

The Royal Wolverhampton NHS Trust

RL4

# Community end of life care

## Quality Report

New Cross Hospital, Wolverhampton Rd,  
Wolverhampton WV10 0QP

Tel: 01902 307999

Date of inspection visit: 2 - 5 June 2015

Website: [www.royalwolverhamptonhospitals.nhs.uk](http://www.royalwolverhamptonhospitals.nhs.uk) Date of publication: 03/09/2015

# 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)
RL4X2	The Royal Wolver Hampton NHS Trust Community Services		







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

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

Where applicable, we have reported on each core service provided by The Royal Wolverhampton NHS Trust and these are brought together to inform our overall judgement of The Royal Wolverhampton NHS Trust

# Summary of findings

## Ratings

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

# Summary of findings

## Contents

### Summary of this inspection

	Page
Overall summary	5
Background to the service	6
Our inspection team	6
Why we carried out this inspection	7
How we carried out this inspection	7
What people who use the provider say	7
Good practice	8
Areas for improvement	8

---

### Detailed findings from this inspection

The five questions we ask about core services and what we found	9
---	---

---

# Summary of findings

## Overall summary

Good

Overall we judged 'End of Life care that people received as good.

Strategies had been developed for improving the end of life care that people received and teams worked together to ensure people were cared for in their preferred place of care.

The trust had introduced a new approach to providing care for people in their last days of life. This was being implemented across hospital and community nursing services (CNS) and aimed to integrate care at the end of life across the whole service. The new approach replaced the Liverpool care pathway following the 2013 review entitled 'More care less pathway'. Providers were required to replace the Liverpool care pathway by July 2014. The trust were rolling out the new approach by training up to 50 staff a month and identifying staff who could act as champions who would support implementation.

People's needs were anticipated and care plans were put in place to assess and meet their needs. Effective pathways had been developed for referrals and discharging people who wished to be cared for at home. The pathway for discharging people home quickly was designed to ensure community nursing staff were able to meet the person's needs before they were discharged. For example, there were processes in place to ensure the person had the medicines and equipment they needed.

The care provided was evidence based and clinical guidelines had been put in place which had been developed by groups of expert clinicians. These ensured patients received high quality, effective care. The professional nurse lead for palliative care was responsible for ensuring hospital and community services followed national policies and guidelines. Records were fully available to the Multi-Disciplinary Team (MDT) involved in care. Patients could access qualified staff at night and a night sitting service could be provided.

Community nursing service staff (CNS) spoke passionately about caring for people at the end of life and showed compassion for the person and their family. There were processes in place to enable the CNS staff to assess and monitor the person's emotional needs as well as their physical needs. There was a strong culture of reporting and learning from incidents. The service responded to identified risks and maintained a risk register. The service also anticipated risks for example the cover required in the event of severe weather.

The service reviewed CNS staff caseloads to ensure the service had sufficient capacity to care for people at the end of life. Team leaders discussed workload and were able to provide cover within teams and cover for each other by staff working extra shifts.

Patients spoke positively about being able to contact the service when they needed to. They appreciated having one number to call and being able to speak with staff who were helpful and polite. Some patients would have preferred an approximate time in the appointment day.

CNS staff were released to attend role specific and mandatory training.

CNS staff spoke highly about their managers and said they felt well supported. Community staff who cared for people at the end of life were supported to cope with the emotional challenges when a patient had died. They also felt well supported by the specialist palliative care team based at the hospice.

Managers and staff told us there was a clear commitment to service improvement and innovation.

We spoke with a total of 26 patients in the community, six relatives, 17 community nurses, four healthcare assistants and two palliative care consultants. We also reviewed six sets of patient records.

# Summary of findings

## Background to the service

Care for people at the end of life was provided by general community teams of District Nurses, Community Nurses, Community Matrons and Healthcare Assistants. Community teams had received training specifically to care for patients at the end of life. Specialist palliative care staff based at Compton Hospice provided community staff with training and advice. Community staff could access advice out of hours. End of life care training was provided for new staff as part of their induction. Community staff felt there were effective working relationships between teams based in the hospital, hospice and community.

Care was provided in different settings: the patient's homes and residential and nursing care homes.

We observed CNS staff when they visited patients in their own home, in nursing homes and on the wards at West Park Rehabilitation Hospital. We also visited Bilston Health Centre and Primrose Lane Health Centre; two of the three locations community staff were based.

CNS staff were able to provide people with a range of care packages depending on their needs. Care was provided for up to twelve months for people who were in the final year of life. A package of care including personal care could be provided for people in the last six weeks of life and there was a package of care for people in the last 72 hours of life who requested to die at home.

The CNS is provided for a population of approximately 239,000 people across the City Of Wolverhampton. Services are organised into three localities. The service was provided from three community bases across the City. The current community end of life service was set up in 2011.

## Our inspection team

Our inspection team was led by:

**Chair:** Karen Proctor, Director of Nursing Guy's and St Thomas' Hospital NHS Foundation Trust

**Team Leader:** Tim Cooper, Head of hospital Inspection, Care Quality Commission

The team included CQC inspectors and a variety of specialists: who were a Medical Director, an Executive Director of Nursing & Quality, a Designated Nurse for Child Safeguarding, a Consultant Physician in Diabetes & Endocrinology, a Consultant in Clinical Oncology, a Outpatients Doctor, a Consultant in Palliative Medicine, a Consultant Orthopaedic Surgeon, a Consultant, formerly Emergency medicine, a Consultant Obstetrician & Gynaecologist, a Consultant in Intensive Care & Associate Medical Director, a Paediatrician and a FY2 (Junior Doctor), a Clinical Nurse Specialist Older People, a Staff

Nurse - End of Life Care & Oncology, a Renal Specialist Nurse, a Principal Radiographer Head of Imaging and Equipment Services, a Surgery Nurse Midwifery, a Senior Staff Nurse Senior management / Nurse - Paediatrics and child health and a student nurse.

