsive although required improvement to be safe, effective and well-led. On the in-patient unit staffing had been problematic due to recruitment problems. The inpatient service was generally covered in terms of nursing numbers but the skill mix was affected as agency staff did not generally have specialist palliative care experience. Patients on the inpatient unit were not always having risks assessed in line with trust policy or pain assessments completed in an effective way and we saw that a contributing factor in this was the recent development of an electronic record system that was yet to be fully embedded. A further contributing factor was the high use of bank and agency nurses and the difficulties this presented in terms of the use of the electronic record system and the specialist nature of the service. The Liverpool Care Pathway had been withdrawn in 2014 and while we saw that staff were reviewing replacement care plans for end of life care, this had yet to be implemented 15 months following withdrawal. This meant that assessment and care planning guidance was limited at a time when the inpatient unit was using a high number of non-specialist nurses.

The specialist palliative care community service was provided by 3 teams of specialist nurses across the region and a community palliative care consultant, all of whom were based at Pembridge Palliative Care Unit. While there

were recruitment issues relating to specialist palliative care nurses, the team had addressed some of this by using a triaging system and prioritising referrals based on need.

We saw evidence of services being responsive to meeting patient's needs and the trust had developed an end of life care strategy that included the identification of specific needs of the local community and there was an implementation plan in development. Staff told us there was a commitment to good quality end of life care at board level within the trust and we saw evidence of this. In some areas however, there appeared to be a lack of clarity in terms of responsibilities for the development of end of life care services between the Pembridge Palliative Care Unit and the trust as a whole. This resulted in some senior staff being unclear of their role in relation to strategy development. There had also been delays in terms of the development of a number of reviews and implementations, including a replacement for the LCP, the use of outcome measures and the review and update of clinical guidelines for use in end of life care. Staff we spoke with demonstrated passion and commitment to good quality end of life care and we saw evidence of good multi-disciplinary working.

Feedback from patients and relatives was mostly positive and we observed staff to be caring and compassionate in their approach. We viewed good initiatives in terms of the development of compassion in care projects, a living well at home group and the development of work streams to focus on the implementation of the end of life care strategy.

Summary of findings

Background to the service

Central London Community Healthcare (CLCH) NHS Trust provided end of life care services through The Pembridge Palliative Care Unit and community services. Pembridge provided Specialist Palliative Care to adults in their own homes, Pembridge inpatient centre, day services and other locations including prison, nursing and residential settings. The palliative care service provided support to patients living in the boroughs of Kensington and Chelsea, Hammersmith and Fulham, Westminster and Brent. CLCH also provided community end of life care services for children.

Specialist palliative care was provided as part of an integrated service across both inpatient and community teams. The specialist palliative care team comprised of 1.8 whole time equivalent (WTE) specialist palliative care consultants and 1.8 WTE speciality doctors. In addition there was one whole time speciality trainee doctor based at Pembridge across both inpatient and community services. Community Nurse Specialists (CNS's) were led by an acting community team leader and were split into 3 locality teams; Kensington, Chelsea and Westminster; Brent; and, Hammersmith. There were 7.4 WTE community nurse specialists. Day care services were led

by a day care sister and day care CNS. Inpatient services were delivered on the specialist palliative care inpatient unit where 13 beds were available and care was delivered by a team of staff nurses and healthcare assistants, led by team leaders and ward managers. Inpatient occupancy had averaged 88% in 2014/15. Referrals to the specialist palliative care team (SPCT) totalled 205 for a 3 month period between January and March 2015. Of these referrals, 80% were for malignant disease and 20% for non-malignant disease.

During our inspection we spoke with a palliative care consultant, speciality doctors, specialist palliative care nurses, managers, ward nurses and healthcare assistants, social workers, a spiritual advisor, administrative staff, pharmacist, massage therapists, community nurses, the end of life care steering group lead, community nurse managers and a divisional director and Associate Director of Quality. In total we spoke with 37 staff. We spoke with 7 patients, two in the community and 5 using the services at Pembridge. We spoke with one relative. We reviewed the records of 7 patients on the inpatient unit and 11 DNACPR (do not attempt cardiopulmonary resuscitation) forms.

Our inspection team

Our inspection team was led by:

Chair: Paula Head, Chief Executive, Sussex Community NHS Trust.

Team Leader: Amanda Stanford, Care Quality Commission.

The team included CQC inspectors and a variety of specialists: Specialist Dental Adviser, Community Paediatrician, Palliative Care Consultant, General Practitioner, Community Matron, Intermediate Care Nurse, District Nurses, Health Visitors, Physiotherapists and Experts by Experience (people who had used a service or the carer of someone using a service).

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme.

Summary of findings

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by the trust and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit from 7 to 10 April 2015. We also carried out an unannounced visit on 29 April 2015.

What people who use the provider say

People who use the service were generally very positive in their feedback. We spoke with 5 patients who told us that the care they had received was good and that staff were responsive to their needs. We received 4 feedback cards that were mostly positive although there were two comments about patients not always having the help they needed in a timely way. One patient commented that the service they had received had been excellent and they had been treated with respect and dignity and that staff had shown high levels of empathy and caring.

Patient's relatives were asked for their feedback on the service. Action taken as a result of this survey was to make more snacks available to relatives who were staying with patients who were at the end of life. We saw the use of a patient survey in the day care unit at Pembridge in December 2014. The survey included questions such as whether the hospice helped patients to cope with their illness and quality of life issues. We also saw a patient survey report relating to the massage service at Pembridge Palliative Care Unit.

Areas for improvement

Action the provider **MUST** or **SHOULD** take to improve

Action the provider **MUST** take to improve

- The patient record system must be reviewed to ensure that all staff are able to participate in recording patient assessments and care plans in a way that meets safety requirements.
- Risk assessments must be completed on all patients in line with trust policy.
- The trust must develop a timely implementation plan for the development of an end of life care plan/guidance to ensure consistency of care.
- The use of pain assessments must be continued to be reviewed to ensure these are being used effectively to assess and manage patients' pain.
- Guidance regarding nutrition and hydration for patients at the end of life must be available to staff caring for them.

