Lancashire Care NHS Foundation Trust

RW5

Community end of life care

Quality Report

Sceptre Point, Sceptre Way, Walton Summit,
Preston, Lancashire. PR5 6AW
Tel:01772 659300
Website: www.lancashirecare.nhs.uk

Date of inspection visit: 27 - 30 April 2015
Date of publication: 29/10/2015

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)
RW5Z3	The Harbour	End of life	

This report describes our judgement of the quality of care provided within this core service by Lancashire Care NHS Foundation 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 Lancashire Care NHS Foundation Trust and these are brought together to inform our overall judgement of Lancashire Care NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We found that Lancashire Care Foundation NHS Trust was providing a high quality service regarding end of life care (EOL). It was delivered by passionate staff who gave patients and their families compassionate care were however there were areas for improvement in the effective domain.

Caseload numbers had continued to increase but shortages were addressed through additional hours by staff and the use of agency staff when required and patient needs were being met. The decreased skill mix of staff had been recognised and changes to work patterns were being discussed. Staff worked with hospices, hospitals, GPs and specialists for advice when needed. The hospice team provided specialist advice and support as requested, coordinated and planned care for patients at end of life in the community. The trust had also not appointed a board member with a specific lead role for end of life care to ensure executive scrutiny.

The trust had developed an EOL framework and an advanced care plan but these were still in draft form and yet to be embedded. The nursing staff were working with primary and secondary health care professionals to adopt nationally recognised best practice tools, including the gold standard framework, preferred place of care, the priorities for care for the dying person and advanced care planning to replace the Liverpool care pathway. It was evident the trust were trying hard to achieve partnership working despite the difficulties of different services being provided under different trusts. However, the timeline of this improvement was slow as this should have been implemented in July 2014.

Staff appraisals were completed however there were inconsistencies in staff supervision. Staff spoke positively about the support they were given by seniors and management within end of life care although staff were not aware of who the trust lead for end of life was.

A review of the data showed there was a shortfall in monitoring systems in place to ensure the trust delivered a good quality EOL service. It was from discussions with patients, relatives, staff and observations that highlighted the commitment and passion staff of all grades had to provide good end of life care. Staff involved patients and their relatives in their care where possible and treated them with kindness, respect, compassion and dignity.

Summary of findings

Background to the service

Lancashire Care NHS Foundation Trust provide 24 hour end of life (EOL) care services for people over the age of 18 years, meeting the individual and often complex nursing needs of patients in a community setting. The service is for people who live in Blackburn with Darwen, Preston, Chorley and South Ribble where district nursing services are provided by Lancashire Care NHS Trust.

End of life care is provided in a variety of organisational settings by a range of health and social care professionals. The range of services includes facilitation of discharge from the acute hospital, rapid response services and centralised co-ordination of care provision in the community.

Teams of community nurses provide EOL care as part of their caseloads and additional support was provided from local hospice services. Inpatient end of life care for patients who lived in or near Longridge was provided on a 15 bedded GP-led ward at Longridge Community Hospital (this is reported in a separate report for community in-patient services). In addition, if patients at The Harbour (a mental health hospital) deteriorated, the hospital had an EOL pathway to follow.

Additional services included: the community matron service which promoted partnership working to improve outcomes for patients to reduce unplanned hospital admissions, reduce length of stay and facilitate seamless transition of care.

The discharge planning team work with multi-disciplinary team members to ensure that patients with on-going nursing needs are discharged from hospital in a safe, planned and timely manner. These team members are specialist practitioners in district nursing.

The care home effective support service offer support to care homes in a variety of different domains. The service offers a proactive and holistic service, which strives to promote the safe and appropriate use of medication, reduce the risk of falls and fractures, ensure appropriate admission to hospital settings whilst preventing unnecessary admission, furthermore they actively support care homes in implementing quality end of life care in the care home setting.

The out of hours community nursing service provides an easily accessible responsive service, which meets the identified nursing needs of individuals and their carers either within their own environment or at the primary care unit. The service includes the professional nursing assessment and advice, management and nursing treatment for patients with palliative care needs and those who are in the terminal phase of their illness, hospital admission avoidance out of hours, assessment and provision of emergency loans and equipment, psychological support and advice and the administration of drugs.

During our inspection we spoke with nine patients and seven patients' relatives, 90 staff including the end of life facilitator/lead for the trust, the deputy director of nursing, community matrons, district nurses and care assistants, allied health professionals from Preston, Chorley and South Ribble and Blackburn with Darwen. We visited St Catherine's Hospice which supported the trust staff with regard to palliative care delivery where we spoke with patients and their relatives who had received district nursing input and specialist community staff.

We observed care and looked at care records. We looked at appropriate policies and procedures as part of our inspection of this service. We reviewed performance information about the trust.

Our inspection team

Our inspection team was led by:

Chair: Peter Molyneux, Chair, South West London and St George's Mental Health NHS Trust

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team Leader: Lorraine Bolam, Care Quality Commission

Summary of findings

The team which inspected this core service comprised a CQC manager, two CQC inspectors, two specialist advisors who are specialist nurses and an Expert by Experience who was a person with personal experience of using or caring for someone who has used the type of service we were inspecting.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

To get to the heart of the experience of people who use services, 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 hold about Lancashire Care NHS Foundation Trust and asked other organisations to share what they knew about the provider.

As part of the inspection we carried out announced visits between 27 and 30 April 2014 and visited The Harbour; The Innovation Centre; St. Catherine's Hospice; Meadowfield Rehabilitation Centre; Geoffrey St Health Centre; Darwen Health Centre; Blackburn and Darwen Rehabilitation Team; Out of Hours Nursing Team ,The Minerva Centre and the Discharge Planning team.

During the visit we held focus groups with a range of staff who worked within the service, such as nurses, health care workers and therapists. During this inspection we visited three patients in their own homes with their permission and we were accompanied by district nurses. We spoke with two patients at St Catherine's Hospice who had received district nursing input from community staff.

