

Plymouth Community Healthcare CIC

1-271962340

End of life care

Quality Report

Local Care Centre
Mount Gould Hospital
Plymouth
Devon
PL4 7PY

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Website: www.livewellsouthwest.co.uk

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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)
1-297622270	Mount Gould Hospital	n/a	PL4 7PY
1-2078154330	Tavistock Hospital	n/a	PL19 8LD

This report describes our judgement of the quality of care provided within this core service by Plymouth Community Healthcare CIC, also known as Livewell Southwest. 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 Plymouth Community Healthcare CIC and these are brought together to inform our overall judgement of Plymouth Community Healthcare CIC

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

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Summary of findings

Overall summary

Overall we rated the organisation as requires improvement for community end of life care services because:

- Treatment escalation plans (TEPs) that included do not attempt cardiopulmonary resuscitation (DNACPR) decisions were not always completed in line with organisational policy. This included poor records of discussions relating to DNACPR and a lack of clarity on whether discussions were taking place with patients and family members. Incomplete mental capacity assessments relating to DNACPR meant that it was unclear that mental capacity was being considered when decisions were made.
- Poor records management following reviews of TEPs and DNACPRs resulted in duplication of forms and had the potential to cause confusion about whether a patient was or was not for resuscitation. This presented a risk of a resuscitation decision not being followed.
- There was a lack of holistic evidence-based end of life care guidance in use across the organisation.
- It was unclear how the service was monitoring patient outcomes specific to end of life care.
- Not all nursing staff delivering end of life care had received syringe driver training or competency assessments.
- There was no completed strategy for end of life care.
- There was no lay person or non-executive director overseeing end of life care and end of life care was not discussed at board level meetings.
- Quality measurement in relation to community end of life care services was limited and there was no clear plan for measuring or improving the quality of end of life care in relation to patient outcomes.

However;

- Equipment for use at the end of life, including syringe drivers, was readily available and there was good use of anticipatory prescribing and monitoring of symptoms for patients at the end of life.
- There was good evidence of incident reporting, learning and improvement and staff were consistently aware of reporting procedures. Lessons were learned from incidents and were shared with all staff.
- We saw evidence of outstanding practice in the development of innovative projects relating to improving the quality of end of life care for people living in vulnerable circumstances. The organisation had developed a resource of end of life champions.
- Feedback from patients and relatives told us that staff treated people with dignity and respect and we observed staff caring for patients in a way that built rapport.
- There were examples of staff going the extra mile to support patients and their relatives at the end of life and to promote individual choices about care.
- Services were planned and delivered to meet people's needs and Plymouth CIC staff were actively engaged with other providers within the locality to improve services
- There was clear, motivated and enthusiastic leadership at service delivery levels within the organisation.
- There was good collaborative working with other providers to improve end of life care through joint working within the locality.

Summary of findings

Background to the service

Plymouth Community Healthcare trading as Livewell Southwest is an independent social enterprise organisation that provides community health and social care services for the people of Plymouth, South Hams and West Devon. End of life care was provided by community nursing teams and on inpatient wards in three community hospitals (Mount Gould hospital, South Hams hospital in Kingsbridge and Tavistock hospital). In addition there was a dedicated end of life care multi-visit team made up of healthcare assistants who worked with Marie Curie carers to provide end of life care in patients' own homes. Specialist palliative care was not provided as part of Plymouth Community Healthcare but they worked closely with local hospice and other services to ensure collaborative care delivery. Between January 2015 and May 2016 there had been 56 inpatient deaths across all three hospitals with 24 at Tavistock hospital, 20 at Mount Gould hospital and 12 at South Hams hospital. Between June 2015 and May 2016 the multi-visit team had undertaken 1826 end of life care community visits.

During our inspection we visited Mount Gould and Tavistock hospitals and visited four patients in their own

homes where we observed care being delivered by district nurses. We also observed care being delivered by healthcare assistants working in the multi-visit team. We spoke with five patients and one relative. We spoke with the end of life professional lead within the organisation and members of the multi-visit team, including the service manager. We met with members of two district nursing teams and spoke with staff including the chaplain, nurses from the drug and alcohol service, a nurse from the learning disability team, a bereavement officer, an out of hours manager and a specialist palliative care nurse from the local hospice. In addition we spoke with community inpatient staff including matrons, ward managers, medical staff, ward nurses, allied healthcare professionals, health care assistants and ward clerks. In total we spoke with 30 staff. We looked at the records of five patients identified as receiving end of life care and 29 treatment escalation plans (TEPs) that included records of DNACPR (do not attempt cardiopulmonary resuscitation) decisions.

Our inspection team

Our inspection team was led by:

Chair: Andy Brogan, Executive Director of Nursing, South Essex Partnership Trust

Head of Hospital Inspections: Pauline Carpenter, Care Quality Commission

Inspection manager: Nigel Timmins, Care Quality Commission

The community end of life sub team included a CQC inspector and two specialist advisers, one a specialist palliative care nurse and the other a retired consultant in palliative medicine.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

To get to the heart of patients' experiences 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?

The inspection team visited the inpatients services at Mount Gould and Tavistock. We observed members of the multi-visit and district nursing teams interacting with patients at the end of life and their families. We met with specialist staff that had developed services for patients at the end of life and we met with service leads that were responsible for the development of end of life care services within the organisation.

Prior to the inspection we reviewed a range of information that we held and asked other organisations to share what they knew about the organisation. These included the clinical commissioning group, Health Education England, the General Medical Council, Local Authorities and local Healthwatch organisations.