The specialists advisors who worked with our community teams had experience: Community Children's Nurse, a Senior Health Advisor for Looked after Children, a Registered Nurse - Nursing and clinical care both acute and primary care, leadership/management & governance systems, a Service Manager District nursing and two Nurses Palliative Care.

There were three experts by experience who were part of the team, they had experience of using services and caring for a person who used services.

# Summary of findings

## Why we carried out this inspection

We undertook this inspection as part of our commitment to review all acute and integrated trusts by March 2016. This service was scheduled sooner because it had incorporated services from the now dissolved Mid

Staffordshire Trust and we wanted to assess the impact of that. It had previously been part of the initial wave of inspections which was pre ratings which was also an consideration in scheduling this inspection.

## How we carried out this inspection

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

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

'Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 02, 03, 04 and 05 June 2015. During

the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists and non-clinical staff. We talked with people who use services both on the day and prior to the inspection during advertised listening events. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced between the dates of 08 to 19 June 2015.

## What people who use the provider say

We spoke with 26 patients and relatives who had used the service. One person said, "Staff were caring and respectful. They said they would know how to make a complaint if they were unhappy and would feel confident to make a complaint if required. They said, "Having one contact number was very helpful. They said, "All in all an excellent and caring service."

One person's relative we spoke with told us "All the staff are really approachable I can't fault them. You can discuss just about anything with them and they will respond. I have always been treated with dignity and respect when they visit. They have been coming to visit three times a week."

Another person said, "They are all great, they explain everything and give me choices. My family all work so they don't worry so much now that I have all these services."

A relative said the community nurse who visited was kind, helpful and patient and explained everything fully once

hundred percent better than the hospital. They said the hospital palliative care team had been great too. They said if they were aware of the role of the Patient Advice and Liaison Service (PALs) and would raise any concerns.

One person we spoke with told us visits planned by the team did not always happen. They said when they contacted the office their name was on the computer but was not always included in the list of patient visits. They said the nurses were fantastic and worked to overcome any problems they encountered."

Another person we spoke with told us the service was,"brilliant". They were not sure how they would make a complaint and said they couldn't imagine having to because the service was excellent.

One person who used the service told us staff are very good and very responsive to my changing symptoms. They said, "They come and visit me at home if I can't go to the clinic." They said, "It was great to be able to talk to a person when you phone."

## Summary of findings

One patient said the community nurses were very nice people but were always short of dressings which meant they had to come back again or had to wait for things to come in." They said, "I wait all day and no one turns up. Or two will turn up separately on the same day. They all seem to have different ways of working and make you feel as if they know best. They said it would improve the service, "if they were able to give me a date and time for the visits".

Another person said the community nursing service was wonderful and staff were always polite, helpful and full of advice and support. They said, "they always come when they said they would and said I should ring up if I have any problems and if I ring up they respond really quickly".

One person said, "Staff are very accommodating and very nice and very helpful. They told us "I feel involved in my care plans and wouldn't change anything about the service."

## Good practice

The care package provide for people in the last six weeks of life which provided intensive health and personal care from a team who were able to provide continuity and recognise and respond to people as their needs changed.

The effective structure and working relationships in place which combined the expertise of district nursing with specialist palliative care knowledge and advice to provide effective care for patients at the end of life.

CNS staff were asked to provide detailed feedback on areas of improvement to the 72 hour end of life pathway to improve hospital discharge processes.

## Areas for improvement



# The Royal Wolverhampton NHS Trust

## Community end of life care

### Detailed findings from this inspection

Good 

## Are services safe?

By safe, we mean that people are protected from abuse

### Summary

Adult community nursing staff understood their responsibility for making sure patients were protected from the risk of harm through unsafe or inappropriate care.

CNS staff reported and analysed incidents to learn from them and make sure they did not happen again. The trust's governance arrangements included mechanisms for discussing incidents and ensuring the appropriate action was taken to improve the safety of the service. The service carried out audits to review clinical practice and make changes to improve patient safety.

The service also actively reviewed procedures to identify improvements and ways of reducing risks.

Guidelines were in place for ensuring medicines were administered safely using electronic pumps and for organising the anticipatory medicines people might need when being discharged from hospital and cared for at home.

CNS staff knew about the arrangements in place for protecting people against the risks of abuse and said they would not hesitate to raise any concerns they had about people's safety.

The CNS teams worked together to review their workload weekly. On occasions community staff would help another team when there were staff shortages or one team had more people who needed care. We saw that when things went wrong staff apologised and explained what had happened. There was a commitment to openness and transparency.