We spoke with seven patients, carers or relatives through face to face interviews or phone who had used the service. We spoke with 90 members of staff from a range of disciplines and roles including the end of life facilitator/lead for the trust, the associate clinical director for integrated community teams, the deputy director of nursing, the assistant director of nursing for community nursing services, community matrons, team co-ordinators, service managers, district nurses, student nurses and care assistants, allied health professionals from Preston, Chorley and South Ribble and Blackburn with Darwen.

We looked at nine care records of which we case tracked three. We attended two handover meetings. One of these was with the out of hours community team and the other with the district nurses. We also reviewed management records and minutes of team and locality meetings. We joined a training session with community staff and spoke with staff. We looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider say

Feedback from patients was mostly positive about the quality of care provided in the community, one patient's relative told us it was, 'professionalism at its best', however two people told us of concerns in relation to time keeping, staff being stressed and staff skills lacked in relation to a specific area. Improvements were made after they raised their issues.

Summary of findings

Relatives told us that conversations did occur, involving themselves and their relatives' families and friends, in which they were updated on the patient's progress. Relatives found staff very helpful, caring and compassionate and they would go that 'extra mile' to support them. One patient's relative said, "x was always treated with compassion, good care, dignity and had a laugh and a joke". Staff were competent when managing pain relief and the syringe driver.

Good practice

The trust had an equipment store facility whereby staff had access to equipment patients required. They delivered a seven day service and showed diligence in the provision of appropriate equipment in a timely way.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- Ensure nurse staffing levels, the skill mix and skills of nursing staff are appropriate to meet the needs of patients.

Lancashire Care NHS Foundation Trust

Community end of life care

Detailed findings from this inspection

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

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

The trust had identified risks associated with staffing levels and it was noted that caseloads had increased significantly over the last year.

Certain teams had experienced staff vacancies and sickness, although we found there were sufficient numbers of trained nursing and support staff to care for patients. This was because staff worked additional hours and there was regular use of bank and agency staff. Managers were looking at ways to resolve the situation.

The mandatory training programme did not include any specific EOL or palliative care training but staff had access to training from St Catherine's hospice who were running a 2 year pilot 'transform programme' which was funded by the CCG. Most of the out of hours team had completed a palliative care course three years ago but had received no further updates.

The EOL staff were aware of the process for reporting any identified risks to patients or staff. All incidents, accidents, near misses, complaints and allegations of abuse were logged on the trust-wide electronic incident reporting system. Staff had access to the electronic system and confirmed that reporting of incidents was encouraged by managers and information learnt from this was shared.

Out of nine records we reviewed, we identified shortfalls in five, for example they did not include preferred choice of care, person centred care plans and there was no evidence of patients' involvement. Equipment used was safe and well maintained, and it was readily available for patients to use at home. Five out of six do not attempt cardio pulmonary resuscitation forms were appropriately completed and we saw that the decision had either been discussed with the patient themselves or, when that was not appropriate, with the family. Patients who did not have capacity to consent to end of life care were treated appropriately.

Arrangements for medications were well planned and executed; the prescription of anticipatory medication, the input from specialist nurses and the use of just in case medication boxes in patients' homes, meant that patients did not have to wait for medications they needed to keep them comfortable.

There is currently no joined-up system for information sharing however there were plans to introduce the electronic palliative care co-ordination systems from July 2015.

Safety performance

- There were informal systems in place to check staff were delivering high quality care. Senior staff told us they checked patients and their records. This would be linked with staff supervision.
- There was limited specific data in respect to safety performance in the end of life service, however community staff data was available which was used in the community services for adults report.
- The number of patients at the end of life on the community caseload had increased from 86 patients in 2014 to 146 patients in 2015.

Incident reporting, learning and improvement

- There were no never events (a serious event that is largely preventable) reported which related specifically to end of life care services.
- Staff were aware of the reporting systems for incidents and staff had access to the trust-wide electronic reporting system.
- Learning from incidents was shared with staff at regular team meetings, handovers and reflective practice.
- Staff confirmed they had received training around incident reporting and they found the system 'user friendly'.
- Shared learning bulletins came via the governance team and staff told us about email communications which highlighted incidents.
- District nursing staff told us how feedback from incidents had recently improved and they understood that incidents were investigated and used as a learning tool to improve the service.
- We were made aware of an incident which involved learning around the management of a pressure ulcer which was shared with staff and practice had improved. Another example was where a patient required symptom control by a registered nurse out of hours. Out of hours qualified staff cover had improved as a result.
- Another example involved a community nurse administering insulin to the wrong patient in a care home. Reflection on this incident has changed staff practice and community staff were always escorted by a member of care home staff to the named patient.
- In addition staff told us how reflective practice could lead to improvement relating to continuity of care, where a gap in communication with the out of hours team was highlighted. Learning from this was taken to the clinical commissioning group to improve the outcome for patients.
- The trust had an alert process in place where staff were informed by email of serious incidents.

Duty of Candour

- Staff were aware of the requirements of the Duty of Candour regulation and were open and transparent with patients when things went wrong.

Safeguarding

- Policies and procedures were accessible to staff electronically for safeguarding vulnerable adults and children.
- Staff received mandatory training in safeguarding children and vulnerable adults that included aspects of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards.
- Staff were knowledgeable about their role and responsibilities regarding the safeguarding of vulnerable adults and were aware of the process for reporting safeguarding concerns and allegations of abuse within the trust.
- The training statistics provided by the trust showed in January 2015 that 78% of community health services for adult staff had completed their safeguarding training. The trust target is 85%. Managers had plans in place for those who had not completed this.
- District nurses in the Darwen team explained how they dealt with a number of complex safeguarding issues and received feedback from the safeguarding team after they had raised a safeguarding alert. However other staff told us they did not routinely receive feedback from a safeguarding alert. This meant some staff were unaware of safeguarding incidents that had been reported within the organisation or of any lessons learnt following the review of such incidents.
- Staff confirmed safeguarding was always raised at multi-disciplinary meetings and feedback would be via a coordinator who received information from the local authority. However North team staff advised us they did not receive feedback on any safeguarding referrals from the trust.