- The trust's resuscitation policy must be updated for staff in line with national guidance regarding mental capacity and DNACPR decisions.
- There should be clear, consistent and coordinated leadership between the trust and the specialist palliative care service in terms of responsibilities regarding implementation of initiatives and reviews of areas such as the review of clinical guidelines, implementation of patient outcome measures and a replacement guide for the LCP.

Action the provider **SHOULD** take to improve

- Guidelines for effective prescribing should be reviewed and updated with clarity on what guidance is to be used.

Summary of findings

- There should be clear, consistent and coordinated leadership between the trust and the specialist palliative care service in terms of responsibilities for the development of end of life care services across the trust as a whole.

Central London Community Healthcare NHS Trust

Community end of life care

Detailed findings from this inspection

The five questions we ask about core services and what we found

Requires improvement



Are services safe?

By safe, we mean that people are protected from abuse

Summary

On the in-patient unit staffing had been problematic due to recruitment problems. The inpatient service was generally covered in terms of nursing numbers but the skill mix was affected as agency staff did not generally have specialist palliative care experience. A recent change from a paper based record system to an electronic record system had been problematic for nursing staff on the inpatient unit at Pembroge. This was largely due to the high volume of agency and bank staff who were unfamiliar with the system and staff also told us the system was sometimes slow. The impact of this had resulted in risk assessments being unrecorded, incomplete or not completed in a timely way for patients who were identified as being at risk.

Staff were aware of their reporting responsibilities and there was evidence of learning from incidents. Medicines were provided in line with national guidance and we saw good practice in prescribing anticipatory medicines for patient's at the end of life. Do Not Attempt Cardio

Pulmonary Resuscitation (DNACPR) forms were completed consistently and we saw that equipment was available for patients at the end of life and appropriate safety checks were in place.

Detailed findings

Safety performance

- A range of safety information was being recorded and used to monitor safety performance at the Pembroge Palliative Care Unit (PPCU). We viewed data on display on the unit relating to falls, pressure ulcers, infection control and medication errors.
- We viewed historical data relating to falls on the unit and saw that in response to an increase in falls in 2014; a deep dive investigation had been carried out to identify the root cause.
- Action taken as a result of the deep dive report into falls included the use of falls assessments on admission and after a fall, a previous e-learning falls training package being delivered face to face and staff break times being changed to ensure adequate staffing numbers on the unit to minimise the risk of falls.

Are services safe?

Incident reporting, learning and improvement

- Staff were aware of their responsibilities in reporting incidents.
- Staff we spoke with told us that when an incident occurred it would be recorded on an electronic system for reporting incidents.
- We viewed incidents that had been recorded within the system that related to end of life care in the community and those that had been recorded for Pembridge. Examples we viewed included the development of pressure ulcers in the community, medication incidents and falls.
- There were no never events for end of life care in the twelve months prior to our inspection. Two serious incidents had been reported relating to Pembridge, one was relating to a patient and another related to a pressure ulcer.
- Incidents were investigated with the involvement of relevant staff and we saw that they were given time to reflect and learn.
- Examples of learning and action included the discussion of a medication 'near miss' being held at a staff meeting to identify key learning points and share information. Other examples included training for care home staff on the prevention and management of pressure ulcers.
- Staff were aware of their responsibilities in relation to duty of candour and being open with patients when incidents occur.

Safeguarding

- We viewed information at Pembridge informing staff of the process to follow should they have concerns about actual or suspected abuse.
- Staff were aware of their responsibilities in relation to raising safeguarding concerns.
- Staff working within the Pembridge Palliative Care Unit had attended safeguarding training relevant to their roles. This included Safeguarding adults at level one and safeguarding children at level one or two. The trust monitored compliance regarding training attendance and for safeguarding this was 86% (safeguarding children level 2), 100% (safeguarding children level 1) and 90% (safeguarding adults level 1).

Medicines

- We found that medicines were stored securely and appropriate emergency medicines were available. Controlled drugs were stored, recorded and audited appropriately. No medicines were kept in the day centre.
- A pharmacist was based in the Pembridge Palliative Care Unit and was part of the multidisciplinary team looking after patients. The pharmacist completed a full medication history on admission and attended multidisciplinary meetings and ward rounds to support medicines optimisation.
- Records of pharmacist interventions were kept and medicines related incidents, including unsafe transfers to the centre, were recorded on datix and reviewed. We heard from nurses that the learning from incidents was discussed and action taken to reduce risks. An example of this was the new prescription and administration record for use in the community. We saw that this was completed for patients discharged home with community nurse support reducing the risk of errors occurring when transcribing the patient's medicine record in the community.
- The pharmacist, as an independent prescriber, supported the discharge process and ensured that appropriate medicines were available for patients when they were required in a form that was appropriate to their needs.
- Prescriptions and administration records we looked at were completed clearly; including the times of administration of medicines prescribed 'as required' and checks to ensure the safe use of syringe drivers.

Environment and equipment

- Inpatient specialist palliative care services were delivered at the Pembridge Palliative Care Unit. Patients were cared for in individual rooms.
- Pressure-relieving equipment was available on site at the Pembridge Centre and staff told us they could access additional equipment if needed.
- We checked a sample of equipment and noted that all pieces of equipment were labelled as to when it had been subject to a safety check. All equipment had been safety checked in recent months prior to our visit.
- In the community, equipment was routinely delivered within 5 working days; however staff told us there were processes in place to ensure equipment for end of life care such as specialist mattresses could be delivered in 4 hours, including at weekends.

Are services safe?

- Syringe drivers were available on the in-patient unit and in the community. Community staff told us that each community team was allocated one syringe driver and that additional drivers could be borrowed from rapid response or neighbouring teams. Community nursing staff we spoke with told us they had never had a problem borrowing a driver when needed and that they had not experienced delays in setting up syringe drivers in the community.
- Specialist palliative care staff delivered syringe driver training at the Pembridge Palliative Care Unit. Nursing staff we spoke with confirmed they had attended syringe driver training in the previous 2 years.