### Incident reporting, learning and improvement

- We spoke with one member of staff who told us CNS staff were encouraged to report incidents and near misses. They said staff knew if they had made an error they would be held to account but there was not a blame culture. They said staff understood it was their professional responsibility to protect people from risk by reporting any incidents which might result in harm. We saw that staff recorded incidents using a computer system which enabled incidents to be analysed across the trust. This meant risks and trends could be identified to allow comparisons within the trust and with other similar services.
- During the inspection we observed an incident whereby a member of staff realised they had made an error with a person's medicines they were about to administer. The nurse realised the potential error, apologised and

## Are services safe?

explained what had happened before replacing the medicine with the correct dose. The incident was immediately reported as a 'near miss' and recorded on the trust's incident reporting system. We discussed the incident with the team manager who told us they would undertake a root cause analysis to identify precisely what had happened and what the service could learn from the incident.

- Incidents were discussed at the 'concise' locality governance meeting where they were reviewed and the actions agreed were tracked to make sure they had been implemented. Staff we spoke with said the locality governance meetings were a good way to ensure that lessons learned were embedded into clinical practice. We saw records of lessons learned from incidents for example drug alerts..
- There had been no incidents reported for the palliative and end of life service in the last four months. It was difficult to identify incidents for the service because the service was provided as part of the integrated community service. The need to separately identify incidents for the service had been recognised. The lead nurse for palliative care was working with colleagues in clinical governance to develop a palliative/end of life section within the incident reporting system to allow incidents to be more easily identified and analysed.

### Duty of Candour

- We saw a leaflet in one of the locality bases we visited which had been produced by the trust for staff and explained what staff were expected to do if an incident occurred which might have caused harm to a patient. The leaflet described the processes staff should follow including providing the patient with information after the investigation. We spoke with two members of staff who were aware of their responsibilities. They told us they had discussed their duty of candour responsibilities at a team meeting and would ask their manager for guidance if they were unsure.

### Safeguarding

- We asked CNS staff about the arrangements in place for protecting people against the risks of abuse. Staff told us a head of safeguarding had recently been appointed to provide leadership for the safeguarding team. The director of nursing was the executive lead for safeguarding.

- Some CNS staff we spoke with told us they were not up to date with safeguarding training but stressed they understood the processes within the trust. Training records showed that 99% of staff had completed safeguarding training.
- We saw posters in community locality bases highlighting who to contact when community staff had concerns about a person who might be at risk of abuse

### Medicines

- The service used guidelines for pain and other symptoms. These had been developed by an expert advisory group of palliative care consultants based in the West Midlands. Staff told us the guidelines provided helpful information for providing effective patient care. Guidelines had also been developed to support anticipatory prescribing which staff could access on the trust intranet.
- Community nursing service (CNS) had access to nurse prescribers. The teams had two non-medical independent prescribers and eight community matrons were nurse prescribers.
- We saw guidelines which had been developed for the safe infusion of prescribed medication for electronic pumps. The guidelines were based on information from the Royal Marsden Hospital Manual of Clinical Nursing Procedures (8th Ed) and had been developed by the West Midlands palliative care physicians.
- The CNS held their own stock of syringe pumps used to administer people's medicines which could be deployed quickly when needed. Records of the pumps were held on the services equipment inventory to ensure they were serviced and maintained.
- An audit had been carried out in February 2015 on the completion of syringe driver monitoring charts. The audit identified that changes were needed to clinical practice and improvements to the monitoring documents. The audit had resulted in changes to refresher teaching and new documentation had been implemented. The audit showed in the community setting 100% of syringe drivers were checked at every visit by a qualified nurse.

### Environment and equipment

## Are services safe?

- Services were provided to patients in their own home. Specialist equipment was provided for people by the Independent Living Service usually within 24 hours of being requested. One person told us, “I was very impressed. I was assessed at home one day and some of the equipment came the next day”.
- CNS staff told us they had experienced difficulties recently obtaining a bed with an air flow mattress for a patient. They told us they had not been able to obtain a bed for a patient but had instigated the escalation process which meant a suitable bed had been found for the patient by four o'clock on the same day the request had been received.
- CNS teams held a store of some small items of equipment they could provide immediately for patients. This included electronic pumps for administering medicines. We saw items of equipment held in community bases had been checked and the necessary servicing had been completed.

### Quality of records

- People's needs were fully assessed and documented. Records were fully available to the Multi-Disciplinary Team (MDT) involved in people's care. CNS staff recorded information their visits. A copy was left in the patient's home and the community nursing service (CNS) updated the main care records held in the locality bases. There were daily records of the care provided for people who were in the last few days of life. This enabled people's care to be closely monitored with information passed to other members of the team to provide continuity.
- We reviewed the records of six patients who had used the end of life service. We found the records clearly documented the person's needs and there were clear plans in place for the person's care. Key documents for example Do Not Attempt Pulmonary Resuscitation (DNACPR) notices were in place and had been completed appropriately. This meant emergency services were aware the person did not wish to be resuscitated if they experienced a cardiac arrest.

### Cleanliness, infection control and hygiene

- We observed CNS staff follow procedures for reducing the risk of infection when visiting patient's homes.

- When equipment loaned to patients was returned to the Independent Living Service it was checked and cleaned before issuing to other patients.