During our inspection of end of life care services we spoke with 30 members of staff. We reviewed the records of five patients and reviewed 29 'do not attempt resuscitation' decision records as part of treatment escalation plans (TEPs). We spoke with four patients and two relatives. We also interviewed key members of staff and held focus groups with various staff groups.

We undertook the announced inspection visit between 21 and 24 June 2016.

What people who use the provider say

We spoke with four patients receiving care from the community nursing teams in their own homes and two relatives. People who used the service and their families said;

- "The nurses are lovely, they can't do enough for me."
- "Staff are very quick to respond if I'm in pain."
- "The carers visiting have very good people skills."
- "We're very satisfied with the service. Staff are caring and attentive. We couldn't ask for more."
- "The care is good. Staff work well together."
- "We are well supported."

Good practice

- We observed outstanding practice in relation to the development of end of life care services for people in vulnerable circumstances. A range of projects had stemmed from staff attending end of life care champions training at the local hospice. They included

initiatives that looked to improve end of life care and planning for people with a learning disability, those with drug and alcohol dependency and people who were homeless.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve;

- The provider must ensure that treatment escalation plans and do not attempt resuscitation decisions are

Summary of findings

appropriately completed and recorded in line with organisational policy and that audits of these lead to measurable action plans used to improve performance.

Action the provider SHOULD take to improve;

- The provider should consider appointing an end of life care lead at board level.
- The provider should ensure that there is a clear, consistent approach in relation to planning care for patients that is based on national and evidence-based guidance.
- The provider should ensure that a clear vision and strategy is developed that incorporates all aspects of community end of life care.
- The provider should ensure that patient outcomes are measured and tools developed to monitor the quality of the community end of life care service as a whole.

Plymouth Community Healthcare CIC

End of life care

Detailed findings from this inspection

Requires improvement



Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as requires improvement because;

- Treatment escalation plans (TEPs) that included do not attempt cardiopulmonary resuscitation (DNACPR) decisions were not always completed in line with organisational policy. This included one case where there was conflicting information held on file relating to a resuscitation decision. This presented a risk of a resuscitation decision not being followed. Of the 29 forms we viewed, 13 did not contain a record of any discussions with the patient or their family. Of the 29, 21 did not contain a completed record of assessment of the patient's capacity to make decisions about their treatment in line with TEP guidance.

However;

- Equipment for use at the end of life including syringe drivers was readily available.
- There was generally good use of anticipatory prescribing for patients at the end of life and we saw that the administration of medicines at the end of life was closely monitored.

- Medicines for use at the end of life were generally available and we saw that community pharmacy issues were a standing agenda item at end of life care locality meetings.
- There was good evidence of incident reporting, learning and improvement and staff were consistently aware of reporting procedures. Lessons were learned from incidents and were shared with all staff.
- Mandatory training attendance for staff working within the end of life multi-visit service was in line with organisational averages.

Detailed Findings:

Safety performance

- A range of safety performance was being monitored over time. Staff in all ward areas used and displayed safety thermometer information. For example, on the inpatient ward at Tavistock Hospital information was displayed that showed close monitoring of infection control areas. This included information such as hand hygiene and infection control training and that there had been no infections such as MRSA and clostridium difficile in the last 12 months.

Are services safe?

- There had been no never events between February 2015 and January 2016. Never Events are serious incidents that are wholly preventable. There had been one serious incident requiring investigation relating to a patient at the end of life with a grade three pressure ulcer.

Incident reporting, learning and improvement

- All incidents requiring investigation were reported to the Serious Incidents Requiring Investigation Panel. This panel was chaired by the Deputy Director of Professional Practice for Quality and Safety and was a subgroup of the Safety Quality and Performance Committee. The role of the panel was to review reports and investigations and to produce a summary report making recommendations, identifying trends or learning and disseminating this across the organisation.
- Staff told us that the tissue viability team had been active in advising staff and reviewing patients with a grade three or four pressure ulcer and that as a result education and learning for staff had improved in this area. There was an overall reduction in grade three and four pressure ulcers of 40% in the community from 2014/15 to 2015/16.
- The tissue viability team were responsible for advising staff and reviewing patients with grade three and four pressure ulcers, and long standing leg ulcers. The team covered residential care homes and patients at home. When asked why the team thought there had been a 40% decrease in grade three and four pressure ulcers they said they felt this was due to improved education and training provided to staff.
- Staff delivering end of life care understood their responsibilities with regard to 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 details of five medication incidents relating to patients at the end of life. We saw that the incidents had been thoroughly investigated with involvement from the nurse managers and where appropriate the chief pharmacist. Specific action included liaising with GPs and pharmacies to address the incidents as they arose and take action in the best interests of the patient. Staff told us that those involved in the incident received feedback, including those staff reporting it.
- Staff told us that incidents relating to prescription errors would sometimes result in nursing staff having to take prescriptions to GPs to have them amended. We asked

staff if they audited prescriptions of anticipatory medicines to monitor this and they told us they believed the local hospice did this. However, they had not seen any results of this and were not aware of any changes made as a result.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm.
- Staff were aware of their responsibility in relation to duty of candour and being open with patients and their relatives when incidents occurred. We saw incident reports relating to medication where it was recorded that the patient and their relatives had been informed of an error and apologised to.

Safeguarding

- Systems were in place to protect people in vulnerable circumstances from abuse. Staff were knowledgeable about their roles and responsibilities in relation to ensuring vulnerable adults and children were safeguarded. Staff understood what constituted a safeguarding concern and knew how to report it.
- All eligible end of life care staff had attended adult and level one child safeguarding training, 89% had attended level two.
- There have been no safeguarding alerts or concerns raised with the CQC specific to community end of life care services.