Quality of records

- The specialist palliative care CNS team were using a palliative care electronic record system. The system had been in operation for a year at the time of our visit. Staff told us the system had been adapted to meet their needs and was working well. CNS' had been given tablet computers to be able to access the system while out in the community although they told us this wasn't yet in operation at the time of our visit. In the meantime, staff would record notes and update the system once they returned to the office.
- On the inpatient unit the care electronic record system had been in use for a few weeks. Staff told us there had been a week long transition where paper based records and electronic records were used concurrently, however the paper based records had been minimised at the time of our visit.
- Nursing staff we spoke with on the inpatient unit told us the electronic system was often slow to load and that because the unit was reliant on agency and temporary staff due to recruitment difficulties there was an added pressure on permanent staff to check entries made by agency staff into the system to ensure records were accurately maintained.
- On occasions this resulted in care plans not being updated in a timely manner. Staff we spoke with confirmed that the hard copy patient handover information was updated regularly but there was a delay at times to update the electronic care plans with this information.
- The system incorporated windows that had been specifically designed for caring for patients at the end of

- life and included the assessment of disease history, symptoms, risks, psychological and spiritual needs, social and financial needs and a review of the patient's activities of daily living.
- We reviewed 11 DNACPR (do not attempt cardiopulmonary resuscitation) forms across four inpatient services during our inspection. All forms were kept in the front of patient notes, 9 had clearly documented decisions with reasoning and clinical information and 8 out of 10 had been signed by a GP or consultant. The majority had clearly recorded discussions with patients or relatives.

Cleanliness, infection control and hygiene

- All areas we visited appeared to be clean. We saw information about hand hygiene displayed in the in-patient unit. We viewed the results of hand hygiene and cleanliness audits and saw that scores ranged from 93 – 100% compliance. From October 2014 hand hygiene compliance had been at 100%.
- We viewed decontamination of equipment records and saw that this included instructions for each piece of equipment used. There was a system in place where each item of equipment had a green strip applied once it had been cleaned to ensure all staff knew that equipment they were using was clean.
- There were daily, weekly and monthly cleaning schedules in operation and we saw that these were all up to date at the time of our inspection.
- Staff had access to personal protective equipment (PPE), such as gloves and aprons. Staff were seen to be using PPE, washing hands and using hand sanitising gel.

Mandatory training

- We viewed mandatory training records for the Pembridge Palliative Care Unit that incorporated training records for both inpatient staff and community specialist palliative care staff.
- Mandatory training included health and safety, fire safety, moving and handling, infection prevention and control, information governance, safeguarding and the mental capacity act.
- Records confirmed that 97% of Pembridge staff had attended health and safety, fire safety and moving and handling training; 95% of Pembridge staff had attended equality, diversity and human rights training; and, that 97% of staff had attended mental capacity act training.

Are services safe?

Assessing and responding to patient risk

- We saw that an action report following a deep dive route cause analysis into patient falls stated that all patients should have a moving and handling/falls risk assessment carried out on admission and a falls risk assessment repeated after a patient has fallen.
- Two out of seven patients had not had a safe handling assessment completed; a third patient's safe handling assessment had been completed 2 days following admission.
- Three out of seven patients had not had a pressure area risk assessment carried out. This included a patient who had a care plan in place for an existing pressure ulcer but had not been assessed for the risk of additional pressure damage on admission.
- One patient did not have a review of safe handling or a falls risk assessment carried out following a fall.
- Staff we spoke with told us that completing risk assessments in a timely way was difficult due to the use of bank and agency staff and the implementation of the new electronic patient record system that they needed instruction on how to use. As a result, permanent staff had to find additional time to check the records and ensure they were up to date.

Staffing levels and caseload

- On the in-patient unit staffing had been problematic due to recruitment problems. We viewed data that showed 51% of registered nursing shifts had been covered by agency or bank nurses for the 4 week period between the 16 March and the 12 April.
- Managers told us they had held a recent recruitment open day and had plans to hold these monthly in an

- effort to attract new staff to the unit. They also told us they tried to ensure continuity of cover as much as possible by requesting agency nurses for block periods of time.
- Nursing staff we spoke with told us that the inpatient service was generally covered in terms of nursing numbers (103%) but that the skill mix was affected as agency staff did not generally have specialist palliative care experience.
 - Staff told us that managers would cover clinically if they were unable to get bank or agency cover and we observed this in action during our inspection.
 - The Specialist palliative care CNS team work across 4 London boroughs (Kensington & Chelsea, Brent, Westminster, and Hammersmith & Fulham). There was an acting Community Team Leader in post and one full time and one part time CNS vacancy. The acting Community Team Leader told us they had experienced difficulties recruiting and that they were participating in recruitment open days along with the inpatient unit.
 - Staff we spoke with in the specialist palliative care community team told us they were able to manage their caseloads although staffing was difficult particularly during holidays. We saw that the management of the service had brought in a bank CNS to undertake an office based triaging role to support the team.

Managing anticipated risks

- Major incident and winter management plans were in place. Senior staff had access to action plans and we saw that these included managers working clinically as appropriate, staff covering from different areas and prioritisation of patient need.
- Emergency equipment was available on the Pembridge unit, including a defibrillator. Staff had been trained in resuscitation.

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

There was good multi-disciplinary working across inpatient and community teams. We saw that permanent nursing staff working on the inpatient unit at Pembridge were competent and experienced in delivering end of life care, however there was limited guidance for bank and agency nurses working on the unit. While managers ensured there was always a minimum of one experienced nurse on shift, the high volume of bank/agency staff in use meant that one member of staff was responsible for monitoring and checking the work of others. The Liverpool Care Pathway had been withdrawn in 2014 but a replacement care plan had yet to be developed. While some steps had been taken to adapt the electronic record system to the needs of patients this was not always accessible to bank/agency staff who were therefore reliant on the permanent staff member on shift to guide them in terms of specific end of life care assessments and care planning.