### Training including mandatory training

- Staff told us they were supported to receive the training they required. They said training time was protected and they were released to attend.
- There were systems in place for alerting staff about any training they required. Staff could access their training records and check what training they needed.
- We saw a staff training board in the staff bases which showed which staff were due to undertake statutory and other training. Staff told us they had personal development plans which identified their future training needs. These had been identified during staff supervision and appraisal meetings. The trust supported staff who requested further support or training including degrees and study at master's level.
- Information supplied by the trust showed compliance with mandatory training was high for both trained nursing staff and healthcare assistants. For example 95% of staff had received training in basic life support and 100% for manual handling.
- Appraisals rates also showed a high proportion of community staff (90% plus) were receiving feedback and their training and development needs were being reviewed.
- CNS staff who provided care for people at the end of life had also completed training in care of the older adult March 2015, Healthcare Assistants had completed a development course in 2014. Training had been provided through the band 7 and 8a nurses forum on breaking bad news, care after death and the rapid home to die care bundle (24/2/15).
- An end of life care and bereavement study day was held monthly which was available to all trust staff. CNS staff accessed training on breaking bad news using a computer based e-learning training package. A 'Rapid Home to Die' education and training program was being rolled out to all staff working in the trust. Staff told us they were aware all staff needed to undertake the training and we spoke with three staff who had completed it.

# Are services safe?

## Assessing and responding to patient risk

- We saw the locality team meetings minutes which showed that incidents and risk assessments had been discussed. Risk assessments had been completed for nutrition, hydration and pressure ulcers. Falls risk assessments were completed if the person had a history of falls.
- We observed the community staff handover in two locality bases where clinical and other risks were discussed. Staff discussed one person's risk of falling and the need for occupational therapy staff to assess the person at home and in the garden. Access to another person's home was discussed in terms of the risk to the patient and community staff. Community staff we spoke with recognised the importance of identifying and reducing risk to patients.
- We saw from the notes of previous handover meetings that risks were regularly discussed and actions to mitigate risk agreed.

## Staffing levels and caseload

- A system was in place for reviewing community staff's caseloads to ensure patients who no longer required the service were discharged. This meant the service could free up capacity for new referrals and manage the existing caseload. The service carried out caseload reviews to identify which patients could be taught to successfully self-care. This meant people were reviewed to check the level of support they needed from the service.
- Consultants specialising in palliative care and end of life were based in the hospital and the hospice. The consultants and medical staff based at the hospital provided cover for each other during sickness and annual leave. A palliative care specialist registrar was also a member of the specialist palliative care team. The consultant in the hospice who provided support for community services also worked within the hospital. Both consultants participated in the 24 hour advice on call service. Clinical nurse specialists based at the hospice also took calls from community patients known to them up until 10pm and calls from health care

professionals needing advice 24 hours. The specialist palliative care team in the hospice and the community cared for patients with cancer and a wide range of other conditions.

- We observed two community teams daily handover meetings. CNS teams met daily at each shift handover to discuss the current caseload and agree any changes to the care provided. This included making referrals to other services for example occupational therapy for people who required a home assessment for any equipment or adaptations they might need.
- The service used a computer based scheduling system which held information about the skills and competencies of staff. The system allocated staff to patients for appointments using information about the member of staff's capacity, competencies and skills. Some staff we spoke with told us the system did not always allocate long enough appointments for visits. They said the system also on occasions allocated more than one member of staff to visit the same patient. On the day we visited one team two staff had been to see the same patient. Senior staff tried to prevent this happening but were not always aware more than one visit had been planned until after the event.
- Some staff told us they did not have enough time to record the information they needed following their visits. Team leaders we spoke with were aware of some of the problems and said they were working closely with the trust's IT team to address these.

## Managing anticipated risks

- A risk register had been developed for community services which was regularly updated. CNS staff anticipated and discussed potential risks at their daily handover meetings. There were no risks identified specifically relating to end of life care during our inspection.
- We observed two community nurse handover meetings and heard risk and other patient safety issues being discussed. This meant there were systems in place for informing community staff about risks to patient safety.

## 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

Evidence based care was provided for people receiving end of life care. We saw evidence of national standards being used and best practice being identified and used to develop how services and care were delivered. This included evidence from the National Institute of Clinical Excellence (NICE) and more local groups of expert clinicians who collaborated to develop clinical guidelines.

CNS staff were well supported with training and development. Trained and untrained staff received end of life training provided by the specialist palliative care team as part of their induction. Regular training updates were provided and staff were able to access higher training to extend their skills and expertise.

CNS staff worked closely with colleagues in the hospice, the hospital and primary care to ensure people at the end of life received high quality, well-co-ordinated care.

CNS staff had a good understanding of the Mental Capacity Act 2005 and acted to make sure people received the care they needed if they lacked the capacity to make certain decisions.

### Evidence based care and treatment

- The lead nurse for palliative care was responsible for monitoring and reviewing standards within the palliative care service to ensure care was based on evidence based practice and complied with national guidelines.
- The service had adopted a number of clinical guidelines which had been developed by the Greater Midlands Cancer Network (GMCN). These included guidelines for the core specialist palliative care for multi-disciplinary review and needs assessment, the co-ordination of patient's palliative care and for the palliative care telephone advice service. We saw services were being provided in accordance with relevant national guidelines for examples Five Priorities of Care. There was a weekly virtual ward round led by a consultant who specialised in care of the elderly who provided community staff with advice about the particular needs of older people.

- We observed members of the Homes In reach Team (HIT) support the nursing staff in a nursing home to care for people at the end of life. The HIT team had been set up earlier in the year on a trial basis and subsequently implemented substantively following an evaluation of the benefits. The service had successfully helped people living in nursing and residential homes to receive care in their preferred place of care at the end of their life and prevent admissions to hospital.
- CNS teams used the Walsall Community Pressure Ulcer Risk Assessment Calculator to assess the risks of patients developing pressure ulcers. We saw examples of completed assessments in four sets of records and saw staff had provided people with advice about regularly re-positioning themselves in bed and drinking fluids to reduce the risk of developing pressure ulcers.