Medicines

- Patients in the community identified as requiring end of life care were prescribed anticipatory medicines. Anticipatory medicines were medicines prescribed in advance to ensure patients received prompt relief from pain and other symptoms.
- We visited four patients in the community of whom three had anticipatory medicines appropriately prescribed. These were available and stored safely in their home in the form of 'just in case bags' for when they were required.
- We were told that monitoring of anticipatory prescribing and 'just in case bags' was undertaken by the hospice

Are services safe?

and end of life care GPs. We viewed minutes of locality meetings where this was discussed although staff did not have information about the process or results of the audit.

- Nursing staff told us it was the remit of the hospice based specialist palliative care clinical nurse specialists (CNS') or locality GPs to prescribe medicines for patients at the end of life.
- Staff we spoke with told us that they had not experienced any difficulties in getting anticipatory medicines prescribed and that these had been readily available from community pharmacies. Support was available from the specialist palliative care team at the local hospice where community CNS's were trained as non-medical prescribers.
- Prescribing guidance was obtained from the local hospice and based on national guidance. For example, anticipatory medicines were prescribed for the key symptoms at the end of life including pain, breathlessness, nausea, restlessness and respiratory tract secretions. There was also guidance available for situations where patients who had advanced kidney disease were unable to tolerate the standard medicines. This guidance indicated the alternative medicines and doses required. Access to specialist advice was available from the hospice both in and outside of working hours.
- Prescriptions and administration records we looked at in the community were completed accurately and clearly.
- Controlled drugs (medicines controlled under the Misuse of Drugs legislation and subsequent amendments) were stored securely with appropriate records kept.

Environment and equipment

- Community nurses we spoke with told us they were able to access equipment for patients at the end of life in the community. This included syringe drivers as well as other types of equipment to enable them to care for people safely in their homes. Staff told us they could access additional syringe driver machines from other community locations if necessary.
- Staff told us that equipment was accessible within twenty four hours for patients at the end of life who were being discharged from hospital via the fast track route. One patient we visited in their own home had a bed delivered a few hours after it had been requested.

Quality of Records

- Community nurses and care staff in the multi-visit team used an electronic patient record system. Care plans were kept in paper form in patient's homes.
- We viewed five care records of patients considered to be at the end of life. We found that the standard of record keeping was good. Risk assessments and summaries of care delivery were in place and records were dated and signed.
- We viewed 29 treatment escalation plans (TEPs). A TEP is a document that aids staff, patients and their relatives in planning ahead in case of deterioration in a patient's condition. The TEP includes 'do not attempt cardiopulmonary resuscitation' (DNACPR) decision making records.
- These records were not always completed appropriately. The forms we viewed generally contained clearly documented decisions with reasoning and clinical information, were generally dated and signed but did not always include a record of discussions with the patient and their family. For example, 13 of the 29 forms did not have evidence of a discussion with the patient or their family recorded.
- The form included a mental capacity section where there was space to indicate if there was doubt about the capacity of the individual to be involved in making decisions. In 21 out of 29 cases this section had not been completed.
- The organisation's policy for dealing with changes in decision making relating to TEPs was to score through the form, sign and date the discontinuation box and file the discontinued form at the back of the patient's medical notes. At Mount Gould hospital we found five patients whose records contained two forms that both appeared to be current as neither had been scored through or filed. In one case the two forms detailed conflicting treatment decisions. When we pointed this out to staff they immediately discontinued the relevant form in line with the organisational policy. However this presented a risk in terms of potential confusion for staff in the event of a cardiac arrest or deterioration in a patient's condition with the potential to result in a resuscitation decision not being followed
- Syringe driver monitoring forms were completed where patients were receiving medicines via a syringe driver. These forms included a record of the amount of

Are services safe?

medicine being administered and also a check of the pump and the site of the infusion. Monitoring in inpatient areas was every four hours and in patient homes this was done at every visit.

Cleanliness, infection control and hygiene

- We observed staff wash their hands, use hand gel between patients and comply with 'bare below the elbows' policies.
- We saw the use of personal protective equipment (PPE) when dealing with patients. Staff told us that hand gel and other equipment was available and easily accessible for their use when visiting patients in their own homes.
- We observed staff following safe infection control practices when visiting patients at home. This included the use of appropriate clinical waste disposal processes and equipment.
- Recent hand hygiene audits showed good compliance with infection control measures.

Mandatory training

- The average mandatory training rate for the multi-visit team delivering end of life care to patients in the community was 91%. Mandatory training for community staff included infection control, basic life support and moving and handling.
- Corporate mandatory training for all staff included fire, equality and diversity, information governance, infection control and customer care. 81.8% of the multi-visit team delivering end of life care to patients in the community had attended this training. This was a little below the overall organisational average of 83%. The training percentage for basic life support for the multi-visit team was 82% which was better than the overall organisational average of 73%.

Assessing and responding to patient risk

- Staff assessed and managed patient risk as part of an ongoing holistic assessment process. We observed good use of general risk assessments for patients receiving end of life care. This included the assessment of risk in relation to nutrition and hydration, falls and the potential for pressure area damage.

- When a patient's condition changed, information was recorded in the daily notes by nursing and therapy staff. Advice and support from the hospice specialist palliative care team (SPCT) regarding deteriorating patients was available.
- End of life care in the community was provided by general community nurses located at each of the four localities (East, South, North, and West) across Plymouth. Specialist palliative care was provided by the local hospice seven days a week, with telephone advice available from the hospice inpatient unit and on-call specialist staff. A consultant in palliative medicine was also available to staff and patients in the community via the local hospice.
- We observed staff discussing patient risk as part of their day to day work. There was evidence of planning for patients who were at risk of deterioration; particularly in relation to ensuring anticipatory medicines were available should they develop symptoms.
- We spoke with relatives who were aware of how to access help and support should a patient's condition deteriorate in situations where they were being cared for at home. This included access to out of hours support.