Clinical outcomes relating to specialist palliative/end of life care on the Pembridge inpatient unit were not being measured. We saw that pain assessments were not always completed although an audit of this had highlighted areas of learning and we saw a plan in place to develop this. A resuscitation policy was not based on current national guidance, although staff we spoke with had an understanding of current practice and national guidance.

Detailed findings

Evidence based care and treatment

- We viewed folders in clinical areas that included summaries of national guidance such as the Francis report, GMC (General Medical Council) guidance on treatment and care at the end of life and NICE (National Institute for Clinical Excellence) guidance.
- Local guidelines had been written by the Pembridge Palliative Care Unit's Senior Pharmacist in collaboration with clinical staff to support effective prescribing at the end of life. This guidance had not been reviewed since 2010. Staff told us the Pembridge Palliative Care Unit had also signed up to the London Cancer Alliance Palliative Adult Network Guidance (PANG). At the time of

our inspection it appeared that both guidelines were in use. We were told that a working party had been set up to review the guidelines although we did not see evidence of progress on this.

- We saw evidence of guidance being used in the records of a patient whose pain medication had been increased in line with NICE Clinical Guidance 140; Opioids in Palliative Care (2012).
- We saw that palliative care CNS' participated in Gold Standard Framework (GSF) meetings with GP practices in their localities. GSF meetings are multidisciplinary meetings that focus on the needs of patients at the end of life and aims to improve coordination and quality of care.
- Staff told us that the Liverpool Care Pathway (LCP) had not been in use since January 2014, prior to a national phase out by July 2014.
- We did not see a replacement for the LCP in operation. Staff told us the electronic Palliative Care system had been adapted as an interim measure so that windows were in use to meet the needs of patients at the end of life. These included windows on the system for preferred place of care, advance care planning, communication and involvement of relatives.
- The electronic Palliative Care system was due to be reviewed and audited after 3 months' use.
- Staff we spoke with told us they were reviewing the individualised plan for care at the end of life from another trust with a view to adapting it for their needs. We were told this would likely take a further 6 – 9 months to fully implement onto the IT system.

Pain relief

- Where appropriate patients had syringe drivers which delivered measured doses of drugs at pre-set times, all qualified nursing staff were trained in the use of syringe drivers. We saw that some patients were discharged from Pembridge with syringe drivers in place and for others medicines were prescribed on a 'just in case' basis to ensure their pain could be managed effectively.
- Pain assessment charts were available and we viewed an example of a care plan for pain control in place. The pain assessment tool included a body map and a 0 – 10

Are services effective?

score for patients and staff to rate the level of pain experienced. We did not view alternative pain assessment tools in use, for example, those available for patients who are unable to rate or verbalise their pain.

- We saw two patients who had been experiencing pain on the inpatient unit and saw that one had a completed pain care plan and pain assessment chart. We also saw a second patient where their pain assessment chart had not been completed each time they experienced pain. This meant that records of pain assessments were inconsistent, although we did not see patients in pain at the time of our inspection.
- We viewed the results of an audit of pain assessment charts that had been carried out by one of the doctor's on the Pembridge unit. During a three month audit period, pain assessment charts were used only 29% of the time and were inconsistently completed. We viewed plans, as a result of this audit, for a teaching session on the use of pain assessment tools.
- We visited a patient in the community who had been experiencing pain and we observed the specialist palliative care CNS assessing the patient's pain and titrating the dose of pain medication to better manage their pain. We also observed nursing staff advising patients and family members about pain control when patients were being cared for at home.

Nutrition and hydration

- We viewed a prevention and management of pressure ulcers policy (valid from June 2014 to June 2016) that stated that all patients should be screened for malnutrition using a MUST (malnutrition universal screening tool).
- We did not see a Malnutrition Universal Screening Tool (MUST) in use at the time of our inspection. Staff we spoke with told us these were not routinely used unless requested by the dietician.
- Nutrition and hydration needs were assessed in line with activities of daily living assessments as part of the Crosscare electronic system that was in the first three months of implementation. This did not include a specific assessment of nutrition and hydration needs at the end of life.

- We did not see specific guidance on nutrition and hydration at the end of life, however we observed staff referring patients to the dietician and speech and language therapist for assessment of their nutrition and swallowing needs.
- We observed a CNS in the community communicating with a patient and their relatives about the focus being on comfort at the end of life in relation to nutrition and hydration, where the patient should be able to decide whether and what they eat or drink.
- We viewed a folder that was kept on the Pembridge unit where staff would record patient's preferences in terms of their nutritional intake. We were told that this information would help guide the catering staff in ensuring that patient's had the food they wanted.

Patient outcomes

- We did not see measures of patient outcomes specific to specialist palliative or end of life care. Staff we spoke with told us that the community specialist palliative care team had previously used the SKIPP (St Christopher's Index of Patient Priorities) as a measure to assess the impact of care delivered. At the time of our inspection we did not see information in terms of patient outcomes specific to end of life care.
- Managers told us clinical outcomes on the Pembridge inpatient unit were not being measured, however they had plans to implement the Integrated Palliative Care Outcome Scale (IPOS) in December 2014. This had not been implemented at the time of our inspection and staff told us this was now planned for July 2015.
- We were told that the trust had not been asked to participate in the national bereavement survey.
- The leads for end of life care told us they recognised there was a gap in the use of audits and the monitoring of patient outcomes and that this was an area they were intending to address in line with the implementation of the end of life care strategy.
- We saw that preferred place of care was recorded onto the Crosscare IT system but did not see an audit or evaluation of this.
- Preferred place of death information for 2014/15 confirmed that preferred place of death was recorded in 98% of records and 96% of patients cared for by this trust had their preferred place of death. This equated to 311 out of 413 patients having their preferred place of death.

Are services effective?