### Pain relief

- The service had clinical guidelines in place for pain management and symptom control. These had been developed by an expert advisory group of palliative care consultants based in the West Midlands. We spoke with a relative who told us CNS staff checked regularly to make sure the person was not experiencing pain. Community staff told us the guidelines provided effective advice for managing people's pain primarily through the use of medicines for controlling pain. This meant people's pain and other symptoms could be managed effectively.

### Nutrition and hydration

- We observed community staff discussing nutritional and hydration needs with people as part of the assessment process. We asked community staff about the guidelines in place for staff to follow. Staff told us they used the Malnutrition Universal Screening Tool (MUST). This was recommended by NICE as the tool to be used for assessing people's nutritional needs and protecting people from the risk of malnutrition.



## Are services effective?

- We saw examples of nutritional risk assessments in all six patient records we saw. This meant community staff were aware of the potential risk of malnutrition and used a tool effectively.
- We asked CNS staff about oral care and they told us they were aware of the importance of mouth care and carried packs for moistening people's mouths. They said they had received training in oral care as part of their end of life training. One member of staff told us they used fruit juices and herbs to clean and stimulate people's palates. We saw from training records that community staff had also completed nutrition training. Information about food and drink was included in the information leaflet 'care and support in the last days of life'. The information described how people's needs should be individually assessed and the choices people could make. The care in the last days of life pathway included a section for recording the person's wishes regarding food and drink.

### Technology and telemedicine

- CNS staff had the skills and training to support people who required electronic pumps at home. We spoke with a senior nurse who told us they were responsible for training community staff to use the equipment. We saw there was a log of staff who had received the training and were competent to use the equipment. They said there were pumps located in community team bases which were used for training and they had been trained in teaching other community staff.
- One member of staff told us about an incident where an out of hours GP had visited a patient but had not realised the patient was nearing the end of life; they had not received a message about the medicine they needed. The community nursing team ensured the person received the medicine they needed by liaising with the person's GP. A consultant in community palliative care told us they were working on an IT based solution to address this problem which meant the out of hours service could access clinical information about patients at the end of life.
- The service used a computer based staff scheduling system for allocating staff to patient visits. The system held information about community staffs skills and competencies. This enabled staff to be appropriately allocated to meet patient's needs.

### Patient outcomes

- Following the implementation of an end of life care strategy across the local health economy between 2009-2013, deaths in hospital in Wolverhampton reduced from 62% to 57%. The Trust was still amongst the 20% of trusts with the highest number of deaths in hospitals. The trust has been developing initiatives aimed at helping people to die in their preferred place of care.
- Nationally, the proportion of non-cancer patients receiving palliative or end of life care has increased from 3% in 1998 to 11% in 2011. The trust's figures suggest the proportion of patients referred to the palliative care team with a diagnosis other than cancer reached 30% in 2014-15, significantly more than the reported national average. The trust had therefore developed a strategy in May 2015 aimed at achieving further improvements in palliative and end of life care across the trust. The objectives for the strategy were to increase the number of people receiving care in their preferred place of care.
- CNS staff participated in monthly forums to discuss clinical practice. The forums were also used for education events for example updates on palliative care and end of life. Staff told us information from the forums was cascaded throughout the team and discussed in team supervision sessions.

### Multi-disciplinary working and coordinated care pathways

- Patients and staff told us there were good communications between the community nurses, doctors, the hospice, care homes and GPs. We observed a member of the community team organise one person's medicines during a home visit. The nurse rang the person's GP surgery and organised the medicines so that they could be dropped off at the person's home later that day.
- We spoke with a healthcare assistant who provided people with personal care for up to six weeks. They told us the service had been developed to ensure the person received person centred care from the same team. They said they had received good professional support from colleagues when a patient they had cared for died. They

## Are services effective?

had received training from specialist palliative care staff to support people at the end of life and could access advice and guidance from other members of the team when necessary.