Staffing levels and caseload

- The vacancy rate between February 2015 and January 2016 for the multi-visit team caring for patients at the end of life in their own homes was 15% which was higher than the organisational average of 9.5%. Staff sickness for the multi-visit team at 1% was lower than the organisational average of 5%.
- District nurses provided nursing support to patients being cared for at home at the end of life. Nurses we spoke with told us there were some difficulties recruiting nurses and that this had an impact on their workload in the community. However they told us they felt able to prioritise end of life care within their workloads although they stated that this was sometimes more difficult than others.
- We observed district nurses and care staff working in the multi-visit team providing care in a way that was focused on the needs of the patient and family.
- Specialist palliative care provided to patients being cared for in their own homes was delivered by CNS from the local hospice.

Are services safe?

Managing anticipated risks

- Patient risk assessment and screening tools were in use including those to assess nutritional risk, falls risk and risks to deteriorating health.
- Staff told us that major incident and winter management plans were in place and that patients at the end of life were appropriately prioritised.

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

We rated effective as requires improvement because;

- There was no end of life care plan based on current national guidance in use across the service.
- There was inconsistent use of an available end of life care plan that focused on symptom control at the end of life.
- Patient outcomes specific to end of life care were not being monitored.
- Not all nursing staff delivering end of life care had received syringe driver training or competency assessments which presented a risk to patients that symptoms may not be well controlled.
- Staff frequently did not record mental capacity assessments, this was missing from the relevant section of the treatment escalation plan. This meant that there was not always clear evidence of the consideration of mental capacity and best interest decision making associated with DNACPR (do not attempt resuscitation) decisions.

However;

- The end of life care champions course had been accessed by a number of staff who had gone on to provide a resource within the organisation and develop service-specific end of life care projects.
- There was good evidence of effective symptom management at the end of life.
- There was evidence that National Institute for Health and Care Excellence (NICE) guidance was discussed at locality meetings attended by the end of life care lead.
- Nutrition and hydration at the end of life was focused on promoting comfort and patient choice.
- Staff were knowledgeable about mental capacity. We saw evidence of a three point mental capacity assessment being carried out in community inpatient settings.

Detailed Findings:

Evidence based care and treatment

- There was some evidence of national guidance influencing end of life care within Plymouth Community

Healthcare. District nurses told us they would attend regular Gold Standard Framework (GSF) meetings with GPs and specialist nurses from the local hospice. The Gold Standards Framework is a model that promotes good practice in the care of patients at the end of life. However, we did not see this in place in the community hospitals.

- There was evidence that National Institute for Health and Care Excellence (NICE) guidance was discussed at locality meetings attended by the end of life care lead. However, there was no evidence of this guidance influencing patient care through the use of evidence-based end of life care plans by staff delivering care.
- The organisation had previously used the Liverpool Care Pathway as a guide for the care of patients in the final days of life. Following the withdrawal of this in July 2014 there was no single approach to replace this with up to date evidence-based guidance for staff. This applied to inpatient areas and in the community setting.
- There was an end of life care bundle of documents in use by community nursing teams and an electronic palliative care plan on the electronic records system within inpatient services. These tools were focused on symptom management and guidance for use in the last days of life where patients were likely to develop key symptoms.
- However, there was no individual holistic plan of care that was specific for patients in the last phase of life. For example, we did not see evidence of the use of guidance such as the Leadership Alliance's five priorities of care in use in either patients' own homes or within the inpatient units. The five priorities of care is a holistic care model that focuses on priorities including recognition of dying, communication, involvement, support and an individual plan of care. The plan of care should include psychological care, social and spiritual support care and food and drink as well as symptom control. While we observed that care was delivered with a holistic focus, care plans were not designed to provide specific guidance for staff on caring for patients at the end of life beyond symptom management issues. For

Are services effective?

example, care plans did not include a focus on specific issues at the end of life such as spiritual and emotional support, advance decisions and involvement of the patient and family.

- There were limited end of life care policies, procedures and guidance in use within the organisation. There was an end of life care policy in place, however this focused on verification of an expected death and care following death. There was no policy or associated procedures that provided staff with a framework for delivering end of life care for patients and their families.

Pain relief

- There were tools available to assess and monitor pain and we saw these consistently in use. Pain assessment tools, included traditional pain scores and also non-verbal assessment tools were available in care and nursing homes where patients and staff were supported by the end of life care team.
- Patients we spoke with told us their pain was well managed and that staff were quick to respond to requests for additional medicines when pain occurred. We did not see patients in pain and relatives we spoke with told us pain was well managed by the staff.
- Where appropriate, patients had syringe drivers which delivered measured doses of medicines at pre-set times to ensure a constant dosage for effective pain management. However, not all qualified nursing staff were trained in the use of syringe drivers and at Mount Gould Hospital we were told by some staff that they tended to use 'as required' doses of medicines rather than syringe drivers where medicines would be continuously administered. However, at the time of our inspection we did not see evidence of this on the wards and we were told that staff could access support from district nurses and the on-site training team as required.
- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were available as needed both during the day and out of hours.
- Anticipatory medicines were available in patients homes where it had been identified they may require medicines to manage their symptoms quickly in the near future. Community staff told us getting anticipatory medicines prescribed was relatively straightforward and advice was available from the specialist palliative care team at the hospice.

