

# Rotherham Doncaster and South Humber NHS Foundation Trust

RXE

# Community end of life care

## Quality Report

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# Summary of findings

## Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RXEDL	St. John's Hospice		
RXE00	Trust Headquarters - Doncaster		

This report describes our judgement of the quality of care provided within this core service by Rotherham Doncaster and South Humber NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Rotherham Doncaster and South Humber NHS Foundation Trust and these are brought together to inform our overall judgement of Rotherham Doncaster and South Humber NHS Foundation 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

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# Summary of findings

## Overall summary

We rated the end of life care services at Rotherham Doncaster and South Humber NHS Foundation Trust hospital as good for safe, effective, caring, responsive and well led.

There were sufficient staff for the number of patients at the hospice. Community nursing had challenging caseloads and often had to prioritise their work. Bank staff were used to backfill sickness and absence. Staff were aware of incident reporting and there was evidence that lessons had been learnt and improvements have been implemented to maintain safety. The hospice and the day care centre were visibly clean, tidy and staff worked bare below the elbow to reduce the spread of infection.

We found staff attendance of mandatory training was slightly less than the trust expected level of 90%. This has been identified by the management and action is being taken to improve it. There was sufficient equipment to deliver care in a safe manner. The hospice had a bariatric bed. Two bedrooms had been designed to support patients with dementia.

There was good evidence that staff were aware of the most up to date guidance, such as the five priorities of care. They explained that the guidance ensured that people and their families are at the centre of decisions about their treatment and care.

We saw patients were regularly assessed and appropriate pain relief was administered in a timely manner by staff at the hospice and in the community. If a patient was not receiving adequate nutrition or hydration by mouth, even with support, the doctor considered other forms of clinically assisted nutrition or hydration, such as intravenous fluids, to meet the patient's needs. The managers were working collaboratively with the service commissioners to improve the monitoring of the services to demonstrate progress.

Patients and family members told us that staff understood their needs, treated them with respect and maintained their dignity and privacy. We observed several examples where staff treated the whole family with care and compassion. This was especially the case when

young parents with children required palliative and EoLC. Patient's records showed that when patients experienced physical pain, discomfort or emotional distress staff had responded compassionately and appropriately.

At meetings, staff addressed each patient's holistic wellbeing by discussing physical, psychological, social and spiritual needs. This meant that that they were able to understand the needs of the individuals and involve them and their family members in the plan of care. Patients and relatives were empowered and supported by staff to manage their own health, care and wellbeing to maximise their independence. The hospice worked closely with different religious groups and had twenty-four hour access to support groups for different religious needs.

There were arrangements in place to ensure patients and their families were able to access the appropriate care without delay. People who used the service knew how to make a complaint or raise concerns. Patients and relatives told us that staff encouraged them to make constructive comments and they felt that staff listened to them.

Patients were admitted to the hospice between 8.30am and 4pm between Monday to Friday. This meant some patients who were eligible for admission were delayed or were admitted to other NHS wards. However, there was on call out of hours cover for patients.

We visited the living well team and found them to be the hub for outreach engagement. They had a membership of multicultural staff and had links with diverse groups of people within the serving population. Independent interpreters were used to help patients and families to help staff meet patient's needs. The facilities at the hospice were focused on Christian worship and staff acknowledged there was work to be done around providing multicultural facilities for people.

The community staff said their strategy was to lead the way with compassionate care, to be a workforce that reflects the community, and to ensure they provided good quality care. The ultimate vision was for staff to work in partnership with all services, take ownership and be proud of care delivered.

# Summary of findings

There was a good supportive culture within staff in EoLC and palliative care teams. We also witnessed management ensuring measures were in place to protect the safety of staff who worked alone and as part of dispersed teams working in the community.

Staff were encouraged to bring their ideas forward and action those where appropriate.

There were clear lines of accountability including clear responsibility for escalating and cascading information between senior management team and the clinicians and frontline staff. Staff made comments that feedback from surveys and investigatory outcomes was delayed in reaching them.

# Summary of findings

## Background to the service

The trust's end of life care services included St John's hospice, Macmillan cancer support, hospice at home, day care, a specialist palliative care service and the living well information and support service.

St John's Hospice provided specialist palliative and end of life care to adult patients and their families in and around the Doncaster locality. The hospice had recently undergone significant development and refurbishment to improve its facilities and the overall environment in which patients and their families were cared for. There were ten fully refurbished single bedrooms, each with en-suite bathrooms and private access to the garden. The hospice had the facility to convert two of the single rooms into double occupancy. Patients were admitted for symptom management or if they were approaching the end of life and had chosen the hospice as their preferred place to die.

Macmillan cancer support was provided by registered nurses with extra training in the speciality of palliative care. There were six Doncaster-based Macmillan nurses and each covered a local area and provided support to nursing homes in the area. They worked in partnership with GPs, district nurses and other health care professionals.

Hospice at home was headed and co-ordinated by a senior sister. It was supported by staff nurses and health care assistants. They assessed and monitored patient's conditions and agreed respite visits and support for

approximately six weeks. They provided one to one respite visits so that carers could take some time out. Care was available at any time of day, including evenings and weekends. The service was usually able to offer two visits every week. Night care was available from 10pm until 7am, to allow carers a night of undisturbed sleep.

The day care centre aimed to maximise quality of life through therapeutic interventions and timely advice, alongside creative and complementary therapies. All patients attending day care were offered a 12 consecutive week individualised program. This was tailored to their needs in order for them to gain as much independence as possible. The day care was open four days each week between the hours of 10am to 3pm.

The palliative medical outpatient clinic was situated in the hospice information and support centre. It provided specialist palliative care services for patients with a progressive, life-limiting illness. Consultants specialising in palliative medicine saw patients in an outpatient setting. The clinic was held every Tuesday morning. Hospital consultants, GPs and clinical nurse specialists referred patients to this clinic.

The living well information and support service was adjacent to the palliative medical outpatient clinic. Its main function was to empower and support the people of Doncaster. It did this by providing quality information and support about cancer, to enable people to make positive changes to their lives to help them live well.

## Our inspection team

Our Inspection Team was led by:

Chair: Philip Confue, Chief Executive of Cornwall Partnership NHS Foundation Trust

Head of inspection: Jenny Wilkes, Care Quality Commission

Team Leader: Cathy Winn, Care Quality Commission

The team that inspected community end of life services included a CQC inspector and two palliative care specialists.

## Why we carried out this inspection

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

# Summary of findings

## How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Before the inspection visit, we reviewed a range of information we hold about these services and asked other organisations to share what they knew.