Competent staff

- Records showed that 90% of permanent nursing staff working on the Pembridge unit had attended a palliative care module.
- The Pembridge unit was staffed with a high number of bank and agency nurses. The managers of the unit endeavoured to ensure agency staff were block booked to allow for better continuity of care, however these staff did not generally have specialist palliative care experience. Staff told us there were generally 2 or 3 agency staff on each shift but that they ensured there was always one permanent experienced nurse on shift to lead. Our review of staffing rotas confirmed that there was a minimum of one permanent experienced nurse on each shift.
- The Pembridge unit delivered regular Introduction to Palliative Care courses, end of life care study days and syringe driver training for staff across the trust. Staff running these study days informed us that there had been some issues with attendance of these study days and we reviewed records that showed the most recent HCA course had been cancelled. This was due to lack of uptake by CLCH Staff. The most recent course for trained nurses in March was run as planned.
- Specialist staff within the Pembridge unit participated in the delivery of end of life care courses.
- An end of life care strategy, developed in March 2015 included guidance for training requirements for staff involved in delivering end of life care. This was based on the National end of life care strategy (Department of Health, 2008).

Multi-disciplinary working and coordinated care pathways

- There was a good approach to multidisciplinary working in end of life care.
- Specialist palliative care nurses participated in Gold Standards Framework meetings with GP practices.
- On the Pembridge inpatient unit referral meetings and handovers involved members of the multidisciplinary team including nursing, medical, pharmacy, social work, allied healthcare and spiritual support staff.
- Each patient requiring end of life care had involvement of the multi-disciplinary team in their care and care was discussed on a daily basis either on the inpatient unit or as part of the specialist palliative care referral meeting.

- We viewed a palliative care CNS pathway that covered the patient journey including referral, assessment, follow up, and liaison with district nurses and GPs.

Referral, transfer, discharge and transition

- Patients were referred and transferred appropriately. Multidisciplinary processes were in place to manage the process of referral, transfer, discharge and transition.
- We observed referral and multidisciplinary meetings and reviewed referral documentation on both the Pembridge inpatient unit and within the specialist community service. We saw that information was sought and shared and that appropriate people were involved to ensure the interests of the patients were considered.
- We saw documentation that was shared with district nurses and GPs and we observed good standards of communication in relation to transfer and discharge.
- Staff told us that equipment and care packages were put in place in a timely fashion although this could vary depending on the region in which the patient lived. Community nurses told us they were able to access equipment within 24 hours for patients going home and in some cases, where discharge was being fast tracked equipment could be accessed within 4 hours.
- Fast track discharge provision was in place. We saw that staff on the inpatient unit and the community team recorded patients' preferred place of care as part of their assessment processes. Staff we spoke with told us that same day discharge was possible but that some regions were more complex than others.

Access to information

- Staff, both permanent and agency had access to relevant patient information.
- We saw that risk assessments and care plans were generally in place for patients at the end of life although in some cases these were not always completed in a timely way.
- The Crosscare palliative care electronic system provided a template for recording patient information. Medical, nursing and allied healthcare information was stored on the system with some paper based documents in use.
- The system prompted staff to carry out 4 hourly reviews, conduct end of life care discussions with the patient and family members, and ensure end of life care medicines

Are services effective?

were prescribed. In addition, staff do 1 hourly documented check rounds of end of life patients (including overnight). Also, at night all end of life patients are checked every 30 minutes.

- We viewed records that included detailed information about the management of symptoms, discussions and interventions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Training around the Mental Capacity Act (MCA) was mandatory for staff involved in patient care. On the Pembridge unit 89% of staff had attended MCA training and we saw a record of the most recent MCA training being held on the unit in the weeks prior to our visit.
- Staff we spoke with told us they had recently attended MCA training and they demonstrated an understanding of best interest decision making when patients have been identified as lacking capacity.

- We saw one patient on the inpatient unit who had been identified as lacking mental capacity in the community prior to admission. We saw that the patient's family were involved in discussions about their treatment and care.
- We saw that a trust wide resuscitation policy (valid from April 2014 – March 2016) that was kept at Pembridge stated that "there is no ethical obligation to discuss resuscitation with palliative/end of life care patients," and, "When a decision not to attempt CPR is made on these clear clinical grounds, it is not appropriate to ask the patients' wishes about CPR, but careful consideration should be given as to whether to inform the patient of the DNAR decision." This was not in line with joint guidance published by BMA, RCN and resuscitation council in October 2014 which states that there should be a presumption in favour of patient involvement and that there need to be convincing reason not to involve the patient (Decisions relating to cardiopulmonary resuscitation, October 2014).
- Staff we spoke with about discussing DNACPR decisions with patient's told us they would generally do so.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

End of life care services were seen to be caring and we were given a good deal of positive feedback from relatives and friends of patients who had been cared for at Pembridge. Patients and relatives told us they were happy with the quality of care they received and that staff were kind, caring and compassionate in their approach. A bereavement service was offered on site, with counselling and spiritual support staff available to support patients and relatives.

Emotional and spiritual support was considered to be a priority within the trust and we saw this through the development of the compassion in care project and initiatives. We saw that patients were treated with dignity and respect both at the Pembridge unit and when visited by staff at home and that relatives were able to access support from staff as they needed it. We saw evidence of support for relatives in the form of a monthly carers café held at Pembridge for carers and facilities within the unit allowed for flexible visiting and space for families of patient's in the last days of life to stay on the unit.

Detailed findings

Compassionate care

- During our inspection we saw that patients were treated with compassion, dignity and respect.
- We observed staff caring for patients in a way that respected their individual choices and beliefs.
- We saw that the trust's end of life care strategy included the delivery of high quality, relationship centred compassionate care.
- Patients and relatives we spoke with told us they were generally happy with the quality of care they received. One patient told us specialist palliative care nurses visiting them at home were always courteous, kind and caring in their approach.
- We observed nursing staff seeking permission to enter a patient's home and witnessed them introducing themselves to the patient and their carers. The nurse listened to concerns and addressed the issues raised in a professional, caring and compassionate manner.
- We observed staff on the ward interacting with patients and relatives in a kind, caring and compassionate way, being mindful of and respecting individuals' dignity.