Nutrition and hydration

- The assessment of nutrition and hydration needs was incorporated into the general nursing assessment in use in the community.
- The use of malnutrition universal screening tool (MUST) was observed as part of routine patient risk assessments. We saw that where the risk was identified as being high staff liaised with the patient's GP and other members of the multi-disciplinary team as appropriate.
- We saw when patients at the end of life experienced swallowing difficulties that their swallowing had been assessed by speech and language therapists (SALT). Alternative modes of providing nutrition had been discussed. We also saw that patients were encouraged to make decisions about nutrition and hydration based on their own wishes and choices.
- We observed one patient in the community, during a visit with the multi-visit team, where there was a focus on assessing and exploring issues relating to the patient's nutrition and hydration needs and their wishes around this.
- There was an emphasis on patient comfort in relation to nutrition and hydration at the end of life. We observed staff following patient's wishes and discussing their needs in relation to this.

Patient outcomes

- We did not see evidence of the use of audit specific to end of life care in the community or inpatient settings. We also did not see end of life care in the community included in the provider's audit plan.
- Data relating to the multi-visit team caring for patients at the end of life in their own homes was focused on activity rather than patient outcomes.
- Patient outcomes specific to identifying the quality of end of life care were not being monitored.

Competent staff

- The percentage of the end of life care staff that had received an appraisal in the last 12 months was 91%.
- The local hospice had delivered a 'Getting it right at the end of life, right person, right time, right place' course for end of life care champions. The aim of the course was to develop end of life care champions across a range of healthcare settings. Sixteen staff from Plymouth Community Healthcare had attended the course

Are services effective?

including district nurses, ward nurses, physiotherapists, and occupational therapists. Also included were staff working in mental health services including those in drug and alcohol services and learning disability services.

- As a result of this training an end of life care champions forum had been developed and was in the process of being embedded. The forum was made up of staff who had undertaken the training as well as those with a specific interest in end of life care. The aim of the forum was to promote and share best practice around end of life care across all sectors of the organisation. Ideas of how to do this included the development of an end of life care champions website where staff could identify individual champions and contact them for advice and support.
- Not all nursing staff had attended syringe driver training. We saw that the policy included a competency assessment and that all nursing staff participating in the administration of medicines via this route had to be assessed as competent. However, only 24% of qualified district nurses and 40% of inpatient hospital nurses had been trained and assessed as competent in the use of syringe drivers.
- During our inspection we spoke with two nurses who had not attended syringe driver training. One at Tavistock told us they would generally be working with a more experienced nurse who had attended training, the other at Mount Gould told us they had previously tended to give 'as required' doses of end of life medicines rather than via a continuous route. This presented a risk that patients' symptoms may not be well controlled. However we did not see evidence of this during our inspection.
- Not all ward or district nursing staff had attended end of life care training. However, all staff we spoke with were aware of their local end of life care champion or the specialist palliative care nurses at the hospice.
- At Tavistock hospital, where there had been a higher than average number of expected deaths across the organisation in the last 12 months, there was a regular ward round that was attended by one of the specialist palliative care nurses when there were end of life care patients on the ward.

- Healthcare assistants working within the multi-visit team told us that training was provided on a regular basis, including ad hoc training to help them to meet the needs of their patients.

Multi-disciplinary working and coordinated care pathways

- The four district nursing locality teams in the community were aligned to GP Practices who had overall responsibility for patient care. The district nurses were also aligned with the clinical nurse specialists from the local hospice. District nurses worked as part of wider multi-disciplinary teams. The community nurses and specialist palliative care clinical nurse specialists also participated in the Gold Standard Framework (GSF) meetings for end of life care that were run by GPs in each locality.
- The multi-visit team was made up of healthcare assistants providing end of life care in patients' homes. They worked together with healthcare assistants from Marie Curie to provide double-up visits to patients and were guided by care plans developed by the district nurses.
- Multi-disciplinary meetings were held regularly in each inpatient area and included attendance from nursing, medical and allied healthcare professional staff. Where there was a higher level of end of life care activity such as at Tavistock hospital clinical nurse specialists from the local hospice would also attend to provide specialist input when there were end of life care patients being cared for. Staff working on other inpatient areas across the organisation told us they could access members of the multi-disciplinary team including specialists in palliative care when they needed to. All staff we spoke with were aware of who the specialist staff were.

Referral, transfer, discharge and transition

- We observed that patients were referred and transferred appropriately for end of life care and to their preferred place of death.
- There was a clear pathway for referral to the hospice-based community specialist palliative care service. Community nursing staff were able to access specialist nurses by phone if they needed advice or input about a patient.

Are services effective?

- Staff we spoke with consistently told us that patients could be supported at home very quickly in the last days of life where they wanted to be transferred from hospital.
- We saw that there was a focus on supporting patients to get home appropriately at the end of life. For example, decisions were made in a patient's best interest if they did not have capacity to be involved in the decision.
- The multi-visit team worked to support patients at the end of life in the community and also those being fast tracked home following a hospital admission. In addition, services were available on a brokerage basis with other community care providers. This meant that if the multi-visit team did not have capacity to provide care then other community care providers would be contacted to step in. There was a crisis team within the local hospice who would provide care for up to 72 hours for patients at the end of life who wanted to be at home.
- The multi-visit team had recently changed locations which had made information sharing difficult at times. They had addressed this by having the team manager transfer information from one site to another to ensure that staff working out of hours had the information they needed.
- In the community paper records were kept in patient's homes and these were kept up to date during the visits we observed. This included DNACPR (do not attempt cardiopulmonary resuscitation) decision where these were in place.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- There were three point mental capacity assessments in place on inpatient wards where patients would be assessed in relation to their admission, care delivery and discharge.
- Staff we spoke with demonstrated understanding of issues around mental capacity and the presumption of capacity. They were aware of the use of formal assessments and best interest decision making.
- There was a section relating to mental capacity as part of each patient's treatment escalation plan (TEP) that included the DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) decision record. Of the 29 TEPs we reviewed, the mental capacity assessment was not completed on 21 of them. Of the 29 TEPs we reviewed, nine were for patients who did not have capacity or whose capacity was unclear. Thirteen of the 29 forms did not have evidence of a discussion with the patient or their family recorded.