During the inspection visit, the inspection team spoke with 26 members of staff, seven patients and six carers, reviewed six sets of health care records and attended four meetings.

## What people who use the provider say

People who used the services included patients and their family members.

They told us that they were always included in the discussions about the treatment plans. They said the doctors gave explanation and sought their consent before starting them on any treatment.

Patients were pleased to find out that they did not need to be in pain to keep awake and enjoy being with the family and that they were able to control their pain with specific medicines. Relatives said that they were so relieved that patients had access to anticipatory medications to keep them comfortable and avoid distress.

Patients and relatives said they had contact numbers for the health care professionals including their GP if they were distressed.

Patients and family members said that they had access to counselling services at the hospice and or at the day care centre.

Patients and their family members were pleased to have regular nurses caring for them.

## Areas for improvement

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

- **Action the provider SHOULD take to improve**

The trust should review access to inpatient beds at St. John's Hospice to enable patient's needs to be met in a safe and timely manner in accordance with patient's choice.

The trust should review access to mandatory training and training records for staff working in the end of life community care services.

### Action the provider **COULD** take to improve

## Rotherham Doncaster and South Humber NHS Foundation 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

We rated end of life care as good for safe.

There were sufficient staff for the number of patients at the hospice. Community nursing had challenging caseloads and often had to prioritise their work. Bank staff were used to backfill sickness and absence. Staff were aware of incident reporting and there was evidence that lessons had been learnt and improvements had been implemented to maintain safety. The hospice and the day care centre were visibly clean, tidy and staff worked bare below the elbow to reduce the spread of infection.

We found staff attendance of mandatory training was slightly less than the trust expected level of 90%. This has been identified by the management team and action was being taken to improve it. There was sufficient equipment to deliver care in a safe manner. The hospice had a bariatric bed. Two bedrooms had been designed to support patients with dementia.

### Safety performance

- A range of safety information had been monitored to assess the performance of end of life care (EoLC) and palliative care provided by the service. The findings informed the service improvement plan to ensure continuous progress.
- One of the tools used was the national safety thermometer. This is a national incident audit which allows services to establish a baseline against which they can track improvement. As part of this, pressure ulcers and falls were monitored. The records showed that the total number of EoLC patients treated during 13 months between June 2014 and June 2015 were ten or fewer, but the incidence of new pressure ulcers in EoLC was high. The records ranged from no ulcers being recorded in four months and a high of four being recorded in January 2015. We found this had been addressed at the governance meeting and staff had been informed of the action they must take to minimise the risk of pressure sores. There was a fall with harm reported in June 2014 and the following 12 months no fall had been reported.

## Are services safe?

- A thirty eight point skin check was completed by staff at the start of care and treatment of all patients to help monitor patients' skin integrity. It was identified that pressure ulcers were sometimes unavoidable, but root cause analyses (RCA) were completed to identify why ulcers had occurred.
- At the time of our inspection, the latest safety thermometer check had been completed on 16 September 2015. It showed safety performance as 100%.

### Incident reporting, learning and improvement

- An electronic reporting system was used to report incidents. Staff were aware of how to use this.
- Reportable incidents were categorised into never events and serious incidents. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Between 1 January 2014 and 30 June 2015 there had been four pressure areas related incidents reported. The records showed that there were two hospice acquired grade 3 pressure sores and one patient was admitted to the hospice with a grade 3 pressure sore.
- Following the incidents of pressure sores, action had been taken to ensure learning and improvements to care. For example, a mattress audit was undertaken to ensure staff had access to appropriate pressure relieving equipment and staff had been informed about repositioning patients and accessing the tissue viability nurses for further help.
- We checked one patient's turn chart and found staff had regularly recorded following repositioning the patient. The manager said and we saw nurses checking the charts including the turn charts at the beginning of their shift. Relatives told us that staff visited the patients in their rooms regularly to move them and make them comfortable.
- There was a serious medicines error at the hospice in 2014 and the hospice staff had acted on lessons learnt from the incident. For example, following the incident when nurses prepare patients' medicines other staff are not allowed to distract them. Managers carried out 'spot

checks' to ensure staff were following the updated hospice's procedures for medicine management. The findings were shared with staff as part of the improvement.

- The types of incidents recorded by the community staff included staff shortages. However, staff told us they did not always report it on the system as it took additional time. This meant the true picture of the shortage was not highlighted to the management by staff.

### Safeguarding

- Staff told us that they received safeguarding training during their induction and updates during their mandatory training. Staff members working at the hospice and in the community had a good understanding of the procedures for making safeguarding referrals. They said the contact numbers were kept in the office and they were accessible to all staff.
- Children were involved when their carers were in receipt of palliative or EoLC. Therefore, staff also received training on safeguarding children.
- During our inspection we observed two multidisciplinary staff meetings. At the community multi-disciplinary team meetings, we saw evidence of referrals being made to the local authority safeguarding team.
- The inpatient manager explained that not all the staff had received updates of safeguarding training as the training provider did not have the capacity to deliver the training. The manager said this issue had been escalated to be added to the risk register for their service.
- Figures provided by the trust showed that none of the EoLC services had achieved the required threshold for safeguarding training.
- Trust records showed the highest level of compliance with safeguarding adults level one was in the counselling service (33%). The highest level of compliance with safeguarding adults level two training was in the hospice (83%). The highest level of safeguarding adults level three training was Macmillan services (80%). The highest level of safeguarding

## Are services safe?

children level one training was in the counselling service (67%). It was unclear if the information provided by the trust was up to date as staff we spoke with told us that they had received update training.

- One of the community practice educators (CPE) informed us that they were responsible for organising training for staff working in the community. They had organised training for band five nurses for up to level three safeguarding training. This included two day refreshers for managers and this was completed by Doncaster Metropolitan Borough Council (DMBC). However, the records provided by the trust did not reflect this.
- One of the CPEs said that due to the changes in the Care Act 2014, from 5th October 2015 onwards they were expecting information and updates from DMBC on safeguarding.