- Staff confirmed that the trust had a specialised safeguarding team who provide them with advice as necessary to promote the safety of vulnerable adults.
- Staff described Deprivation of Liberty safeguards and when safeguards needed to be put in place. We saw completed documentation where Mental Capacity Act assessments had been undertaken for EOL patients. Best interest meetings had been held to provide care and treatment when a person lacked mental capacity to make decisions.

Medicines

- There were effective procedures in place for managing medicines for patients receiving end of life care within the community. However, as none of the district nurses were advanced prescribers, this meant any changes to patients' medicines were made with the patient's GP.
- Staff were able to access policies and procedures and staff followed clear guidelines for prescribing medicines for patients receiving end of life care to ensure national guidelines were followed.
- Anticipatory end of life care medication, medication patients may need to make them more comfortable, was prescribed appropriately. We looked at four medication administration record charts where we saw appropriate prescribing. This was good practice as it enabled community nurses to give symptomatic relief without delay for the patient in their own home and easy access to anticipatory drugs can prevent inappropriate readmissions to hospital.
- Anticipatory medicines were stored in secure boxes as required in patients' homes and risk assessments were in place to support this. This meant that patients receiving end of life care could access medications in the out of hours period if they experienced new or worsening symptoms. Systems were in place for the appropriate disposal of drugs; we saw a controlled drug destruction kit so wastage could be dealt with and records made of how much medication was administered and how much was wasted.
- Syringe drivers to administer sub-cutaneous medication were available for patients use and were readily available if a deteriorating patient was in need of this treatment urgently. Staff told us they had received training in the use of these and a group was looking at developing competencies for use of 'McKinley' syringe drivers. We observed a nurse changing a syringe driver who used a correct and clean technique, with a second nurse present in line with trust protocol for controlled drugs. Staff followed clear guidelines for prescribing medicines for patients receiving end of life care to ensure national guidelines were followed.
- Staff were able to gain advice and support re EOL medications from the local hospices as required.
- Red files" had recently been introduction in patients own homes, these included the appropriate records regarding medications and emergency contact details.
- A syringe driver management group consisting of pharmacists, community nurses and medicines management nurses to address related issues provided support to staff.

Environment and equipment

- The trust had an equipment store whereby staff had access to equipment patients required availability and delivery was a seven day service. The out of hours team confirmed that access to+ equipment was good. We were told how nebulisers to assist patients breathing were available at short notice which contributed to preventing hospital admissions for patients. Relatives and carers we spoke with confirmed this service was responsive to their needs.
- Equipment such hoists and syringe drivers were routinely serviced to ensure they were safe to use. The community nurses told us that they could access the patient equipment they needed which could be delivered the same day if requested. Essential equipment, such as syringe drivers and pressure mattresses, were readily available and were replaced promptly if they became faulty.
- We saw appropriate risk assessments were in place for the use of equipment.

Quality of records

- Patients' records were held in their own home including a system of red folders which included patient information regarding medication, contact details and care plans.
- We saw evidence of records which were dated, signed and included risk assessments. This included five out of six do not attempt cardio pulmonary resuscitation which were signed appropriately. Nursing notes were completed in accordance with guidelines. Nursing assessments were fully completed.
- The individual staff members were responsible for the security of patient records.

- The trust used both electronic and paper based patient records. During the inspection we looked at the paper based patient records for nine patients. The records were structured and legible and were kept up to date. However, we saw that five case notes (out of nine) did not include patients' personal preferences choices, core care plans were not person centred and there was no evidence of patients' involvement. Staff listened to our feedback regarding shortfalls in the records and agreed to address the issues discussed.

Cleanliness, infection control and hygiene

- Staff were aware of current infection prevention and control guidelines. Staff adhered to the community trust hand hygiene bare below the elbow and infection prevention policy.
- Staff had access to portable hand gels and personal protective equipment, such as gloves, if needed. We observed staff using hand washing facilities in patients' homes and hand gel.
- Staff wore trust uniforms.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps.

Mandatory training

- All staff employed by the trust completed a core mandatory training programme. Staff were able to show us they were mostly up to date with mandatory training. This training did not include any specific EOL or palliative care training. Community matrons confirmed there were only 'pockets' of EOL training but this was not general across the trust.
- Training was being addressed through bespoke training from St Catherine's and East Lancashire hospices. Through CCG funding, St Catherine's Hospice were providing an education and training programme to provide a 2 year community transform project. Their target was to provide education across the health economy including GP practices, district nurses and the integrated neighbourhood teams (INTs) providing a consistent approach to professionals, patients and carers.
- The topics for the workshops, aimed at health care professionals included advanced care planning, gold standards framework and electronic palliative care co-ordination systems. 24 community staff had attended training at the time of this inspection around advanced care planning, especially around difficult conversations and best practice in completing forms.
- This training did not feed into the trust monitoring. A new starter nurse was positive about the training they had undertaken at the hospice in end of life care.
- The out of hours team told us how most of them had completed a palliative care course however this was approximately 3 years ago and there had been no formal update training since.
- Consistency for induction across teams was being planned. We visited the care home effective support service team whose goal is to prevent readmission to hospital. The local induction records for two staff showed their induction was on-going.

Assessing and responding to patient risk

- On referral to the end of life care services, the community nurses carried out appropriate risk assessments and these were completed correctly. The community nurses also carried out a detailed nursing assessment for each patient that was referred to them.
- Staff providing community care told us they relied on risk assessments and individual nurses' clinical judgement to determine if a patient was at risk due to deteriorating health.