- A patient attending the day care service told us staff had supported them to feel more confident and that this had helped them to enjoy life despite their physical limitations.
- Information leaflets were available for relatives and friends on what to do when someone dies and dealing with loss. Information included practical advice and information around follow up support that was available through the Pembridge Palliative Care Unit and from other agencies.
- We saw that care after death honoured people's spiritual and cultural wishes. Faith leaders from multiple faiths were accessible and a spiritual advisor was available to patients, relatives and staff. There was a focus on the support available not being just religious support, but emotional and spiritual too.
- The trust had developed a Compassion in Care Project. The project incorporated the 6 c's of care, compassion, competence, communication, courage and commitment. The project focused on how compassion could be put into practice. Examples we saw in practice included bereavement support and a day care course that focused on keeping patients well at home by using techniques such as mindfulness, massage and relaxation.

Understanding and involvement of patients and those close to them

- Patients and family members we spoke with told us they felt involved the care delivered.
- We saw that staff discussed care issues with patients and relatives where possible and these were generally clearly documented in patient's notes. One specific example on the inpatient unit we saw of patient's choices and preferences being recorded was in relation to their food choices, preferences and requirements being recorded on a specific form and updated daily.
- We observed patients and relatives in the community being involved in their care at planning, delivery and review stages.
- We observed an open discussion with medical staff and a patient's family about symptom control and future expectations.

Are services caring?

- Guidance literature was available for patients and their relatives. This included leaflets about loss and bereavement and information about services available.
- Patients were able to participate in Coordinate My Care (CMC), a service which helps to record the patient's views and wishes about their care within an electronic personalised care plan. The care plan is then available to all professionals involved in the patient's care and can be updated and amended.
- The trust had not participated in the National Survey of Bereaved People. The survey works to collect information from relatives and friends about the quality of care provided at the end of life. The research looks at areas such as respect and dignity, pain relief and whether the person died in their preferred place of care.
- A carer's board was visible on the Pembridge inpatient unit. This included information about a monthly carers group, resources available and a directory of support agencies available.
- We viewed information on action taken as a result of an inpatient satisfaction survey. What was this survey, dates and findings. This included work to improve Wi-Fi access and the availability of snacks on the unit.
- We saw the use of a patient survey in the day care unit at Pembridge in December 2014. The survey included questions such as whether the hospice helped patients to cope with their illness and quality of life issues. We also saw a patient survey report relating to the massage service at Pembridge. Feedback from patients about the day service and massage service were positive.

Emotional support

- Staff told us that visiting times were flexible and we observed a family room available for relatives to stay and support patients who were at the end of life.
- The Pembridge unit social work team provided a counselling and bereavement support service. Staff members had additional counselling qualifications and they provided the service on the inpatient unit, through outpatient appointments and home visits.
- Members of the specialist palliative care team told us they participated in the delivery of specialist palliative care training for general staff and that this included elements of communication skills training to support patients and their family members at the end of life.
- Where possible, patients at the end of life were given the option to move to a side room to ensure their privacy and dignity and time with relatives.
- Two senior members of the Pembridge palliative care team had attended training in the use of Schwartz rounds. Schwartz rounds are meetings which provide an opportunity for staff from all disciplines to reflect on the emotional aspects of their work. This project is due to be implemented by August 2015 and managers are aiming for it to support the continued development of compassionate care.

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

All patients requiring end of life care had access to the specialist palliative care team. We saw that referrals to the community specialist team totalled 205 for the 3 month period from January to March 2015. Bed occupancy at Pembroke averaged 88% in 2014/15 and we saw that referrals were generally responded to in a timely way. Specialist palliative care referrals were mostly for support with pain and symptom management, with additional support provided for patients and family members for people with complex end of life care needs. The community specialist team offered a 7 day service and while this was generally a telephone advisory service at weekends, nursing staff were able to visit patients at home if needed.

Services were planned and delivered to meet people's individual needs. We saw that the trust had considered the needs of different groups of individuals within the local demographic, in particular we saw that the end of life care strategy included the development of end of life care support services for prisoners and people with a learning disability. Staff, patients and relatives told us that end of life care services were responsive and we saw evidence of this during our inspection. Out of hours advice was available through a regional on call service, ensuring that staff had access to specialist input when needed.

Detailed findings

Planning and delivering services which meet people's needs

- Services were planned and delivered to meet patients and relatives needs. Staff were able to demonstrate how they were focused on the needs of individuals within the local community and ensuring that care was delivered as close to home, family and friends as possible.
- Preferred place of care at the end of life was recorded on the Crosscare electronic system by the community specialist palliative care team and nurses on the inpatient unit. This meant that patients referred to the service would be asked about their preferred place of care as part of a routine admission assessment.
- Patient stories were used to gain an understanding of the healthcare experience of individuals in order to

provide focus and improve the quality of services. We read two patient stories relating to patients being cared for at Pembroke and staff told us these were useful in helping them identify what they do well and where they can improve services.

- For the three months from January – March 2015 the SPCT had 205 new patient referrals. 80% of referrals were for patients with cancer, 20% for patients with non-malignant disease. Face to face and indirect contacts with patients averaged 976 each month.
- The trust has developed its own end of life care strategy, identifying key priorities relating to meeting the needs of people in the region. One key aspect of this is the increasing need for end of life care in the community, with year on year increases in patients at the end of life wishing to be cared for at home.
- We saw that 6 key elements of the end of life care pathway had been identified as part of the strategy. These included discussions as end of life approaches; assessment, care planning and review; coordination of care for individual patients; delivery of high quality services in different settings; care in the last days of life; and, care after death.
- The strategy also incorporated good quality end of life care for patients in prisons, those with a learning disability and children with life-limiting or life-threatening conditions.