### Medicines

- All medicines, including controlled drugs (CDs) were handled safely. Medicines requiring refrigeration were kept at the right temperature and there were records to confirm this.
- Records relating to CDs were clear and accurate. The trust's chief pharmacist was also the hospice's accountable officer. It was their responsibility to ensure that controlled drugs were not mishandled or misused.
- Medicines which did not require refrigeration were kept in a cupboard in a room. The temperature in the room was noted to be between 26 and 27 degrees centigrade. This was outside recommended temperature for the drugs. The recommendation is 25 degrees centigrade. We informed the ward manager of this and they agreed to take immediate action.
- Medicines for emergency use was readily available, clearly labelled and were checked regularly by staff. This was evidenced by staff records with their signatures.
- We observed examples of safe medication practice. This included a nurse checking the patient's personal details before administering medicines and talking to another patient about the medicines they were taking home. This included giving explanations and providing a reminder chart to help them take their medicines at the correct time when they were at home.
- Our pharmacist inspector looked at the prescription charts belonging to all six in-patients at the time of our inspection. They noted one gap in the administration record. This was drawn to the attention of the nurse who was looking after the patient.
- The majority of medicines discontinued were signed and dated, or just signed, by the doctor. We did find two instances where doctors did not sign and date the medicine chart when drawing a line through an entry to discontinue a medicine. This was unsafe because there was no record on the chart of the person responsible for discontinuing medication. We discussed this with the nurse who was present during our inspection of medicines.
- We saw nurses ordering and signing for stock CDs. This would have been acceptable if CDs were supplied from an RDaSH pharmacy, however this was not the case as they were supplied by a different local acute trust. We discussed this with the ward manager who said that the hospice would look into this practice and take any necessary action.
- The hospice was visited regularly by a pharmacy technician and supported by a specialist pharmacist. The specialist pharmacist contributed to the nurses' training programme. Our pharmacist inspector attended the session that was taking place on the day of our visit. The training was attended by district nurses, palliative care nurses and the hospice staff. The content enhanced the nurses' knowledge of pharmacokinetics (what happens to drugs in the body).
- A medication audit by the pharmacist in August 2015 included management, storage and records of medicines within the hospice showed 100% compliance.
- We asked patients for their permission to visit them in their homes. During our visits to patient's homes we observed patients and relatives getting involved in handling medicines. This was overseen by the community nurses or the Macmillan nurses.
- To respond to EoLC patient symptoms promptly, prescriptions of anticipatory medications were made available to staff. Community nurses kept spare syringe drivers and consumables, such as syringes, locked in a large security coded box in the patient's house. We were informed that the spare syringe driver was to be used to

## Are services safe?

administer medication which was not compatible to be mixed with the ones the patient was already on. We were informed that all nurses attending to the patient knew the code for the box. This is to ensure patients medication was kept safe.

### Environment and equipment

- St John's hospice inpatient unit was refurbished 18 months ago to ensure single occupancy rooms with ensuite. The unit was light, airy and welcoming.
- Community nurses informed us, as part of their initial assessment they carried out an environment assessment of the patient's home. This was to ensure they took necessary action to minimise any risk to patients and the visiting staff. Nurses said they organised sufficient equipment to make sure patients and staff were safe. We saw two sets of risk assessments in patients' homes where records indicated safety action had been taken as a result of environmental risk assessments.
- We were informed by the service manager that there were plans to make St John's hospice building more homely. This included facilities for a cafeteria and better outside space and garden so patients and relatives could relax.
- Staff and patients told us that sufficient equipment was available to deliver care in a safe manner. The hospice had a bariatric bed; hoisting equipment was available. Two bedrooms had been designed to support patients with dementia. A patient-led assessment of the care environment (PLACE) was introduced in 2014 assessing the quality of the patient environment by people using the service. The assessments apply to hospitals, hospices and day treatment centres providing NHS funded care. The site score on appearance, condition and maintenance for St John's hospice was 99%. This compares to England average of 92%. Dementia friendliness of the inpatient unit scored 77% compared to England average 84%, which was less favourable.

### Quality of records

- Patients' records were held in different formats. All nursing records for in-patients and in the community were held electronically. The in-patient medical notes were paper records. This made it difficult for multidisciplinary staff to have remote access to information when giving advice. To address these computers for the in-patient unit had been provided so

that all notes could be transferred to the electronic record systems. We saw proposed plans to link in with the local acute trust and specialist cancer hospital computer systems so that clinicians were able to receive the results of scans and the bloods tests without delay.

- We observed people's individual care records being managed and stored in a way that maintained people's confidentiality. We observed that paper notes were securely kept in a locked office and the computer records were only accessible to authorised staff. The in-patient manager said that the quality audits of the records were yet to be carried out.
- The community palliative care nurses and the Macmillan nurses used an electronic palliative care coordination system known as EPaCCS. This is a patient register which can be accessed by primary care services in the community such as GP's, district nurses, hospice at home teams and the hospital and community specialist palliative care team (SPCT). Use of EPaCCS minimises the likelihood of patients at the end of life being asked sensitive questions more than once.
- We looked at four patient's records with the permission of each patients and /or their representative. The records were patient focused and incorporated the areas of physical, social, psychological and spiritual wellbeing of the patient. They had been updated during each shift at the hospice or during each call in the community.
- Folders were used in houses with syringe driver paperwork, suggested instructions on pain relief and comments on the patient's condition and wellbeing. This was accessible to the patients and their relatives.

### Cleanliness, infection control and hygiene

- We observed the hospice to be visibly clean, tidy and staff worked bare below the elbow in accordance with infection prevention and control policies.
- Community staff were also seen adhering to the infection prevention and control policies when they attended to patients in their homes.
- One episode of hospice acquired *Clostridium difficile* (C-diff) was discussed at the staff meeting on 29 May 2015. The discussion included post infection review and updated processes for staff.

## Are services safe?

- We viewed monthly staff meetings minutes for three months (June to August 2015). We saw cleanliness, infection control and MRSA screening had been discussed to raise awareness to staff of their responsibilities.
- Infection prevention and control (IPC) monitoring was in place and there were link nurses who attended meetings and shared updates with their colleagues.
- Visitors, staff and patients had access to hand sanitisers. We observed people using them.
- Staff used protective clothing when handling bodily fluids or clothing belonging to patients and washed their hands between tasks.
- Staff had a good understanding about providing infection control and promoting hygiene. They said that they had received training during their induction.
- The last hand hygiene audit scored 100% compliance in all but one area. That the hospice at home service scored 83.3%, but this was above the expected 80% baseline.
- The service expected 80% of staff or more to be compliant with infection control level two training. Hospice at home scored 83.3% and community Macmillan service and day care services scored 100%. St Johns hospice staff attendance was 76%.
- We observed staff handling waste and clinical specimens in a safe way. This included storage, labelling, handling and disposal of waste.

### Mandatory training

- Staff told us that they received information on training but were not always able to attend training due to staff shortages. They said often they were called into work when they arrived for training due to shortage of staff.
- Data from the trust showed that staff attendance of mandatory training was below their expected level of 90% in many areas. Examples of this included St Johns hospice (67.6%), community Macmillan service (75.5%), counselling service (72.7%), day care service (73.7%) and hospice at home (73%).
- We looked at individual areas training compliance on the mandatory topics, such as moving and handling for people handlers, health and safety, fire safety, infection

control, safeguarding adults and children training and clinical risk assessment. These results highlighted considerable gaps in staff training. For example in the in-patient hospice and in the day centre staff attendance for moving and handling training was 75% and 79 % respectively, 55.9% and 50% for fire safety training, and 16.7% and 27.6% for clinical risk assessment training.