- We observed a multidisciplinary team meeting being arranged for a palliative care patient, in the patient's home. The meeting was planned to involve the patient, the patient's family, domiciliary carers, speech and language therapists, district nurses, occupational therapists, palliative care nurses and social services. This meant that a holistic package of care and treatment could be arranged between all the services, with the patient's knowledge and consent, and that any potential issues could be resolved between the agencies at the same time. This would result in a better service for the patient.
- A social worker/ community care assessor was responsible for carrying out community care assessments of the patient prior to discharge from hospital, involving the patient and their family. They provided carer assessments and organised social care packages to ensure safe discharge home. They were also able to provide advice on welfare benefits for patients and community staff.
- The service held specialist palliative care multi-disciplinary team (MDT) meetings weekly to discuss the care patients required. We observed community staff discuss one patient they planned to refer to the MDT for advice on symptom control. We saw the notes of MDT meetings where patients had been reviewed. The decisions made took the person's condition and their home situation into consideration as part of the decision making process. We saw for example one person's family did not feel able to support the person at home and it was agreed the service would arrange care in a hospice or a care home.
- We saw a pathway which had been developed for children and young people which ensured they received appropriate palliative and end of life care. Medical and nursing staff described three situations where hospital and community staff in children and adult services had worked together to support children and young people at the end of life.
- An advanced nurse specialist identified patients in hospital who required end of life care in the community.
- There was a part time rapid access end of life facilitator who assisted with patient's discharge if the person wanted to return home, a care home or to the hospice to receive end of life care. Staff told us the service had developed plans to extend the rapid discharge facilitator to a seven day role which they planned to implement.
- An audit had been undertaken in November 2014 to review practice around end of life decisions. The audit found the majority of patients (79%) had a ceiling of care documented but of those who responded only 29% discussed their preferred place of care at the end of life or their specific wishes regarding their end of life care. The results of the audit had been used to inform the development of the services 'rapid home to die' care pathway which the service was now piloting. The pathway for discharging patients at the end of life from hospital to home quickly had been developed. The objective was to facilitate a safe, timely and well coordinated discharge home for patients who were imminently dying and expressing a wish to die at home or in a nursing or residential home. The pathway was designed to return patients home within 24 hours, ensuring the appropriate services were in place to support the person.
- Prior to rapid discharge taking place the CNS was made aware of the impending discharge and confirmed they were able to support the patient to die at home. The environment needed to be suitable with the necessary equipment in place, medications had to have been reviewed, prescribed and dispensed ready for discharge and suitable transport booked. Feedback was requested from the community teams about any problems encountered during the rapid discharge process to make further improvements to the process.
- The trust had developed SWAN champion roles to promote the pathway which had been developed for care in the last days of life. This pathway was also known as the SWAN pathway because of the logo used by the service. We spoke with a SWAN champion who worked in one of the community teams. They told us they had received training in the use of the SWAN policies and practices and continued to be involved in the development of the approach. This included

### Referral, transfer, discharge and transition

## Are services effective?

working with their team manager to ensure staff received the necessary training and support to ensure people on the pathway were followed up and people received appropriate care in the last days of life.

- Referrals were made to other specialist palliative care services via completion of service specific referral forms and via telephone referral to the Wolverhampton Urgent Care Triage and Assessment Service (WUCTAS) for other community services for example the 'Heatun' social support service, occupational therapy and clinical psychology.
- There was a process to identify capacity for new referrals. The CNS met daily at each shift handover to discuss their current caseload and agree any changes to the care offered. This included making referrals to other services for example occupational therapy for people who required a home assessment for any equipment or adaptations they might need.

### Access to information

- We saw the service had developed a leaflet for the patient and their family to explain what care and support they could expect in the last days of life. The leaflet described the symptoms the person might experience and the help the service could provide to alleviate the symptoms. The leaflet stressed the importance of reviewing each person's needs individually. If the person was being cared for at home and required an electronic pump to supply medicines, the leaflet described how the district nurses would set up the equipment and how medicines would need to be collected from the chemist.
- The place of care in the last days of life section described what additional support could be provided for example a night sitting service, for patients being cared for at home. The arrangements for meeting religious, spiritual, emotional and cultural needs were

also described. The leaflet contained a section for writing down questions to ask doctors and nurses and provided advice on organ donation. Copies were available in six different languages.

- We saw the notes of multi-disciplinary team discussions concerning people's care. We saw the team considered the person's medical history and any recent diagnosis if the person's condition had changed or they had more than one medical condition. The team discussed the person's medicines and how to manage the person's symptoms including pain. The team also discussed the person's prognosis and if they required a particular pathway to be put in place for example a 72 hour pathway for someone approaching the end of life over the next few days. The person's home situation, the wishes of the family and the person's preferred place of care were discussed. We saw examples of end of life care plans which took all these factors into consideration. We also saw examples of discussions where the team wanted further information, for example from another consultant and arranged to review the person's care plan at the following weeks multi-disciplinary team meeting. People's spiritual and psychological needs were also discussed and present in their records.

### Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We saw examples of decisions made in a person's best interest. These had been made following a mental capacity assessment and discussion with members of their family. People who lacked the capacity to make decisions were assessed and decisions made in the persons best interests to ensure they received the care they needed. We found staff had a good understanding of the Mental Capacity Act 2005 (MCA).
- When we visited the community staff team base we observed staff discussing whether a person required a mental capacity assessment to determine if some decisions needed to be made in their best interest.



## Are services caring?

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

### Summary

Patients receiving end of life care told us community staff were compassionate and caring.

We observed community staff when they visited people at home and saw they treated people with dignity and respect. The service had developed daily monitoring sheets for patients in the last days of life to help monitor their condition closely and adjust their care plan to ensure their needs were met as far as possible.

All the community staff we met showed understanding and concern for the patients they were caring for; they involved patients and relatives in decisions about their care and respected the decisions patients made.

One person said, "Staff are very accommodating and very nice and very helpful. They told us "I feel involved in my care plans and wouldn't change anything about the service."

### Compassionate care

- We observed community nursing staff being caring and compassionate with one person and they responded to their relative's distress.
- One member of the CNS team told us about one person they were visiting several times a day that died at home alone. They told us how upset they had felt about the person dying alone and how the team tried to watch out for someone's condition deteriorating so that the person could be supported if they wished.
- One community team member had become a SWAN champion to promote the trust's policy on providing care and support in the last days of life. They were part of the trusts end of life working group and told us how much they enjoyed contributing to the development of the trusts end of life policies.
- Staff told us their managers and colleagues provided support for each other, for example when they had

cared for a patient who had died. Support was offered as part of supervision with opportunities available for specialist support when necessary. This meant staff were helped to provide emotional support

### Understanding and involvement of patients and those close to them

- We observed one person's needs being assessed. The community nurse carrying out the assessment listened carefully to the person's wishes. The community nurse discussed the risk of the person developing pressure sores and the need for specialised equipment to reduce the risk. The patient understood and agreed.
- On another occasion we observed a patient and their relative being involved in decisions about the person's care and the equipment they needed in their home. Community staff provided people with the information they needed to make decisions about their care. The information was recorded and a copy was left in the patient's home.
- The names of people receiving end of life care were clearly displayed on a white board at the community team base. This meant community staff could see at a glance which patients were receiving end of life care if they were responding to a telephone enquiry for example from a relative or GP.