Access to information

- We saw that risk assessments and care plans were in place for patients at the end of life. Patients were cared for using relevant plans of care to meet their individual needs.
- There was an electronic patient record system in place that was accessible to members of the multi-visit team, district nurses and hospital staff and mobile devices were in use. Some staff told us there were occasional connectivity issues relating to this. For example, district nurses told us they would be sent work updates electronically but did not always receive these in a timely way because of the connectivity issues.

Are services caring?

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

Summary

We rated caring as good because;

- Feedback from patients and relatives told us that staff treated people with dignity and respect.
- We observed staff caring for patients in a way that built rapport. They demonstrated empathy towards people who were at the end of life, in pain or distressed and were skilled in providing comfort.
- Patients and relatives told us they were involved in care and decision making. Their social and cultural needs were taken into account and they were helped to maintain their independence whenever possible.
- There were examples of staff going the extra mile to support patients and their relatives at the end of life and to promote individual choices about care.

Detailed Findings:

Compassionate care

- Patients and relatives we spoke with told us that staff were professional, caring and kind. We observed care being provided and saw that patients were treated with compassion, dignity and respect.
- We observed staff caring for patients in a way that built rapport with both patients and their families. Staff consistently responded with a caring attitude.
- All patients and relatives told us they were highly satisfied with the quality of care they received and that staff treated them with respect and maintained their dignity. For example, one patient told us that staff were very attentive and went out of their way to provide care.
- We heard stories of situations where staff had gone the extra mile to support patients. For example, members of the multi-visit and district nursing teams staying late to support family members when a patient was close to death. We were also told that a patient at the end of life at Tavistock hospital had got married on the ward and that staff had arranged for a special meal to be provided and had gone out of their way to make sure that the day was special.
- A relative told us that they were well supported by nursing staff and healthcare assistants in the community and that staff were caring, compassionate and treated the patient with dignity.

Understanding and involvement of patients and those close to them

- All patients and family members told us they felt involved in the care delivered.
- We saw that staff discussed care issues with patients and relatives and these were clearly documented in patients' notes. We observed staff using an approach that cared for the whole family when supporting them at the end of the patient's life.
- Patients and family members we spoke with consistently told us that staff took the time to ask for their input and opinions about care. We saw evidence of advance care planning and staff providing support to ensure that this was carried out.
- We saw that staff working in learning disability services adopted an approach that advocated involvement of patients and their families in relation to both end of life care and bereavement. We observed the use of a variety of tools to promote this including advance care planning tools in an easy read format, talking memory books and a wishes tree.

Emotional support

- Staff told us they felt they generally had the time to spend with patients and provide the emotional support to meet their needs. We observed end of life care being prioritised in relation to this.
- We observed community nurses and healthcare assistants assessing the emotional needs of patients at the end of life and their families as a matter of routine when visiting them at home.
- Bereavement support was provided by staff in the community immediately after death where nurses would undertake a visit to the family. Information about bereavement services were available. There was a bereavement officer based at Mount Gould Hospital who would support relatives through the practical steps following the death of a loved one. This was a service provided by nursing staff at Tavistock and Kingsbridge hospitals.
- The chaplaincy service provided emotional support to patients and their relatives through chaplains and lay volunteers.

Are services responsive to people's needs?

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

Summary

We rated responsive as good because;

- Services were planned and delivered to meet people's needs and Plymouth Community Healthcare staff were actively engaged with other providers within the locality to improve services
- Staff had a good understanding of equality and diversity and end of life care patient information was available in other formats
- We saw outstanding practice in relation to meeting the needs of people living in vulnerable circumstances. There were innovations in both learning disability and alcohol and drug use services to improve end of life care for these groups of people.

However;

- The organisation had a lack of data in relation to the proportion of patients achieving their preferred place of death.

Detailed Findings:

Planning and delivering services which meet people's needs

- The end of life care professional lead within the organisation was actively involved in end of life care and were engaged with other services. For example, they represented the organisation on an end of life care operational group and attended quarterly meetings where aspects of end of life care affecting the locality were discussed.
- We saw that a strategic advisory group existed within the locality and was led by the clinical commissioning group to develop services and that this fed into the operational group which in turn fed into the Plymouth CIC end of life champions group.
- As a result we saw that the organisation was involved in planning of services locally to meet people's needs. Issues being addressed included improving the use of treatment escalation plans (TEPs) across the whole of the community and addressing issues relating to community pharmacy services relating to care at the end of life.

- Services were planned and delivered to meet the needs of patients and their relatives. Staff told us a priority was to ensure that patients were cared for in their preferred place of death wherever possible. However, the organisation did not collect data relating to the effectiveness of this.
- The organisation had focused on developing end of life care services for people with substance misuse issues and also those with a learning disability. Through the development of the end of life care champions programme, specific projects in these areas had been developed.
- Staff were focused on the end of life care needs of the local population and how services could work together to meet them.