- We noted that staff have been given future dates for training to achieve better compliance.

### Assessing and responding to patient risk

- We saw four patient records that had comprehensive risk assessments. These were referred to and amended regularly as the patient's needs changed.
- Patients and their relatives were included in the discussions about the way the risks were managed to ensure people's preferences were considered. We saw examples of this.
- There was open access to advice and guidance out of hours to respond to patient risk. Community nurses confirmed that they could call the palliative care consultants on their mobile if they needed them in an emergency situation for support.
- Staff used the Situation Background Assessment Recommendation (SBAR) tool during handing over sessions. This tool consists of standardised prompt questions within the highlighted four sections, to ensure that staff were sharing concise and focused information. This also allowed them to ensure that staff were communicating assertively and effectively, reducing the need for repetition. We observed two meetings where staff handed over using this tool. This helped staff to focus on the patient's risks and respond promptly.

### Staffing levels and caseload

- The managers and staff confirmed that they did not use any acuity (measurement of the intensity of care required for a patient) tool and the levels of staffing were based on historical models and needs. The senior managers informed us that they were well aware of the staffing difficulties and were kept informed by the incident reporting system, the staff skill mix and staffing levels. They said that they were looking at alternative ways of helping staff manage their workload.

## Are services safe?

- During our inspection, there were six inpatients and there were three nurses and two health care assistants (HAC) for the morning shift. For the afternoon shift, there were two nurses and two HCAs, and two nurses and one HCA were allocated for the night shift. The manager said if the occupancy increased they would be looking at increasing the staffing.
- In the community, most care and treatment was delivered by the district nurses. Nurses said that around four district nurses were allocated to a GP surgery and often looked after EoLC and palliative care patients from the surgery. Nurses told us that their caseloads varied and they shared the jobs amongst them and prioritised the palliative and EoLC patients to meet their needs.
- Staff told us that bank staff were used to cover staff shortages.
- The managers said that bank staff were often their regular staff or some who had worked at the hospice before and had undergone induction. We saw evidence of staff being thanked for working overtime in the minutes of staff meetings.
- There was adequate medical cover during 8:30am and 5pm between Mondays to Friday. There was out of hours on call cover provided by palliative care specialists and GPs.
- Counselling service and physiotherapy service have raised their views on requiring more staff with the senior manager.

- Additional domestic staff were employed to ensure the refurbished building was maintained.

### Managing anticipated risks

- All staff working in the community were conversant with the trust lone working policy. They told us knowing the procedure was in their own interest and to maintain their safety.
- Business continuity plans were in place.
- The ward manager and the nurse consultant told us that when there was disruption to staffing levels due to illness or bad weather they work as nurses to ensure patients received the appropriate care.
- The staff were aware of the winter weather contingency plans. They said that by knowing their patients in the community they were able to prioritise and maintain safety of patients.

### Major incident awareness and training (only include at core service level if variation or specific concerns)

- There was a major incident policy in the staff office with contact numbers and staff were aware of this.
- Staff told us if there were to be a major incident they would contact the senior nurse manager in charge and follow their instructions.

## 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 effectiveness of the community end of life care services as good.

There was good evidence that staff were aware of the most up to date guidance, such as the five priorities of care. They explained that the guidance ensured that people and their families are at the centre of decisions about their treatment and care.

We saw patients were regularly assessed and appropriate pain relief was administered in a timely manner by staff at the hospice and in the community. If a patient was not receiving adequate nutrition or hydration by mouth, even with support, the doctor considered other forms of clinically assisted nutrition or hydration, such as intravenous fluids, to meet the patient's needs. The managers were working collaboratively with the service commissioners to improve the monitoring of the services to demonstrate progress.

### Evidence based care and treatment

- Staff told us about the most recent guidance from the Department of Health, 'One Chance to Get it Right, June 2014'. This document looked at improving people's experience of care in the last few days and hours of life. Following on from this came the Alliance's five Priorities for Care. The Five Priorities for Care is based on recognising and respecting the dying person's needs and wishes, communicating clearly, involving the person who is dying and those important to them in decision about care, reviewing and revising the care regularly, keeping staff caring for the person, involved in decisions.
- During our meetings with staff they demonstrated a good understanding of the use of the five Priorities for Care. They explained that it put people and their families at the centre of decisions about their treatment and care. They said that the computerised care plans used by them addressed the five priorities in a

methodical manner. One of the nurses went through a patients care plan to demonstrate the way care was planned and how different people were involved in the patient's journey.

- Staff also knew the recommendation made by the independent Neuberger review of the Liverpool Care Pathway (LCP) and the phasing out of it in July 2014. They said Alliance's five Priorities for Care had replaced LCP and was now in use. The managers and staff told us that within the hospice and community patients receiving EoLC had individualised care plans based on the five priorities and that LCP was no longer in use.
- The service manager told us that through emails and staff meetings they cascaded information to staff and this was confirmed by staff during interviews. They received the latest guidance on evidence based practice, medication alerts, information on better use of EPaCCS, dignity at end of life issues in the media, articles around dying in the place of preference and reference to relevant journals to enable them to keep up to date with the changes. Staff were able to tell us about recent changes such as the use of Hyoscine Butyl bromide for secretion.
- As part of the action to reduce hospital acquired sores by patients, from April 2015 the trust started supplying dressings to patients as part of their treatment. The assessment of skin integrity moved to the Walsall tool. The Walsall Community Pressure Ulcer Risk Calculator assists in the identification of the main contributing factors in the development of pressure ulcers. It has been validated for use in the community/domiciliary environment.

### Pain relief (always include for EoLC and inpatients, include for others if applicable)

- Patients were regularly assessed and appropriate pain relief was administered in a timely manner by the staff at the hospice and in the community. Patients in their homes told us that nurses helped to control their pain most of the time. They told us about the different ways staff assessed the pain. Relatives told us that often staff

## Are services effective?

asked them whether patients were in pain and asked them to score the pain between one to ten and sometimes one to five. Relatives told us that the scores were clearly explained to patients to avoid confusion. We saw staff using a pictorial tool with a patient who was unable to communicate.