### Emotional support

- Patients receiving palliative or end of life care with a cancer diagnosis were able to access psychology services. Staff told us they hoped to extend access to psychological services for other patients. A bereavement support service was provided by the hospice.
- CNS staff told us patients could access support through the department of spiritual and pastoral care. They said there were chaplains and volunteer chaplaincy visitors were available for most faiths. The service could be accessed 24 hours a day to listen, help and support patients, families and staff.

# Are services responsive to people's needs?

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

## Summary

People's needs were fully assessed and documented. Records of visits were left in the patient's home and community staff updated the main care records held in the locality bases. There were daily records of the care provided for people who were in the last few days of life. This enabled people's care to be closely monitored with information passed to other members of the team to provide continuity.

Patients could access qualified staff at night if they experienced problems and a night sitting service could be provided.

CNS teams reviewed their caseloads to identify people who could be supported to self-care or who could be discharged when they no longer needed the service. Team leaders also worked together to review team caseloads weekly and some community staff would help another team if they had a high number of people at the end of life requiring intensive support.

## Planning and delivering services which meet people's needs

- We reviewed five care plans and found people's needs had been fully assessed and clear plans developed. We found there was timely identification of people as they approached the end of life. We observed one member of staff discuss the person's consent and document that they did not wish to be admitted to hospital for treatment.
- The service had system of case load reviews in place to ensure patients who no longer required the service were discharged. This meant the service could free up capacity for new referrals. Community teams met daily at each shift handover to discuss the current caseload and agree any changes to the care offered. This included making referrals to other services for example occupational therapy for people who required a home assessment for any equipment or adaptations they might need.
- A personalised care planning document 'My care' had been created by the Royal Wolverhampton specialist

palliative care team which was used to inform patients about the symptoms they might experience and the choices they could make about the care received. The choice patients made were recorded in a written care plan.

- The trust commissioned a service to support older people and people with life limiting conditions to lead active lives in their community and to provide support for carers (Heantun). The service provided advice and guidance about housing, assistance in accessing other services for example housing and support for carers to enable them to have a break. The type of service provided included a sitting service to provide respite, assistance with shopping, small household tasks, spiritual, cultural and emotional support and helping people to get out. We observed community staff discuss how this service could help one person who lived alone and did not often get out of their home. The person was pleased at the prospect of being assisted to visit the shops and the community centre.

## Equality and diversity

- Staff told us cultural awareness training had been provided in the past but not recently. We saw examples of documents produced by the trust.

## Meeting the needs of people in vulnerable circumstances

- We observed one person who had a life limiting condition was reluctant to undergo tests in hospital as they currently cared for a relative who also had a life limiting condition. Community staff explored ways of helping this person to remain at home which included visits from a specialist nurse and support on a daily basis from the hospital at home team.
- We observed a community nurse assess another person's needs. The person was anxious about being left alone at night. The community nurse organised night sitters and arranged for the community team to support the person with personal care. On another visit we observed one person was offered a night sitting service and support from another team.

## Access to the right care at the right time

## Are services responsive to people's needs?

- New referrals were received by the Wolverhampton urgent care triage assessment service (WUCTAS). The details of the person who required the service were recorded and passed to the lead community nurse on call for the service that day. The senior nurse on duty received for the day all the new referrals by fax or telephone depending on the urgency before arranging an appropriate package of care.
- Band seven nurses were all nurse prescribers who were able to prescribe anticipatory medicines. The HIT team nurses worked alongside the district nurses when care home staff needed help to provide the level of care the person required.

### Learning from complaints and concerns

- We spoke with a member of staff from one of the community teams about complaints. They said the trust's policy required staff to try and resolve the complaint as soon as possible within the service. They said this usually involved trying to speak to the person on the phone and if possible or resolving the matter in person. They told us they would apologise to the person, they were aware of the duty of candour and the need to be as open and transparent as possible if anything had gone wrong. They said complaints and their outcomes were discussed at team meetings together with any action the service might take as a result.
- We saw an analysis of complaints which showed five were about appointment times, four were about the care provided and one was about the attitude of a member of staff. The complaints had been investigated and responded to in line with the trust's policy.
- Staff we spoke with was aware the trusts policy on complaints and it was available on the trust's intranet. Staff also said they would encourage people to access advice from the trusts Patients Advice and Liaison Service (PALs) if they had concerns and wanted to complain, especially if they did not want to raise the concern directly with staff.
- Staff we spoke with was aware of the complaints procedure and we saw complaints had been discussed at team meetings. One of the themes which had emerged was timed visits. We saw this issue had been discussed in response to concerns raised by patients. Staff had apologised and explained why it might not be possible to give precise times for visits. One of the team leaders told us they were keeping the situation under review and said the service was trying to respond to concerns raised.

## 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

Community staff told us they felt their role made a difference to patients. They felt the trust and their managers valued their contribution. They said community services had strong visible leadership and managers listened to their views.