Equality and diversity

- Equality and diversity training was part of the mandatory training for all staff within the organisation and was part of corporate induction training.
- 82% of the multi-visit team delivering end of life care in the community had completed equality and diversity training which the same as the organisational average.
- Staff we spoke with were able to demonstrate their understanding of equality and diversity.
- Patient information and leaflets including letters to patients could be provided in a person's own language, large print for people with visual impairment or in easy read versions. For example, advance care planning and end of life care planning documents had been developed in easy read formats for people with a learning disability.
- There was a multi-faith prayer room available at Mount Gould hospital and we were shown plans to develop a multi-faith quiet room at Tavistock hospital in the summer house.

Meeting the needs of people in vulnerable circumstances

- During our inspection we met with nursing staff working within the learning disability team who had attended the end of life care champions training. Specific work that was being undertaken with people with learning

Are services responsive to people's needs?

disabilities included advance care planning and focusing on working with people to make decisions about their future care while they have the capacity to do so.

- Other initiatives have included training all staff within the learning disability team on issues relating to end of life care such as recognising when someone might be in the last 12 months of life. An internal end of life care course had been developed as well as a range of tools to support end of life care decision making. Specific tools included memory boxes and a talking memory book for people who had the potential to lose their memory and specific pain profile tools to assess pain levels and the effectiveness of interventions.
- There were arrangements in place for telephone interpreting and face-to-face interpreting and staff told us these were easily accessible when needed.
- Some nursing staff working within drug and alcohol services had attended the end of life care champions training. Specific projects that had stemmed from this included focusing on bereavement support for families who were bereaved as a result of drug and alcohol related deaths.
- As well as focusing on bereavement support this service also looked to improve care through a 'living well to the very end' programme where people at risk of dying as a result of drug and alcohol use would be supported. Strategies included a focus on matters relating to dying and helping them to identify what their priorities, wishes and choices were in relation to quality of life by working with them to identify what they wanted to do before they died and how they wanted to be remembered.
- Staff working within drug and alcohol services were also working with the local hospice on a project to develop end of life care champions for homeless people.

Access to the right care at the right time

- Community specialist palliative care in patient's own homes was provided by the local hospice who were aligned with the district nursing teams in each locality. Staff reported that this service was accessible and that hospice staff were responsive to patient's needs and the support needs of community nursing staff.
- Referrals were prioritised based on assessed patient need. Staff, patients and relatives consistently reported that the community nursing teams were able to respond

quickly to end of life care issues as these were prioritised as part of daily work activities. The organisation did not have data specific to end of life care relating to this.

- The multi-visit end of life care service provided healthcare assistant support for patients being cared for at the end of life in their own homes. The service provided combined Plymouth Community Healthcare and Marie Curie care workers to deliver care to patients at the end of life who needed that level of support. Staff told us this service enabled patients to be discharged to their own homes more quickly at the end of life. We were told that the service, along with other local services, such as a hospice based crisis team available to deliver 'crisis' care for up to 72 hours, made it easier for patients to be cared for at home.
- Patients we spoke with told us staff were responsive to their needs. We spoke with families who had accessed the service for patients at the end of life and they told us that the community nursing and out of hours teams were consistently quick to respond to changing needs.

Learning from complaints and concerns

- We viewed one complaint that had been made that had been identified as relating to end of life care. We saw that the complaint had been investigated and staff told us that any issues raised relating to complaints were generally discussed openly within the relevant teams to identify learning and changes in practice.
- For example, one staff member told us that a complaint relating to the responsiveness of the out of hours service had resulted in a review of the information shared regarding response times to reduce the risk of misunderstandings. Information had been updated as a result on the out of hours service website and in terms of the information leaflets given to patients and relatives.
- A quarterly patient experience report was compiled by the organisation. It reviewed a range of information from patients and relatives including complaints, compliments and results of feedback and survey reports. The report was broken down into different areas and services. We saw that end of life care was included in this report as a service although we did not see specific data that related to end of life care.

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 rated end of life care as requires improvement because;

- There was no completed end of life care strategy for end of life care.
- There was no lay person or non-executive director overseeing end of life care and end of life care was not discussed at board level meetings.
- Quality measurement in relation to community end of life care services was limited and there was no clear plan for measuring or improving the quality of end of life care in relation to patient outcomes.
- Governance procedures were not fully established in relation to the safety and effectiveness of end of life care services.

However;

- The end of life and service leads were respected by staff. They were knowledgeable about end of life issues and priorities.
- There was clear, motivated and enthusiastic leadership at service delivery levels within the organisation.
- There was evidence of innovative practice in end of life care with clear examples of initiatives to improve care for patients
- There was good collaborative working with other providers to improve end of life care through joint working within the locality. Overarching plans to develop a strategy and specific end of life care guidance were in discussion stages within this context.

Detailed Findings:

Service vision and strategy

- Staff were aware of the vision and strategy for the organisation, for example, around ensuring that people were cared for at home where possible.
- In relation to end of life care staff consistently articulated a clear aim in relation to patient choice and decision making with regards to their care. However, the organisation had yet to formalise their vision or strategy.

The professional lead for the service told us this was something they planned to address through the development of the end of life care forum that had been launched at the beginning of the year.

- Plymouth Community Healthcare was represented in terms of locality meetings where strategic discussions about service development across all providers were held. We viewed minutes from these meetings and saw that there was a clear relationship between this group and the CCG in relation to strategy development.