Staffing levels and caseload

- The EOL strategy (Adults) 2014/15-2016/17 Chorley, South Ribble and Greater Preston. Integrated Health and Social care Economy highlighted that NHS Benchmarking outlined that end of life nursing levels should ideally be 2.58 per 100,000 population. Based on the current populations across Chorley, South Ribble and Greater Preston end of life nursing levels should be 9.96 whole time equivalent (WTE). However; staffing levels are currently 7.4 WTE, which highlights an under-resource in this area.
- A number of the teams reported recruitment problems to particular posts. Staff reported they were busy however their caseloads were manageable. Despite being short staffed at times, particularly weekends this did not impact on the provision of EOL care. Community palliative care nurses at the hospice stated they were

aware of staff shortages and some inequity of skills within the community nursing teams. For example, some staff could take bloods and some could not which had an impact on their service.

- Darwen and North Central teams reported frequent use of bank and agency staff however this was on the risk register as an issue re numbers and skill mix of staff. The trust was in a consultation period with staff regarding changes to shift patterns which was thought would alleviate some of the bank and agency usage.
- The national shortage of band 6 nurses was recognised by the trust and affected the teams. The North team told us about the development role for band 5 nurses that had been started. This was to progress staff to follow the clinical specialist palliative care course in the future and was currently working well with eight staff.
- Staff in 'out of hours' team would cover shortfalls in other areas as required. This was having an impact on the continuity of care in the community because the temporary staff were less familiar with the patients.
- Community staff helped each other when demand increased and all teams highlighted their priority patients as EOL patients who were usually first. Staff felt supported by band 6 nurses and specialist nurses.
- Nurse staffing levels were not determined using a management tool. The manager told us planning was historical however they were currently looking at the skill mix of staff and hoped to introduce an acuity tool in the future. Community nursing teams held regular team meetings, however when busy these would be cancelled.
- There had been an increase in the number of patients identified for EOL care. In January-March 2014 there were 86 patients on the district nursing caseload, on an EOL pathway. In Jan-March 2015, 143 patients were on the district nursing caseload on an EOL pathway. This showed on-going improvement in patients identified for an end of life pathway and patients' palliative care nursing needs were being supported by district nursing services in patients' own homes.
- There were inconsistencies in staff members' availability to be able to attend the Gold Standard Framework (GSF) meetings, (GSF is the national training centre which enables frontline staff to provide a gold standard of care for people nearing the end of life). Due to staff pressures these GP led meetings were not regularly attended by the Chorley, South Ribble and Greater Preston district nursing team due to the demand on their service. Within each team, local managers had risk registers in place with the goal of putting plans in place to reduce risks. The shortfall of Band 6 nurses was recorded on the risk register with a staff development plan to develop both the band 5 and band 6 nurses.

Managing anticipated risks

- Staff were able to tell us how they cared for patients in the community during severe or extreme weather conditions. Examples included priority visits or directing patients to local health centres.
- Darwen community team had a local business continuity plan for staff to access. Staff told us of access to the local emergency services and their vehicles as necessary.
- There was no joined up system for information sharing. However from July 2015 the district nurses will have viewing rights through the electronic record system. This electronic palliative care co-ordination System allows all clinicians involved in a patient's end of life care to view and edit patients' records. This will provide a joined up health economy wide approach to record sharing and improve quality of care for patients approaching end of life.
- Lone working procedures were in place. The teams had systems and processes to make sure staff were safe when visiting patients and relatives in the local community.

Major incident awareness and training

- Staff were trained in incident awareness and described actions they would take in the event of a major incident.
- Police would escort staff in severe weather to ensure nurses can reach patients.
- There was a local business plan for community staff; this gave instructions on how to manage key risks potentially affecting patient care and treatment. An example included patients being told to access their nearest health centre if possible, staff would look at priority visits and use emergency services to support them.

Requires improvement

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

The trust no longer used the Liverpool care pathway for the dying patient which was removed nationally in July 2014. The service had been consistently using a ratified interim EOL care plan following the removal of the Liverpool Care Pathway which was in use by the District Nursing teams. As planned, the new advanced care plan was being piloted in one team prior to roll out across the organisation.

The trust had developed an integrated EOL framework and was working towards ensuring care was planned and delivered in line with evidence based guidance across community services, promoting partnership working. A system was in place to audit the community nursing records annually.The service reported each quarter to the CCG, which included a review of the clinical recording for EOL patients.The service has been consistently compliant with this audit.

It was noted that the appropriate skill mix was not always adequate to ensure that patients were safe and received the right level of care. The trust had recognised this and was undertaking a staff development programme to address this. Clinical support was provided by patients GPs, hospice or hospital consultants. Staff could access telephone support from a consultant based at a local hospice or Lancashire Teaching Hospital.

Access to out of hours services for prescription changes was proving difficult in one particular area.

Staff were patient focused and achieved good outcomes for the patients in the communities they cared for however we found no evidence that the trust participated in the National Care of the Dying audit.

Patients we spoke with reported their symptoms were well managed and patients who were too unwell to hold a conversation with us appeared comfortable and hydrated.

Multi-disciplinary care was being provided and links were supportive with good communication between disciplines. Management structures were in place and clearly understood.

The integrated community team leader had identified four areas for action and development including: analysis of data around the need to admit patients to hospital; continue to work around hospice at home development, continue shadowing opportunities and collaborative working with specialist nurse practitioners and contributing to the training skills development programme, led by St Catherine's hospice.

Evidence based care and treatment

- The trusts end of life care framework included themes from the National End of Life care strategy (DOH 2008), the review of the Liverpool care pathway (LCP) the 'One Chance to Get it Right' document 2014 detailing current need, service provision and future plans to provide an integrated EOL framework for all patients.
- Care and treatment followed national guidance which staff had access to. For example, National Institute for Health and Care Excellence and best practice guidance were available to staff.
- Following the phasing out of the Liverpool care pathway which staff confirmed was no longer used, the trust had developed an interim EOL care plan. In line with national guidance a new advanced end of life personalised care plan for the dying person in the last days and hours of life for the community nursing services was being piloted in one team prior to being rolled out across the organisation. The trust was working towards ensuring that care was planned and delivered in line with evidence based guidance across community services, promoting partnership working, however these care plans were not yet embedded. The care plans included a section to demonstrate if patients' spiritual and religious needs had been assessed and recorded which was in line with national policy. The care plans we looked at included an integrated nursing assessment.
- Once fully introduced these care plans would be audited to assess their effectiveness. A system was in place to audit the community nursing records annually.