- We spoke with patients who had been admitted for symptom control. This was often for the management of pain. One patient said that they did not realise that the pain they suffered could be controlled and they could have a reasonable quality of life without being asleep most of the time.
- Anticipatory medication prescriptions for pain relief were in use and this was in line with the appropriate guidance. This is only used for people requiring EoLC.
- Relatives and patients informed us that symptoms such as nausea and vomiting sometimes increased when pain was not under control and this was carefully managed by their doctor and the nurses.
- At the MDT meetings all the patients were discussed, including in-patients and those in the community. Their symptoms were discussed and plans were agreed to ensure patients received appropriate support to control their symptoms effectively. This included pain relief. .

### **Nutrition and hydration (always include for Adults, Inpatients and EoLC, include for others if applicable)**

- We saw four patient records where nutritional needs were assessed and dietetic advice had been sought to ensure patients were in receipt of adequate nutrition.
- Patient hydration was also monitored and patients were given advice on the choices of drinks to help them have sufficient fluid intake. We spoke with a patient about their food and drinks and observed two further patients' fluid balance and food records. The records were up to date and the patients said that they were given sufficient food and drinks.
- Staff were aware that palliative care and EoLC patients were prone to mouth ulcers. We saw staff encouraging and helping patients maintain good mouth hygiene to minimise sore-mouth so that they were able to eat and drink well.

- We saw discussions at staff meetings about the need to keep accurate recordings of food and fluid intake of patients. This was a result of a concerns raised by relatives. As a learning action, all staff were instructed by the manager to record on charts only after the patient had eaten or drunk and not when it was delivered to them. Nurses checked the charts at the beginning of each shift to make an assessment. During our inspection we observed staff encouraging patients to drink.
- Medical staff were fully aware of the updated 'Good medical practice guidance' (2013), which included specific guidance regarding nutrition and hydration for end of life care.
- We saw the use of subcutaneous fluids for a patient. Staff gave us the rationale for using subcutaneous fluids for patients with extremely dry mouth to keep them comfortable.

### **Technology and telemedicine (always include for Adults and CYP, include for others if applicable)**

- SystemOne was used as the electronic record system. There were different programmes to enable care plans and record keeping.
- To maintain continuity, the hospital and the community staff accessed SystemOne.
- EPaCCS was on SystemOne and only visible to district nurses, occupational therapists, physiotherapists and some GP services.
- Community nurses informed us that having the mobile computer was very useful. However, they said they were having to come to the office each morning to upload information before they set off to see patients. In some cases it added half to an hour to their day.

### **Patient outcomes**

- There were a number of audits carried out to monitor patient outcomes, such as safety thermometer checks, monitoring of patient's preferred place of death, medication audit by the pharmacist, audits on pain management during palliative and EoLC. Care planning and the quality of clinical records were scheduled to be audited between October and December 2015 as part of a trust-wide programme.

## Are services effective?

- We saw evidence of management sharing the audit results with the staff through notices, emails and at staff meetings to ensure necessary improvements were implemented to promote good outcome for the patients. Some examples were, purchasing of new mattress for the hospice, revision of the medication administration policy for community and inpatients.
- The managers informed us that they were aware of the gaps in their audit programme such as the formal monitoring of the DNACPR forms to ensure information was up-to-date and they had been authorised by an appropriate senior clinician. However, the recording of the DNACPR decision in the Electronic Palliative Care Co-ordination Systems (EPaCCS) was audited quarterly.
- They also said that they had not yet participated in local or national audits to benchmark their service. Specialist palliative care services contribute data about end of life care to the National Minimum Data Set. They had not contributed to the data set.
- The Safety thermometer measured the incidents of pressure ulcers and falls. This was measured as 100% safe during our inspection on 16 September 2015.
- Medication audit by the pharmacist in August 2015 showed 100% compliance.
- Currently the service manager was reporting patient outcomes to the local CCG. We saw the action plan in progress with dates for completion of tasks.

### Competent staff

- During our inspection, we observed staff to be competent when involved in the care and treatment of the patients and their relatives. Staff were interested in the welfare of the people and they were committed to deliver the best care they could. This included doctors, ward staff, palliative care staff, EoLC specialists, domestic staff, catering staff, district nurses, health care assistants, bank staff and voluntary workers.
- A rigorous recruitment process was in place to ensure that staff with the correct knowledge, experience and suitable character were employed. This was continuously monitored by supervision sessions by the line managers. We spoke with two staff about their recruitment and induction process. They told us that they were inducted, given opportunity to shadow staff and competency was assessed before they were allowed to work alone.
- Staff who joined the service from other organisations took part in the Leicester clinical assessment tool to demonstrate their competencies. The Leicester assessment package is used to test the reliability and clinical competency of staff.
- All staff registered with their professional bodies have their registrations checked. This included checking to see if their qualifications had been validated as part of their registration competency check.
- Staff and the managers informed us that they had workplace one to one reviews six times a year, clinical supervision every two to three months and yearly appraisal. Nurses said that it was difficult for them to have clinical supervisions as they had to find supervisors and organise time to attend. Most staff said they had regular one to one reviews and they found it beneficial. All staff we spoke with said they had received their annual appraisal.
- Band six nurses in the community and the band seven managers at the hospice and the day care centre held the records on supervision of staff members and the names of their supervisor's. The records showed that staff who had not attended supervisions regularly had been given dates to attend and the reasons for the omissions had been recorded
- In April 2015, all staff were informed by the trust managers that they needed to ensure they are up to date with their core training and their individual development plan should have been discussed at their one to one with their line managers by October 2015. Staff said that they were aware of this and that they were up to date with clinical competency training. This was confirmed by a community clinical educator, the unit manager and the nurse consultant.
- Staff said bank nurses had the opportunity to work along with a regular staff if they were not familiar with patients. However, when agency staff were used they had no support or supervision. They said this rarely happened in the community and agency staff were used more in the hospice where they were able to be overseen by regular staff.

## Are services effective?

- Staff told us that their managers were good at encouraging and giving them opportunities to go on courses and develop professionally. Due to the shortage of staff both in the hospice and in the community, securing time for training was proving to be difficult for staff.
- All staff we spoke with said that they had received training on Advance Care Planning (ACP). The electronic record system accommodated the care planning, reviews and updates which we observed.
- Hospice at home and specialist community staff had good links with the community practice educators (CPEs). CPEs were embedded in district nursing teams. They provided standardised community nurse training and also bespoke training such syringe driver training and EPaCCS training to ensure staff in the community had the correct competency and support.
- The managers gave us examples where poor staff performances had been identified and appropriate action had been taken. Often staff received further training and close supervision to support them.
- To ease the community nurse workload, health care assistants were being upskilled to take on duties such as taking blood and carrying out base line observations.