Equality and diversity

- We saw that all patients receiving end of life and palliative care were treated as individuals.
- Training records showed that 95% of staff working at the Pembroke Palliative Care Unit had attended equality, diversity and human rights training as part of their mandatory training programme.
- Multi-faith information was available on the Pembroke palliative care unit. In particular we saw a list of multi-faith holidays and celebrations for the coming weeks and months detailed on a notice board on the unit.
- Spiritual support services were available for people of different and no faith backgrounds.

Meeting the needs of people in vulnerable circumstances

Are services responsive to people's needs?

- The trust's end of life care strategy had been developed with national guidance around the care for people with learning disabilities. Guidance included 'The Route to Success in End of Life Care – Achieving quality for people with learning disabilities'; NHS Improving Quality (2015) and guidance from Mencap. This had been in place since March 2015.
- Specific issues and challenges relating to end of life care for patients with a learning disability included access to healthcare, increasing quality, flexibility, advanced care planning, working with carers, autonomy and choice.
- Staff we spoke with told us they could access interpreters where needed.
- We were informed at our unannounced visit to the inpatient unit that two patients had not been admitted to the unit that day due to staffing issues. There was no information available regarding how often this happened.
- We observed an example of a patient with complex symptom control issues in the community being discussed at a Community referral meeting and saw that while there was a discussion about capacity to be seen in the community in a timely way, the patient was seen later that morning.
- Specialist palliative care nurses were available 7 days a week at the Pembridge unit, providing mostly telephone advice at the weekend but also available for urgent referrals and visits should the need arise.
- The medical on call rota for Palliative Care Consultants is shared between Pembridge and a local hospice. The Pembridge first on call medical rota is made up of Pembridge specialty doctors. The on call rota ensures 24 hour medical specialist palliative care is available.

Access to the right care at the right time

- The SPCT responded to referrals from GP's, community staff, hospitals and consultants for patients who had complex support or symptom management needs at the end of their lives. The SPCT aimed to respond within 24 – 48 hours of receiving the referral.
- Data showed that 82% of patients were seen within 48 hours, with 80% seen within 24 hours. 18% of patients referred were seen outside of the 48 hour period. Staff we spoke with told us this was largely due to the referral being received over a weekend and it being non-urgent. Staff told us that all urgent referrals would be processed on the day they were received.
- Referrals to the SPCT would be discussed at a referral meeting each morning and they would be prioritised based on patient need.
- Referrals to the inpatient unit would be discussed at a daily referral meeting. We observed a referral meeting in action and saw that referrals were discussed by the multi-disciplinary team including staff from medical, nursing, social work, management and other support disciplines.

Learning from complaints and concerns

- Complaints and concerns were listened to and learning was used to improve services. For example, in response to family concerns about communication, the Compassion in Care Lead worked with the team to improve communication between staff and the patient/family.
- Four complaints relating to end of life care had been received in the 12 months prior to our visit and we saw that in all cases the complaint was investigated and action taken to address the issues raised when required.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We saw evidence of innovations and initiatives in end of life care but we also saw that key activities had been delayed in terms of implementation. This included the review of clinical guidelines, implementation of patient outcome measures and a replacement guide for the LCP. For example, the LCP had been withdrawn from the Pembroke unit in January 2014 but 15 months on, we did not see progress in terms of a replacement and we were told a replacement document was a further 6 – 9 months away from completion. There appeared to be a lack of clarity in terms of responsibilities for the development of end of life care services between the Pembroke Palliative Care Unit and the trust as a whole and staff told us there had been some difficulties with integrating what was seen as a relatively independent unit with the wider trust as a whole. Clinical outcomes relating to specialist palliative/end of life care on the Pembroke inpatient unit were not being measured.

The trust had developed a vision and strategy for end of life care, which was only completed in March 2015, that incorporated 6 key elements around end of life care that included the delivery of end of life care in different settings. We saw that the trust was working on a strategy implementation plan and work streams that involved key staff, including some members of the specialist palliative care team. We were told that these work streams had only just been implemented and not all staff invited to participate had attended a meeting at the time of our inspection, we were also told that while specialist staff were invited to participate in work streams they did not have a lead role in this. End of life care was discussed at board level and we saw evidence of learning from patient experiences.

Detailed findings

Service vision and strategy

- There was a vision and strategy for end of life care that was being rolled out across the trust. The strategy had only been completed in March 2015 and work streams had been developed to encompass 6 key elements that

had been identified. The development of priorities had incorporated national guidance including the national end of life strategy and the Leadership Alliance for Care of Dying People (LACPD) guidance on the needs and wishes of people at the end of life and those closest to them.

- Staff we spoke with told us they felt the trust had begun to prioritise end of life care, with some staff citing the past year as being significant in terms of the progress being made at trust level. Staff at Pembroke told us that key individuals had been asked to participate in work streams, for example the lead SPCT nurse was involved in the advance care planning work stream.

Governance, risk management and quality measurement

- Specialist palliative care reports within the structure of the long term condition directorate.
- The service maintained a risk register. The risk register was reviewed regularly and some staff were aware of the risks in their service area.
- An end of life steering group is led by the Compassion in Care Coordinator and the Deputy Chief Nurse. We viewed minutes of a Clinical Effectiveness Steering Group meeting and saw that the end of life care steering group is a standing agenda item and that the end of life care strategy is discussed at these meetings.
- Clinical outcomes relating to specialist palliative/end of life care on the Pembroke inpatient unit were not being measured.
- The Pembroke inpatient unit had a programme of planned quality audits for 2014/15, these related to general rather than specialist palliative care issues and included audits of out of hours advice, medicines management, hand hygiene, environmental infection control and falls.
- The leads for end of life care told us they recognised there was a gap in the use of audits and the monitoring of patient outcomes and that this was an area they were intending to address in line with the implementation of the end of life care strategy.
- We viewed a deep dive report into falls (April 2014) and saw that action had been taken, including changing

Are services well-led?

staff break times to ensure a consistent staffing level on the unit. We were told that quality audits and reports would go to the relevant steering group, for example the falls steering group or the pressure ulcer steering group. Information from these groups would then be fed through to the relevant scrutiny group, for example the patient safety group, the clinical effectiveness group or the patient experience group.