Are services effective?

The service reported each quarter to the CCG, which included a review of the clinical recording for EOL patients. The service had been consistently compliant with this audit.

- Clinical support was provided by patients GPs, hospice or hospital consultants and staff could access telephone support from a consultant based at a local hospice as required.
- Preferred place of care (PPC) information was currently recorded by hand, which reflected an encouraging picture for patients achieving their PPC. Since October 2014 to March 2015 there was a significant rise in patients achieving their preferred place of care. From January – March 2015 twenty patients did not die in their stated preferred place of death, the main reason for this was noted to be hospitalisation due to rapid deterioration. The integrated community team leader had identified four areas for action and development including: analysis of data around the need to admit to hospital; continue to work around hospice at home development, shadowing opportunities and collaborative working with specialist nurse practitioners and contributing to the training skills development programme, led by St Catherine's hospice.

Pain relief

- Patients and relatives we spoke with told us symptom control was well managed and we observed staff administer pain relief in a timely way, who explained they sought prescribing advice as necessary. Anticipatory prescribing took place to ensure pain relief was administered to patients in a timely manner.
- The North West end of life care model stated staff could access appropriate pain relief for patients via their own GPs. The six patient's medication records we looked at, showed that patients received appropriate pain relief and they were treated in a way that met their needs and reduced discomfort. The hospice is one of the trust's partners in end of life care and the hospice consultants/ hospice specialist nurses get involved if there are patients with complex symptom management needs. The GPs would review a person's needs, prescribe appropriate medications and make decisions on DNACPR orders.
- District nurses at Blackburn and Darwen told us there were some barriers at weekends, mainly difficulties in management of prescription alterations by the 111 service. This was because the on call doctors did not know the patients, they had to visit them and this was time consuming. Problems with prescribed ranges for syringe driver medications had been acknowledged and were being addressed through a syringe driver working group which recognised the need to make improvements. The nurses heard about EOL care improvements nationally through weekly newsletters which were very informative.
- Staff followed guidelines and procedures, examples included symptom control, syringe driver and protocol for single doses.
- In order to provide a standardised system, senior managers told us the trust had introduced a 'red file' which included EOLcare drugs recommendations, the preferred place of care and the DNACPR. There were inconsistencies in the information held in these files from the records we looked at. The trust did not have systems in place to audit all DNACPR forms.
- Specialist palliative care advice was sought from the local hospice in relation to symptom control on a 24 hour basis by both medical and nursing staff.
- The community nurses did not undertake local audits to assess the effectiveness of treating pain and pain management.

Nutrition and hydration

- The new individual plan of care included a nutrition and hydration assessment to record reasons for decision making and who it had been discussed with.
- The procedure for identifying nutritional risk was due to be implemented. This included prompts to trigger care and further interventions about nutritional need. The use of a malnutrition universal screening tool would identify patients at risk of malnutrition and a nutritional care plan would be commenced as necessary. Staff were fully aware of the need to assess patients for nutritional support.
- A speech and language therapist and a dietician expressed some concerns about the shortfall of pathways in place in relation to decisions to end enteral feeding. Enteral feeding or nutrition, also known as tube feeding, is a way of delivering nutrition directly to the stomach or small intestine.

Technology and telemedicine

- Community nursing staff used hand held computer 'tablets' to gain or record information when visiting patients. Although staff told us these were useful they

did not always work efficiently due to connectivity problems with the network. These concerns were identified on the trust's risk register which confirmed it had been identified as an area to address.

Patient outcomes

- A clinical audit to determine adherence to the NICE quality standard 13 for End of Life was completed in February 2015. Actions included ensuring patients have a person centred care plan, staff to document clearly patients' spiritual and religious beliefs and how patients will be supported to provide these.
- The trust had systems that looked at timely identification of patients receiving EOL care and supported them to receive care in their preferred place of care either through rapid discharge home, hospice or care home ensuring high quality care for patients.
- Patients identified as requiring EOL care received expert input from specialist respiratory or cardiac nurses as necessary.

Competent staff

- There were pockets of expertise and specialist training for EOL care however this information was not captured on the central training log. For example in Meadowfield House, the CHESS team had expertise around symptom control pain assessment, care in last days of life and palliative care emergencies. There were leads for EOL care on each district nurse team.
- Staff training around EOL care and the competencies required in order to provide care to dying patients was included informally rather than formally as part of the trust training package. Staff were trained in core subjects including safeguarding, infection control and equality and diversity. Some specific training, for example, use of syringe drivers was part of trust mandatory training.
- Out of hours staff told us that they had completed a palliative care course. However, they had not received any other additional training within the last three years. Staff competencies were informally recorded.
- Expertise was available particularly for EOL patients with respiratory or cardiac problems from clinical nurse specialists. Consultant support was provided by St Catherine's hospice. Three staff from a team of thirteen at Darwen had completed palliative care training and two nurses had completed an advanced course in communication.
- Staff could access professionals allied to medicine by a referral process, for example occupational therapists and physiotherapists. Allied health professionals were disappointed as prior to this inspection they had lost their specialist role in palliative care.
- A team leader told us that they improved their knowledge by working with nurses with more complex cases and also through informal learning from the specialist palliative care nurses. "We get lots of support to deliver excellent EOL care and our seniors come to meet the patient with us. I feel policies and procedures are stringent to help us develop and deliver a first class service".
- Newly qualified nurses spoke about their preceptorship time as being 'supportive', where they gained competencies from experienced community nurses.
- Access to formal clinical supervision for staff was in place but was informal in practice.
- Staff raised some concerns about shortfalls in funding for further university study.