### Multi-disciplinary working and coordinated care pathways

- Patient care and treatment involved a multidisciplinary approach. Every Wednesday two multidisciplinary staff meetings were held. These were to discuss in-patients and community patients. The meetings were attended by palliative care consultants, the ward doctor, a pharmacist, care co-ordinators, an occupational therapist, and a physiotherapist. Also in attendance were counselling staff, Macmillan nurses, hospital at home staff and any staff involved in the delivery of care. We attended the meetings and found them very patient focused, discussions were open and transparent and all attendees' views were considered when discussing the management of patients.
- Monthly GP meetings were also held to involve and share the care of the EoLC and palliative care patients in the individual GP practice. We attended this meeting and saw that GPs had a team approach to problem solving. They discussed visiting their EoLC patients at least every two weeks to avoid the patients having to have a post mortem causing the families unnecessary grief. They commented on nurses verifying death and how it helps them.
- Every morning there was an in-patient referral meeting which was attended by multidisciplinary staff who made the decisions and prioritised admissions.
- The hospice doctor and the consultants worked in partnership with the specialist pharmacists to ensure good use of available medicines.
- We met with a group of district nurses. They said that they were well supported by the Macmillan nurses and Marie Curie nurses. They could ring the hospice to discuss patients and were able to contact the consultants if they needed to.

### Referral, transfer, discharge and transition

- Patients were referred by their GP or the other health care organisations. If a patient was known to the service, other professionals could contact the hospice or go through their Macmillan or hospital at home team to be admitted to the hospice.
- All referrals are assessed and as far as possible managed in the patient's own home with appropriate care packages.
- To prevent any problems with the IT and to ensure patients had the necessary information on discharge home, a summary of paper information is sent home with the patients so that visiting professionals would be able to have access to information.
- Patient discharges were organised by staff at the hospice with the family members if appropriate. Staff contacted the community nurses or the Macmillan nurse and the patient's GP before organising transport for discharge.
- We met a patient who was being discharged and their family provided transport. Family members told us they were well informed of the support the patient was going to have at home and that they had been given telephone numbers to contact if they had any problems. They also had summary documentation about the patient's condition to take home so that visiting professionals would be able to check.

## Are services effective?

- We were informed that patients within the trust were also referred to hospice symptom management. This was an internal transfer and patient information would be transferred to the hospice.
- As part of efficiency monitoring of the discharge arrangement, it has been identified that not having a social worker attached to the hospice had delayed patient discharge.

### Access to information

- Patients' records were held in two formats; electronically and paper based. All nursing and allied health professionals' records were on the electronic system and were accessible to other professionals. Medical records were held in paper format, which staff told us was difficult to access. There were plans to roll out the electronic system for all staff.
- Where care is provided remotely in people's homes, the community nurses have mobile computers with access to the information. The system enables access to an electronic palliative care coordination system. All staff have access to this except the ambulance staff who used a different electronic system to the trust. This has been identified as a risk to patients and has been escalated to the senior managers.

### Consent, Mental Capacity act and Deprivation of Liberty Safeguards (just 'Consent' for CYP core service)

- All staff including medical and nursing staff told us they had received training on gaining valid consent from patients. This included understanding MCA and when DoLS application should be completed and by whom.
- We spoke with patients and relatives who said that treatment choices had been explained and they were given the opportunity to ask questions at every point of their journey. They said they always felt involved and if in any doubt they were able to speak with a doctor or a nurse without being worried.
- We saw completed MCA 1 and MCA 2 forms completed due to the changing condition of a patient. Staff were familiar with the processes.
- Community staff said the GPs were not always forthcoming at completing do not attempt cardiopulmonary resuscitation (DNACPR) forms. We saw three DNACPR forms at the hospice and two in the community. Discussions and decisions were clearly documented; the forms were completed with the signature and date by the appropriate senior medical practitioner.
- We were informed that DNACPR forms were not audited. However, the recording of the DNACPR decision in the Electronic Palliative Care Co-ordination Systems (EPaCCS) was audited quarterly.

## Are services caring?

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

### Summary

We rated caring in community end of life care as good.

Patients and family members told us that staff understood their needs, treated them with respect and maintained their dignity and privacy. We observed several examples where staff treated the whole family with care and compassion. This was especially the case when young parents with children required palliative and EoLC. Patient's records showed that when patients experienced physical pain, discomfort or emotional distress staff had responded compassionately and appropriately.

At meetings staff addressed each patient's holistic wellbeing by discussing physical, psychological, social and spiritual needs. This meant that that they were able to understand the needs of the individuals and involve them and their family members in the plan of care. Patients and relatives were empowered and supported by staff to manage their own health, care and wellbeing to maximise their independence. The hospice worked closely with different religious groups and had twenty four hour access to support groups for different religious needs.

### Compassionate care

- Patients and family members told us that staff understood their needs, treated them with respect and maintained their dignity and privacy. Patients said when they were visited by regular nurses and care staff; they were able to build trust and understanding.
- We spoke with a chaplain and a priest who visited the hospice and the day care centre. They informed us that they worked closely with the different local religious leaders and made contact with them when patients of other denominations were admitted. They shared some stories about helping patients seek peace and comfort. They said that they attended meetings with the hospice staff to discuss their findings and observations about the spiritual aspects of care. They felt their comments were valued by the staff team. We saw two patients welcoming the chaplain warmly and speaking with them in their rooms.
- The hospice worked closely with different religious groups and had twenty four hour access to support

groups for different religious needs. They also had a link with funeral directors in Bradford who would attend twenty four hours a day. This was relevant to some cultures who would want to take the patient home.

- We observed several examples where staff treated the whole family with care and compassion. This was especially the case when young parents with children were diagnosed with palliative and EoLC. The in-house counsellors spent time with children to get them to understand what was happening and what death is. We saw the children's counselling room which was well planned and child friendly. There were books and toys for the children to use and rugs on the floor for the adults and children to sit and talk.
- Patient records showed that when patients experienced physical pain, discomfort or emotional distress staff had responded compassionately and appropriately. Relatives told us about three examples where staff had taken swift action to address distressed patients and managed their pain.
- In the community, staff and relatives had access to telephone contact with professionals to help support distressed patients and they have access to anticipatory drugs to maintain pain control. In the hospice and in the day care centre patients had access to doctors and counsellors to help them.

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

- At the MDT meetings staff addressed each patient's holistic wellbeing by discussing physical, psychological, social and spiritual needs so that they were able to understand the needs of the individuals and involve them and their family members in the care.
- We looked at the records which showed that most people's preferred place of death (PPpOD) was in their own home. Patients considered this option only if it could be facilitated and if their families could be given necessary support.
- The service monitored the number of patients who died at the hospice when their wish was to die at home. The analysis for the first six months of this year showed that

## Are services caring?

56.5% of patients cared for by the Macmillan nurses in the community died at the hospice, compared to 31.1% of patients from the hospital at home team that died at the hospice.