There were forums for community staff to meet to discuss issues with their peers and managers. Community staff teams met daily to review patients and raise any concerns with managers. Community staff told us this worked well and they were usually able to resolve concerns quickly.

Some staff were unhappy about the computer system used to allocate patient visits to staff but they said managers were aware of the issues and they were keeping the situation under review. Managers confirmed they were aware of community staff's frustration with the system and they were working closely with the IT department to improve the existing system or replace it.

CNS staff understood the strategy for developing the care people received at the end of life and the role they played in implementing the strategy.

### Service vision and strategy

- The specialist palliative care service had developed a three year strategy for the service in May 2015. This described plans for providing excellence in person centred palliative and end of life care in acute hospital and community settings. The aim was to build on existing services and agree a plan for further improving and developing services.
- The trust wanted to ensure that palliative and end of life care was everyone's business within the trust. The strategy emphasised the importance of developing a culture which strived to consistently deliver high quality, person-centred care to meet the needs and expectations of palliative patients and their families.
- The strategy contained six objectives, supported by an overarching ambition to deliver compassionate care. The strategy provided an overview for each objective and identified the key milestones the service planned to

achieve. The six objectives included: access to care which was safe, excellent assessment, treatment and care, an appropriately skilled workforce, positive patient and carer experience, palliative friendly environments of care and leadership in research and innovation.

- The strategy also emphasised the need to affirm life and treat dying as a normal process, provide relief from pain and other distressing symptoms. Integrating the psychological and spiritual aspects of patient care and offering support to help patients live as actively as possible until death, helping families cope with illness and bereavement were also part of it. Staff we spoke with were familiar with the goals set out in the strategy and supported the objectives.

### Governance, risk management and quality measurement

- The team requested the relative's views of the service six weeks after bereavement. A condolence card was sent to the relative asking for their views. We saw the results were compiled into a quarterly report which was discussed by staff in the service. The response rate to the survey had fallen to below 30% and staff were considering how to improve feedback.
- Management meetings were held every Monday when team leaders met with the senior matron to discuss any incidents and key issues for the week ahead. Monthly performance meetings were also held to monitor the service being provided against the contract and other performance targets. Two of the team leaders we spoke with told us they reviewed the number of end of life patients across each of the three localities to ensure teams were in a position to provide the intense support people needed. They told us staff might provide support for another team which had a high number of end of life patients.
- We asked CNS staff if there were systems in place for staff lone working in the community. They described

## Are services well-led?

how they could telephone the senior nurse on call if they required assistance. They said two staff went out on home visits after 6pm rather than one during the day. A lone workers policy had been developed by the trust.

### Leadership of this service

- Team leaders told us they felt able to raise issues with their manager and that these were usually addressed.
- We observed effective leadership at operational level. Staff we spoke with told us they thought there was good leadership and support at team level.
- We learned that one of the locality teams had previously worked as two teams but been supported to merge to improve the effectiveness of the service. Staff told us they had been supported to integrate the teams and felt a strong commitment to making the new structure effective despite the additional work involved in organising the new team.
- There was effective medical leadership for the end of life service in the community.

### Culture within this service

- We found communications in community services was good and there was effective team work.
- Healthcare assistants told us they had good support from trained staff and if they had any concerns about a patient they could ask for the patient to be reviewed. One member of staff told us about a situation where they had visited a patient to provide personal care. Shortly after they had left the person's relative had contacted them because the person had become very distressed. They said they had contacted one of the trained staff who had visited shortly afterwards and been able to help alleviate the person's symptoms and provide reassurance.
- The inspection team found CNS staff were passionate and committed to providing high quality care for people as they approached the end of life.
- We observed a culture which was open, enabling community staff to contribute to discussions and raise concerns. We observed less experienced staff asking for guidance and support and saw senior staff offer advice. The manner in which advice was offered was supportive and encouraging, not directive.

### Public engagement

- At the team handover meetings we heard staff discuss the comments and concerns raised by patients. The concerns which had been raised were taken seriously and staff discussed what the service could do to respond.

### Staff engagement

- The trust involved staff throughout the trust in giving feedback through a staff survey 'Chat back'. The trust provided us with information from the 2014 survey results for community services which showed the response rate was slightly lower 22% in community services than the trust average of 22.6%. 80% of community staff who responded felt they understood their role and how it contributed to what their department was trying to achieve. 89% felt good practice and continuous improvement in patient safety was the responsibility of all staff within the department.

### Innovation, improvement and sustainability

- We asked community staff about innovation and service improvement. One member of staff told us they were involved in a project for community staff that would enable staff to request prescriptions and equipment using a hand held device.
- The specialist palliative care service was taking part in a research trial to investigate the benefits of hydration in cancer patients in the last days of life. The trial was open to recruitment from April 2015. This meant the service was carrying out research which could be used to improve the quality of care for patients.
- We saw the service planned to develop to support ways of improving patient choice. The views and of patients and carers would be captured and used to plan service improvements. The service had also developed plans to assess the needs of carers so that the service could improve the support and information to carers to carry out their role.
- Members of the adult community teams had begun measuring dependency scores and patient related outcome measures for palliative care patients. The measures were a set of tools which could be used for planning people's care. They included measures for patient's physical symptoms, psychological, emotional and spiritual, and information and support needs.

## Are services well-led?

- The service had plans for developing an electronic palliative care co-ordination system to be used across the trust.