Multi-disciplinary working and coordinated care pathways

- Staff reported that partnership working had started to improve during the last 12 months as staffing levels had gradually improved, they stated they have much better lines of communication with other disciplines. They stated that they were always on the phone to GP's, social services or Marie Curie. However due to the pace of recruitment, the staff shortages had led to a decline in the frequency of staff meetings. We spoke with nurse specialists for community services and the service manager at St Catherine's hospice to gather their views on the interface with district nurses. Despite the specialist nurses encouraging joint assessments and reviews for complex patients these had been less frequent of late possibly due to demands on district nurses. Nurses would advise they do not have capacity to attend joint reviews.
- Of the nine records we looked at there was evidence of multi-disciplinary meetings to make plans for the management of patients who were nearing the end of life.

Requires improvement

Are services effective?

- The trust supported patients to achieve their preferred place of care. This may be via a rapid discharge from hospital, to a hospice from home or to a nursing home.
- The trust showed commitment to improving and developing EOLC across Lancashire Community trust via the EOL steering group, the 'Lancashire Care Forum' which has representation from a number of disciplines including GPs, social workers and local hospice specialists.
- We saw the minutes of an EOL steering group meeting that showed issues raised and how information was shared across the trust.
- The out of hours service told us how they worked in partnership with other health, social and independent care providers between 6pm and 8am, 365 days per year.

Referral, transfer, discharge and transition

- The aim of the district nursing service was to provide an easily accessible responsive service which met the identified nursing needs of individuals and their carers within their own environment. The management and nursing treatment for patients with palliative care needs and those who were in the terminal phase of their illness.
- Patients were referred to the district nurses by GP's, community clinicians, and the community discharge team (when patients are discharged from an acute environment). Staff spoke positively about access to other specialists and that this was invaluable including seeking advice from other professionals, for example breast cancer nurses.
- Patients and staff spoke positively about the single point of access service provided. This is a service that provides a single point of access to provide assessment, triage and signposting for new referrals into services. In Preston the service had been in operation for nearly four years. One patient told us: "We can rely on the same nurses from the same team coming to see me which I like. The staff respond promptly and the night team check on me too". Out of hours support was available from community staff based at St Catherine's hospice who provided an accessible responsive service, which meets the identified nursing needs of individuals and their carers either within their own home or in a residential setting.
- Staff from the discharge team spoke with enthusiasm about ensuring that patients discharged home or to a care home had appropriate end of life nursing care and support. We were told there had been an increase by 24 cases of patients fast tracked home, 138 patients were fast tracked in 2014 so people can die in their preferred place of care. The discharge team spoke positively about 'time being of the essence' in these circumstances and the nurses responded favourably to support these discharges.

Access to information

- The trust has plans to introduce electronic palliative care co-ordination systems, an electronic system that provides a palliative and end of life specific record sharing for clinicians. This system allows all clinicians involved in a patient's end of life care to view and edit a master copy of the patients' records. Therefore providing a joined up health economy wide approach to record sharing and improve quality of care for patients approaching end of life. Managers spoke with enthusiasm about this and how it was modernising their service.
- Out of Hours staff talked to us about their use of hand held tablets where they recorded each contact with patients.
- Information leaflets regarding EOL care were at the printers so not currently available for people at the time of this inspection. These provided guidance and information about organisations that could offer support and details about how to make a complaint.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff received mandatory training in Deprivation of Liberty Safeguards (DoLS). There were no patients with DoLS restrictions within the end of life care services at the time of our inspection. However, the staff we spoke with demonstrated a good understanding of the trust's DoLS policy, which outlined the process for DoLS. Staff we spoke with were aware of this policy and the legal requirements of the Mental Capacity Act 2005.

Good

Are services caring?

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

Summary

Staff at Lancashire Care Community Trust provided compassionate care to patients. Staff were sensitive to the needs of patients who were seriously ill and recognised the impact this had on those close to them. Staff were enthusiastic and passionate about providing good EOL care. They told us patients for EOL care were always their priority. Patients' confidentiality and privacy were respected and promoted wherever possible.

We spoke with three patients in their own homes briefly as they were too unwell to talk for any period of time where we accompanied the district nurses. In addition we spoke with relatives by phone and we spoke with patients at St Catherine's hospice who had used district nursing services. Feedback from patients was mostly positive about the quality of care provided in the community, one patient's relative told us it was, 'professionalism at its best', however two people told us of concerns in relation to time keeping, staff being stressed and staff skills lacked in relation to a specific area. Improvements were made after they raised their issues.

Staff told us they felt able to have time to interact with families and relatives using their service and were able to signpost them for additional guidance and support as necessary.

Compassionate care

- We spoke with seven relatives of patients who were EOL who had been involved with the community nurses who told us how they were encouraged to participate in their loved one's care if they chose to, for example with mouth care. Staff were competent when managing pain relief and the syringe driver. All the family feel they can't speak highly enough of the district nurses who attended their relative." Another relative said, "I felt the care for my loved one who was safe, nurses were competent and knowledgeable. They always asked me how I was doing and treated all the family with respect and courtesy."
- We observed staff treating patients with compassion, dignity and respect in the patient's own homes and relatives told us staff were caring. Staff provided care and support in a calm, friendly manner.
- Staff told us they had sufficient time to spend time with patients and their relatives when they were delivering EOL care. They told us EOL patients were always their priority; including making time for people's relatives.
- Day care services and complementary therapies were made available to EOL patients at St Catherine's Hospice. We spoke with two patients who had accessed this service and spoke positively about it.

Understanding and involvement of patients and those close to them

- We saw evidence of family involvement in records where people were involved in care planning.
- Staff spoke passionately about EOL care and the way a patient was treated with dignity after they had died.
- One nurse told us, "We work well holistically, to make sure psychological and physical needs are met".
- Delivery of care was respectful and compassionate. Nurses were observed asking a patient for consent to carry out their initial assessment and talked through the care with the patient's relative as the patient was very tired.
- We spoke with staff from the children's integrated therapy and nursing service who advised us there were no children on an EOL pathway at the time of this inspection; however a package of care may be commissioned by the consultant.
- EOL care for children was provided by Derian house, a children's hospice under the care of a consultant paediatrician.