- Staff told us that the use of EPaCCS ensured that they had access to patient's wishes and therefore sensitive communication was able to take place between staff, dying person, and those identified as important to them in a consistent way.

### Emotional support

- Patients and relatives were empowered and supported to manage their own health, care and wellbeing and to maximise their independence. This was helped by staff having a good understanding of the patient's circumstances and their condition.
- Patients and family members had access to counselling services at the hospice and at the day care centre. However, patients who were nursed at home did not have access to the counselling service. This was due to lack of trained counsellors being employed.
- Patients did not have access to a psychologist or alternative therapists, such as acupuncturists.
- Staff told us in the community some families did not want to show the patients how upset they were and put on a brave front. Staff said that they could see the effect on the relative's wellbeing and often signposted them to see their GPs and ask for help. One relative told us that having once a week care staff to sit with the patient gave them a break and they were able to meet up with friends.
- The counselling staff said they set specific, measurable, attainable, realistic, timely (SMART) goals for patients to achieve. This diverted their attention and gave them something to focus on which was within their control. Patients were encouraged to set their own goals, print them off and sign with the understanding that they can be changed and re-written. One patient told us that such activity gave them strength and focus in life.
- Staff helped patients to complete a "Getting to know you" booklet with the help of their family. The booklet helped others to understand the patient and offer emotional support when the patient lost their independence.
- Staff told us that bereaved families were contacted a month and a year after patient's death to find out how they were dealing with the bereavement and to offer further support.

# Are services responsive to people's needs?

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

## Summary

The community end of life services were rated as good for responsive.

There were arrangements in place to ensure patients and their families were able to access the appropriate care without delay. People who used the service knew how to make a complaint or raise concerns. Patients and relatives told us that staff encouraged them to make constructive comments and they felt that they were listened to by staff.

Patients were admitted to the hospice between 8.30am and 4pm between Monday to Friday. This meant some patients who were eligible for admission were delayed or were admitted to other NHS wards. However there was on call out of hours cover for patients.

We visited the living well team and found them to be the hub for outreach engagement. They had a membership of multicultural staff and had links with diverse groups of people within the serving population. Independent interpreters were used to help patients and families to help staff meet patient's needs. The facilities at the hospice were towards Christian worship and staff acknowledged there was work to be done around providing multicultural facilities for people.

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

- Service specification and shared goals have been developed by the local Clinical Commissioning Group (CCG) and the service manager for the hospice was leading on the action plan. The shared goals for the next five years included the need to increase staffing levels, up-skilling staff, seven day admissions, better use of day hospice and a move to five day service, seven day working of Macmillan nurses, improve physiotherapy input and explore other alternative therapy, increase availability of electronic systems and look into different ways of communication such as Skype calls and telehealth to support the service.
- The service planning for people living in Doncaster who required end of life care involved other agencies, including social care agencies.

- Facilities were in place for families to sleep over, play rooms were available for children, and facilities to cook and make drinks were available at the hospice.

## Equality and diversity

- The living well team within the hospice provided outreach engagements. They had membership from multicultural staff and had links with diverse group of people within the serving community. They shared information with patients and relatives and signposted people to the different services. Staff told us that they had visited community centres and spoken with groups of people promoting the activities at the hospice and the day centre.
- There was a chapel at the hospice. Staff acknowledged there was work to be done to ensure access to multi-faith worship.
- The hospice chaplain had built relationships with faith leaders and was meeting with an imam and his wife regarding a patient.
- We saw staff using an independent interpreter in the community to consult with a family about the needs of the patient. Staff told us they had sufficient contact with interpreters.
- The environment was suitable for wheelchair users.

## Meeting the needs of people in vulnerable circumstances

- We saw that the service provided coordinated care for patients with complex needs in the hospice and in the community. However, it was accepted by the managers that there was a lack of service planning to take account of people with dementia or those with a learning disability. At the moment patients with dementia and learning disabilities are treated and cared for on the main wards of the hospital.

## Access to the right care at the right time

- The preferred place of death for patients receiving end of life care was monitored. During the first six months of 2015, 68% of patients died in their preferred place. This was much higher than the national average

## Are services responsive to people's needs?

- There were arrangements in place to ensure patients and their families were able to access appropriate care without delay. This was aided by the staff working well with tertiary providers.
- We found the Macmillan nurses worked Monday to Friday 8.30am until 4pm and had a telephone service. Relatives said they found difficulty contacting a Macmillan nurse. Hospital at home nurses worked jointly with the district nurses and community specialist nurses and had access to a care agency staff. The care agency had been involved in fast tracking services for EoLC patients. The hospital at home team and Macmillan team were involved in utilising their service.
- During a home visit, we noted the district nurse prioritising the time of the visit as the patient and the family would be more receptive. We heard the district nurse explaining to relatives about the deterioration and changes in the patient and supporting the relative. The visit was over 30 minutes and the nurse did not rush, although they had a number of patients to visit. They asked about how the family was managing at night-time and informed them about other services for help if they wanted support.
- We found that there was specialist palliative care advice to relatives and staff at any time of the day or night from the consultants.
- St John's Hospice inpatient unit had ten beds. Bed occupancy between January and June 2015 was reported as 71%. During our inspection, the occupancy fluctuated between 50% and 60%. Although there were beds available, the admissions process limited admissions. A referral meeting took place each morning between Monday to Friday to accommodate patients who were on a waiting list to be admitted to the unit. We attended a referral meeting where six patients were waiting to be admitted and on that day, only two patients were prioritised to be admitted. This was due to the availability of medical staff who were able to admit patients between 8.30am and 4pm only. The doctors worked on the unit between 8.30am and 5pm from Monday to Friday. There was on call cover during out of hours to deal with emergencies and the on-call doctor attended the hospice on a Saturday and Sunday to review patients with complex needs.
- Delayed discharges at St John's hospice had been monitored between 1 October 2014 and 31 March 2015. The results showed there were four delayed discharges totalling 42 days in this period.