Governance, risk management and quality measurement

- Governance arrangements were in place to enable the effective identification of risks, monitoring of such risks and the progress of action plans. There were risk registers in place for both organisation-wide end of life care and community adult services. We saw one area of risk identified relating to end of life care and working arrangements between Plymouth Community Healthcare and Marie Curie through the delivering of the joint multi-visit team providing end of life care in patients' homes. Risks had been identified and specific action taken to mitigate them, including the development of joint working arrangements and clear reporting structures.
- Quality measurement within community end of life care services was limited. There was little evidence of quality audit or focus on continuous improvement of these services. However, we did see that areas specific to end of life care had been considered in relation to quality measurement and development. For example, at Tavistock hospital we saw that senior staff had developed a framework to review care after death, where the quality of care was reviewed. We were told there were plans to share this work across the organisation.
- We saw that the organisation's end of life care lead was actively involved in a locality group where quality issues were discussed. However, we did not yet see how this was translated into activities within Plymouth Community Healthcare. For example, we saw that issues around the quality of treatment escalation plans (TEPs)

Are services well-led?

was discussed at these locality meetings and we saw some evidence of audits of TEPs being started at Tavistock hospital. However, we did not see a clear plan for how this would be taken forward within Plymouth Community Healthcare to ensure quality improvement.

Leadership of this service

- The professional lead for adult nursing within the organisation was also the lead for end of life care. They had a profile for end of life care both within and outside of the organisation and we saw that they were actively engaged with end of life care developments and projects, working collaboratively with other organisations. .
- We observed clear leadership from the end of life care lead and other staff in leadership roles within the organisation, both in community and inpatient settings. There was a good deal of enthusiasm and prioritisation for good quality end of life care.
- All staff we spoke with in leadership roles had a good understanding of the importance of high quality end of life care and we consistently heard from staff that end of life care was prioritised based on patient need.
- We also saw that leadership for end of life care at local and service levels had led to the development of end of life care initiatives across mental health and specialist services.
- However, in the absence of an end of life care strategy and clear leadership for end of life care at board level, it was unclear how the leadership elements of the service were working together to ensure that end of life care was developed across the organisation as a whole.

Culture within this service

- Staff we spoke with demonstrated a commitment to the delivery of good quality end of life care. We observed staff delivering care to people at the end of life in a way that was consistent with the organisational vision of supporting people to be safe, well and at home.
- There was evidence that the culture of end of life care was centred on the needs and experience of patients and their relatives. For example, staff consistently told us they felt able to prioritise the needs of people at the end of life in terms of the delivery of care.

- We observed good collaborative team working across services and organisations in relation to ensuring patient care was prioritised. We also saw that there were opportunities for staff to learn and develop in relation to end of life care.
- Staff worked together to ensure that patients at the end of life could be cared for in their preferred place of care where possible.
- Staff said they worked well together as a team and staff morale was generally good. However, staff shortages in some teams impacted on staff morale at times.

Public engagement

- A quarterly meeting of the service user and carer engagement forum enabled service users and carers to influence the future direction of the organisation and to be involved in the debate of relevant issues.
- Patients were able to feed back their views on the services provided via the friends and family test to say if they would recommend the service. For example, we saw that information displayed at Tavistock hospital included friends and family test feedback of 98.97% of patients who would recommend the service.
- People were encouraged to share their experiences. We saw evidence of patient comments being responded to. For example, at Tavistock hospital where there were a higher number of patients at the end of life, comments requesting a cooked breakfast had been responded to by implementing a cooked breakfast two mornings a week for patients on the ward.
- There was no bereavement follow up survey sent to families of people who died under the care of the community nursing or inpatient services. However, a quarterly patient experience report looked at all patient and family feedback sources including friends and family test results and analysis of all complaints. This included feedback relating to end of life care services although we did not see this specifically in the report we viewed.

Staff engagement

- There was a staff forum where representatives of different teams and staff groups met regularly to discuss staff concerns and suggestions. These issues were then discussed at board level.

Are services well-led?

- Staff we spoke with told us they felt they were able to contribute to the running of and development of the organisation, raise concerns and that they felt listened to by managers and members of the executive team.
- The end of life care champions forum was a group meeting that provided an opportunity for staff who had attended the champions training to contribute to end of life care across the organisation. Staff that had a specific interest in end of life care were also able to attend the meetings and contribute.

Innovation, improvement and sustainability

- The end of life care champions course provided an opportunity for staff working within general community services to develop skills in relation to end of life care and share this experience with colleagues to improve services for patients at the end of life. There was a culture of innovation in end of life care as a result, particularly in relation to end of life care for people with learning disabilities, those with drug and alcohol dependency and those who are homeless.
- Specific areas of innovation included the development of bereavement support and advance care planning initiatives for people with a learning disability. This came about from issues identified by members of the learning disability team who saw that people with a learning disability were not always supported through bereavement in a holistic and person-centred way. In addition, they identified that people with a learning disability did not have the same opportunities to plan for the end of their life in the way that gave them a voice in their future care. With this in mind staff within the learning disability team had developed advance care planning tools that would help them and staff working in other services to better support people in planning their care.
- Staff working within the drug and alcohol services had developed initiatives around improving end of life care by opening up conversations and focusing on quality of life issues for those people identified as being at risk of dying. In addition, they were developing support services around support for people who had been bereaved as a result of drugs or alcohol. They were currently working with other services to identify end of life care ambassadors to support people who were homeless.

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

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

17 (1) (2) (c) Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided

The provider had failed to ensure that patients were protected against the risks of unsafe or inappropriate treatment in relation to the maintenance of accurate records of treatment escalation and resuscitation decisions.