Emotional support

- Recently bereaved relatives we spoke with talked about the support they were provided with which included a visit post bereavement from the district nurse and the provision of links to bereavement and counselling services for example via their GP.

Good

Are services responsive to people's needs?

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

Summary

We found evidence of planning and service delivery to meet the needs of the local population. There was evidence of staff using a joint approach towards EOL care. The community nursing teams worked in partnership with other providers ensuring timely and effective integrated care. The community nursing services provided an accessible responsive service to support patients and their families to remain in their home and to avoid unnecessary hospital admission. As demand for the service has increased there was an impact on workloads for staff.

Reviews of the service had been undertaken to identify areas where they could improve and there was work in progress. The out of hours service responded to patients in a timely way despite comments like, "We feel like the forgotten service as we are tucked away here."

Staff spoke positively about the rapid discharge pathway that enabled patients to be discharged from hospital to home in the last hours/days of their lives. Staff gave examples of how this policy worked in practice and where this had happened for patients.

Planning and delivering services which meet people's needs

- We found evidence of planning the service delivery to meet the needs of the local population. The Department of Health 2008 highlighted that many people receive high quality care in hospitals, hospices, care homes and in their own homes but a considerable number do not. Up to 74% of people say they would prefer to die at home, but currently 58% of people die in hospital. There is considerable geographical variation. On average people spend almost 30 days in a hospital bed in their last year of life.
- For the period from 1 January-March 2015 there were approximately 5182 patients on the total district nursing caseload each month. Overall caseload numbers have continued to increase reflecting the increased referral rate due to the winter season and the capacity demand within district nursing services.
- Lancashire care Foundation Trusts EOL Care framework acknowledged this and planned to provide integrated EOL care services that embed best practice, whilst working in partnership with providers to provide choice for patients in a variety of settings.
- We spoke with the assistant director of community nursing services. In the last 18 months there have been changes towards improvement in EOL by working in a joint approach, driven by the 'patient journey'. They are trying hard to achieve partnership working despite the difficulties of different services being provided by different trusts.
- The Harbour, a new mental health hospital, and Longridge Community Hospital both had facilities for families to stay overnight as required to support loved ones at EOL.
- The overnight, rapid response and palliative care team had come together providing a good mix of staff skills. Within the community team there was out of hours cover available to families. We listened to the handover from the district nurses and calls made directly to the OOH team which included staff requiring to give telephone advice or attend in person if a visit was required.
- Staff were staying up to date with national drivers by linking in to network meetings.
- There are patient representatives on the local EOL care steering group and they have a service user engagement lead that supports this. They also have a link with the Alzheimer's Society,
- Quarterly reports from district nursing teams in Preston, Chorley and South Ribble identified any trends; lessons learnt and practice developments to support EOLC.

Equality and diversity

- In the services we visited we did not see any leaflets available for people whose first language was not English.. However, staff were aware of information available on the trust intranet and knew how to access interpreters if necessary and were aware these could be booked in advance. Staff gave an example whereby they supported a patient to use an interpreter, rather than a family member as the issue was around consent to treatment.

Good

Are services responsive to people's needs?

- There was an opportunity for any staff who were able to speak another language other than English to provide interpretation if they chose.

Meeting the needs of people in vulnerable circumstances

- Staff at the discharge planning service, spoke of the challenges to provide the service effectively with the current staffing levels. Another service told us they did not have a discharge liaison nurse to support patients when they are going home to die.
- Staff received training in how to safeguard children and adults which was mandatory for staff.
- Two of the nine patients' records we looked at showed patients had been assessed and found to lack capacity to make decisions. We saw evidence of mental capacity assessments having been completed which involved families.

Access to the right care at the right time

- There were rapid discharge protocols and procedures in place that were effective in patients reaching their preferred place of care prior to their death.
- Part of the role of the nurses was to ensure that patients die in their preferred place of care and they communicated with patients and families to ensure this.
- The trust report showed that between January – March 2015 twenty patients did not die in their stated preferred place of care. This was a slight increase from the previous quarter; however the overall number of patients on the pathway had increased. The main reason identified was hospitalisation due to rapid deterioration.

Learning from complaints and concerns

- We saw evidence of learning from complaints which were managed in line with trust policy. There were few complaints logged specifically about EOL care. One included issues around consent which included action for learning by the trust and another highlighted the need for staff to follow the complaints procedure and for improved communication if a relative was not direct next of kin. Complaints would be handled by the matron in line with trust policy. Staff gave examples of how they dealt with issues before they became official complaints in a positive way. They spoke with family members or patients to try and resolve any issues early.
- Any actions would be reviewed at the monthly risk meeting. The minutes from the risk meeting in February 2014 showed a negative comment on a patient feedback survey form, and this was discussed at the staff meeting to ensure learning from the event.
- Informal arrangements were in place to discuss any concerns; during the inspection a manager attended the hospice to discuss concerns around the deployment of staff and community nurses failing to notify specialist staff when a patient had died.
- Information leaflets were waiting to be launched specifically around EOL care including information to inform patients and relatives about how to make a complaint.
- Bereavement services were available from the hospice and community nurses provided one visit after a patient had died.

Good

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

The service was aware of the challenges they had to address. We saw they were responding to national initiatives and local ones.

We saw local service leadership that was working to drive improvement to services for the benefit of dying patients and their families. The staff we spoke with told us they were led at local level by supportive and encouraging people. However, staff felt the pace of change was too fast and at times difficult. Staff were not clear who board members were and many we spoke with had never come into contact with them. This supported the feeling that teams and services were driven by local leadership.

There was a trust framework for end of life care. Staff we spoke with were aware of its contents or how it had an impact on patient care and had been consulted on its development. They had linked with The Pennine Lancashire Integrated Health and Social Care's End of Life strategy 2015-2018 with an aim of improving end of life care in a 'joint approach' which was being driven by the 'patient journey'

The trust was rolling out an advanced care plan which included a holistic assessment, spiritual and psychological support and partnership working. There was evidence of some monitoring of EOL care to ensure standards were being met. We looked at the at the clinical audit reports for 2013/14 and 2014/15 which aimed to identify trends, lessons learned and practice developments to support EOL care in community settings for patients in their own homes.