- The trust did not participate in the national bereavement survey.
- Monthly morbidity and mortality reviews were carried out, including for patients on the Pembridge unit when a trigger tool was used to identify those who required review.
- Learning from patients experience was apparent. We viewed two patient experience reports for patients who had been cared for within the Pembridge Palliative Care Unit. We saw that patient experience was an agenda item at board meetings and that these would be considered in a way that prioritised learning.
- Clinical staff at the Pembridge Palliative Care Unit told us that information sharing meetings were held on a regular basis but that these did not include discussions around clinical governance or strategy development although we saw that strategy and clinical governance relating to end of life care was discussed at relevant steering groups. One member of the senior clinical team told us they felt it was not always clear who had the authority to make decisions.
- Senior medical staff we spoke with told us they were not aware of complaints relating to end of life care and were not involved in a review of complaints or incidents.

Leadership of this service

- Staff we spoke with told us there was good senior level engagement, including the executive board, in improving end of life care.
- We saw evidence of good local leadership in both the inpatient and community settings with end of life care being seen by staff as a priority in terms of quality and meeting patient needs and wishes.
- Staff spoke positively about the leadership of the specialist palliative care service and we saw evidence of specialist palliative care staff providing clinical leadership to community and inpatient staff in relation to end of life care.
- We saw that some areas of end of life care development and implementation were delayed, such as the

development of a replacement care plan for the end of life care pathway and the use of patient outcome measures. For example we did not see progress made in the development of a last days of life care plan since the LCP had been withdrawn in January 2014 and while patient outcome measures had been used in the past and were planned for the future, they were not in use at the time of our inspection. Staff we spoke with did not give us an explanation as to why this was, although we were told consistently that staffing difficulties had impacted on the development the service wanted to make. For example ward based nurses told us they were needed to cover the unit so there was limited opportunity to be involved in the development of the service.

- Staff within Pembridge told us that on the ground the unit was still seen as being independent but that they were working hard to integrate within the wider trust although they felt that this had at times been a difficult transition. We were also told that while senior Pembridge staff including palliative care consultants were feeding into strategy workstreams they were not leading on them.

Culture within this service

- There was a culture of good quality end of life care within the trust. Staff we spoke with were enthusiastic about the care they were able to deliver. We saw that staff were proud of the service they were able to deliver and there was a culture of sharing feedback from family and friends of patients who died.
- There was a commitment to ensuring patients and their families were supported as much as possible at the end of life and we saw that staff worked collaboratively across multi-disciplines to support this.
- Staff told us Pembridge had been relatively independent in the past and that recently there had been a good deal of work done in order to better integrate Pembridge with the trust as a whole and there was a move towards greater consistency in terms of end of life care across the trust.
- One example staff told us of where improvements had been made was in the reporting of staffing difficulties and how they would now datix and report staffing issues as an incident and contact the CLCH on call manager. This meant that trends and issues were being identified and monitored in a more integrated way.

Are services well-led?

- Senior staff at Pembridge received external supervision to support them in their role and we saw that other groups of staff were able to attend group supervision sessions. Staff told us that supervision provided them with an opportunity to reflect on issues relating to care and their daily work, as well as issues around future planning and service development.

Public engagement

- Patient's relatives were asked for their feedback on the service. Action taken as a result of this survey was to make more snacks available to relatives who were staying with patients who were at the end of life.
- We saw the use of a patient survey in the day care unit at Pembridge in December 2014. The survey included questions such as whether the hospice helped patients to cope with their illness and quality of life issues. We also saw a patient survey report relating to the massage service at Pembridge. Feedback from patients about the day service and massage service were positive.
- We saw evidence of feedback from friends and family of patients cared for at the Pembridge Palliative Care Unit and we saw that this was shared with staff.
- A monthly 'carer's café' was held at Pembridge. This was an event for carers, relatives and friends of patients who use the palliative care service to socialise, gain support and attend relaxation sessions.

Staff engagement

- There were bi-monthly operational management meetings held at Pembridge where key members of the management team would meet.

- We viewed minutes of staff meetings where staff were encouraged to attend and were able to raise issues as needed.
- We saw records of annual appraisals having been carried out.
- Staff received support from the spiritual advisor in a responsive way, enabling them to reflect on situations and voice their feelings and point of view.

Innovation, improvement and sustainability

- We saw a number of initiatives that were in the process of development across the trust.
- An end of life care strategy had led to work streams being developed in key areas and we were told an implementation plan was in the process of being developed.
- The trust employed a compassion in care coordinator and had developed a number of compassion in care initiatives across the trust. Specific to end of life care we saw examples such as a member of the housekeeping team who had developed a food and drink preference folder where they kept up to date information about patient's likes and dislikes. Another project included planting sunflower seeds with family members of patients who were at the end of life.
- A staying well at home group had been developed within the day service by the occupational therapist. This involved patients attending the group to gain support in managing breathlessness and fatigue and to attend relaxation sessions.
- We were told that a volunteer coordinator had recently been appointed at Pembridge and that this was going to lead to the appointment of a number of volunteers to support the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <ul style="list-style-type: none">• There should be clear, consistent and coordinated leadership between the trust and the specialist palliative care service in terms of responsibilities regarding implementation of initiatives and reviews of areas such as the review of clinical guidelines, implementation of patient outcome measures and a replacement guide for the LCP.• Ensure that the patient record system must be reviewed to ensure that all staff are able to participate in recording patient assessments and care plans in a way that meets safety requirements.• Risk assessments must be completed on all patients in line with trust policy.• The trust must develop a timely implementation plan for the development of an end of life care plan/ guidance to ensure consistency of care.• The use of pain assessments must be continued to be reviewed to ensure these are being used effectively to assess and manage patients' pain.• Guidance regarding nutrition and hydration for patients at the end of life must be available to staff caring for them.• The trust's resuscitation policy must be updated for staff in line with national guidance regarding mental capacity and DNACPR decisions.