The community staff were passionate about the service they offered and there was some monitoring to improve the quality and safety of the services that they offered. Staff and patients had felt engaged in the change process. There was some monitoring of end of life care to ensure standards were being met.

Staff were awaiting the launch of the new individual care plan; this will be monitored to ensure staff had accurate information with which to make informed decisions about patients' care.

Service vision and strategy

- There was a draft trust framework for end of life care dated March 2015 which had been through the nurses' forum. The framework utilised themes from the National End of Life Strategy (DOH 2008), the Review of the Liverpool Care Pathway (2013) and the 'One Chance to Get it Right' document (2014). Staff we spoke with were aware of its contents and how it had an impact on patient care. Staff had been consulted on in developing documents.
- There was an action plan linked to delivery of the strategy. There were three work streams and a work plan re this.
- There was evidence of monitoring of EOL care to ensure standards were being met. We looked at the clinical audit reports for 2013/14 and 2014/15 which aimed to identify trends, lessons learned and practice developments to support EOL care in community settings for patients in their own homes.
- Over the last 18 months the trust had been working towards improving end of life care in a 'joint approach' which was being driven by the 'patient journey'. By linking with The Pennine Lancashire Integrated Health and Social Care's End of Life strategy 2015-2018 which included 3 hospices, East Lancashire hospitals trust, 2 clinical commissioning groups, a commissioning support unit, Marie Curie cancer care, East Lancs medical services and Greater Manchester, Lancashire and South Cumbria Strategic Clinical networks, partnership working is proving challenging as different services come under different trusts.
- Lancashire Care Trust had developed a framework which was currently in draft format. It was not clear when this would be ratified. The trust was rolling out an advanced care plan which included a holistic assessment, spiritual and psychological support and partnership working. This was developed following an audit of quality standards and was awaiting ratification.

Good

Are services well-led?

Governance, risk management and quality measurement

- There was a governance framework. However the trust had not appointed a board member with specific leadership for end of life care. It was recognised the trust needed more clarity about how their EOL framework should be embedded.
- The two CCGs had EOL as a priority. There was an internal audit of EOLC quality standards last year but the service did not take part in any national audits. This highlighted that capturing data around patients' spiritual needs was poor; staff were having these conversations but needed to improve the documentation.
- Monthly meetings were held to discuss risks to the community nursing services. We found risks to services such as concerns about staff shortages and recruitment to particular posts were identified and recorded on locally held risk registers.
- There was some monitoring of complaints, incidents, audits and quality improvement projects for the service. This encouraged areas for improvement to be identified in local teams. Information was shared with staff.

Leadership of this service

- The community and district nurses told us they felt well supported by their line managers and community matrons.
- Staff felt part of being a wider team. However staff told us they did feel the trust's main focus was mental healthcare. This was supported by information received in the news letters which highlighted mental health issues.
- Staff felt information was shared, for example the OOH staff reported they were made aware of changes as their team coordinator lead on the EOL strategy which met monthly.
- The Band 7 nurses were all in leadership roles. They were aware of the strategies which were cascaded through the steering group. There was representation on the steering group from adult mental health, pharmacy and prison services to reflect the local wider community. Representation for learning disability services was being reviewed.
- Trust leads were not felt to be visible. Staff were not aware who the trust executive team were.
- A number of staff saw recruitment as the trusts greatest challenge and maintaining a mixture of staff with up to date practice and those with expertise. Staff felt the trust were supportive and were looking at various ways to address recruitment. The discharge centre were looking at 'succession planning' and encouraging new staff to gain experience in the field.

Culture within this service

- Staff were passionate about the quality of end of life care provision and said they were well supported by the matron and team members.
- Hospital staff described good, supportive working relationships with the specialist palliative care team.
- We saw evidence of close working relationships and how teams supported each other when short staffed. Some staff spoke about the impact on their roles and responsibilities as teams had merged and the support they had received. However, it had left some allied health professionals feeling they had lost their specialist role particularly in relation to EOL care. There was a culture of sharing knowledge and expertise through formal and informal teaching opportunities.

Public engagement

- Information leaflets regarding the role of the district nurse in EOLC and a syringe driver information leaflet for families and patients were currently at the printers.
- Reviews of the service included patient experience surveys. Information was shared with staff from feedback and results of the NHS Friends and Family survey.
- The EOL forum included representation from members of the public.

Staff engagement

- Staff spoke positively of the more recent improvements in communication and staff told us they felt listened to. There was a regular newsletter with a community focus which included compliments received. The OOH staff commented how the team leader kept them informed of trust issues and the intranet was a useful source of information which included updates from board members. Some teams reported shortfalls in staff had led to a reduction in team meetings. This lack of engagement may impact on staff morale.

Good

Are services well-led?

- Staff engagement was through an annual appraisal which we were told worked well. Staff reported gave them an opportunity to address any problems.

Innovation, improvement and sustainability

- Staff spoke positively about the equipment and community loan storage facility. Staff were able to source equipment quickly and effectively with few limitations.
- There were improvements to auditing the EOL quality standard which has led to recognition of areas where improvements can be made, including the preferred place of care.
- Fast tracks for healthcare funding were not being approved in a timely way. The trust has worked with the commissioners to improve this process.
- The speech and language team (SALT) and occupational therapists were working more closely with nursing teams. The SALT are looking at a project to explore more multidisciplinary working, to include adopting EOL care with dementia as a life limiting condition. The SALT team felt confident about presenting this higher up the trust. There was on-going work to develop the hospice at home service to support patients and relatives at EOL.

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
Nursing care	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found nurse staffing skill mix did not always meet the needs of the patients as the caseloads had increased but recruitment was challenging and some teams reported frequent use of bank and agency staff. Regulation 18 (1)