### Learning from complaints and concerns

- People who used the service knew how to make a complaint or raise concerns. Patients and relatives told us that staff encouraged them to make constructive comments and they felt that they were listened to by staff and that they were confident to speak up.
- The complaints procedure was available to in-patients and those in the community from staff.
- The inpatient manager said that they had not had any formal complaints from patients or their relatives in 2015. They said that any concerns received were handled without delay by staff before they escalated to be a formal complaint. They said that they did not monitor concerns to see if there were any themes.
- We were informed by the trust that there had been two formal complaints which had been investigated during this year and that the incidents referred to occurred during 2014. One complaint investigation was ongoing.
- Staff told us that during handover they discussed any issues raised by people and discussed how best to deal with them and any necessary changes to practice. They said when passing on information to family members, staff needed to be clear and make sure people fully understood what was said and not presume their understanding.
- Staff and the manager of the community nurse team explained that since they had started case management, there had been less comments and concerns raised by people. This was due to people being seen by the same group of nurses. This gave people continuity and the opportunity to build a rapport. They said they used to have complaints of late calls, missed calls and staff not being familiar with the patient's treatment plan. Due to the continuity of staff there had been better communication and understanding, and therefore less concerns.
- Band six nurses in the community managed the band five nurses and dealt with any complaints. We were informed that formal records of all complaints and

## Are services responsive to people's needs?

concerns were not held centrally by the manager. We were told that any concerns raised by patients or relatives were recorded in the individual patient's nursing records and it was accessible to managers.

## 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 well-led as good.

The community staff said their strategy was to lead the way with compassionate care, to be a workforce that reflects the community, and to ensure they provided good quality care. The ultimate vision was for staff to work in partnership with all services and deliver care which they take ownership and are proud of.

There was a good supportive culture within staff in EoLC and palliative care teams. We also witnessed management ensuring measures were in place to protect the safety of staff who worked alone and as part of dispersed teams working in the community.

Staff were encouraged to bring their ideas forward and they try to action those where appropriate.

There were clear lines of accountability including clear responsibility for escalating and cascading information between senior management team and the clinicians and frontline staff. Comments were made by staff that feedback from surveys and investigatory outcomes was delayed in reaching them.

### Service vision and strategy

- The trust strategy and vision for this service was to provide 'fit for purpose' hospice services to patients and their families, maximising reach and quality, to influence other organisations and healthcare professionals to improve the care of everyone at the end of life by sharing experience and expertise, and to work together across Doncaster. They had a five year plan to achieve this. Working collaboratively with the commissioners to achieve a shared goal, the trust had an action plan with priorities for 2015 and 2016. The plans had addressed some of the gaps we have identified during our inspection in the provision of the service. These included the lack of seven day working, the need to increase permanent staffing levels and up-skilling staff to carry out more procedures, providing more symptom control services for non-cancer patients and better use of day care service.

- Recruitment of two substantive specialist palliative care consultants was achieved during our inspection to comply with the service level agreement.
- We spoke with the managers and staff about their interpretation of the strategy and vision for this service. The community staff said their strategy was to lead the way with compassionate care, to be a workforce that reflects the community, ensure they give good quality care. Staff explained that they were serving their own community, patients are their family and friends. They felt that not only were they health professionals but that they could also be patients one day and therefore good care mattered to them. In-patient staff said they understood the strategy was to enable death to be peaceful and care to be patient focused.
- The ultimate vision was for staff to work in partnership with all services, deliver care which they take ownership of and are proud of.
- Annual progress against delivering the strategy is monitored and reviewed. The next review is due in November 2015.

### Governance, risk management and quality measurement

- The Electronic Palliative Care Co-ordination Systems (EPaCCS) was introduced in 2009-2010 as a national pilot to enable the recording and sharing of people's care preferences and key details about their care with those delivering care.
- In Doncaster an EPaCCS quality pilot ran between November 2014 to March 2015, and the study recommended the following improvements.
- Develop a communication strategy to ensure staff are trained, updated and using EPaCCS
- Training to be included on the New Starter/Staff Update Community Nursing Programme
- Develop an education programme in advanced communication skills (ACS) training for generalist staff and involvement of community Macmillan Team.

## Are services well-led?

We saw evidence of progress during our visits and when checking the records.

- There were clear lines of accountability including clear responsibility for escalating and cascading information between senior management team and the clinicians and other staff on the front line. However, front line staff stated that although the communication had improved from the trust level they needed to find out when they had done well, what the staff survey results were and the outcome of the investigations of complaints without delay. They said the timing of any feedback took too long and this meant that the information became outdated.

### Leadership of this service

- There had been major changes to the staff structure of this service over the past 18 months and as a result there was an interim service manager in place who took up post in June 2015. They were well respected by staff for being approachable and for interacting with patients.
- The ward manager was also a recent appointment. She told us that the service manager supported her and she met with him most days to discuss the day to day management of the unit. We found the managers had the capacity and experience to lead effectively. However, they have not had the time to demonstrate how the changes they had made so far to improve the service had been embedded.

### Culture within this service

- There was a good supportive culture within staff in EoLC and palliative care teams.
- Staff said that they were respected and valued by their line managers.
- Community staff, which included Macmillan nurses, told us that they treated each patient as their priority and the teams helped each other and worked together.
- They said the palliative care consultants were available to them for advice and they had been given their direct contact number to use in an emergency to avoid any delays.
- We observed staff handover where staff talked about the person as a whole and not the condition.

- Measures were taken to protect the safety of staff who work alone and as part of dispersed teams working in the community. Staff working in the community told us that it was mandatory that they were familiar with the lone working policy and they discussed any incidents or changes at their cluster staff meetings. During night shifts they ensured each team knew who was working and where they were and who to contact if they needed assistance.

### Public engagement

- Day care staff said they promoted public engagement by holding charity events. These were attended well and people were very generous.
- On discharge, in-patients and their families were given comment cards referred to as 'Your Opinion Counts' which include the Friends and Family test (FFT) questions.
- Staff told us that they have been informed that there was a poor response from the patient experience surveys.
- We heard some very positive comments to staff by visitors and patients.
- Staff said some relatives gave them constructive criticisms or suggestions as part of verbal feedback. They discussed this at their staff meetings.
- Staff said when they received letters and cards they always responded and acknowledged them.
- The managers said the hospice service website was being reviewed and improved to invite the public to comment on their service.

### Staff engagement

- All staff including the managers told us that they had filled in staff surveys. No staff could recall getting any feedback from the surveys. We spoke with the service manager who informed us that the last staff survey action plan was complete and was required to be shared with all departmental heads so that it would be cascaded to the frontline staff.
- All staff said that since June 2015, when their new service manager took over, they were able to speak openly about their concerns and share any ideas and not be worried about being judged.

## Are services well-led?

- Frontline staff said they were included in all discussions around changes, reviews of their service and they received updates from the monthly head of department meetings.

### **Innovation, improvement and sustainability**

- The managers for the hospice and the community told us that they had increased staff supervision by band six nurses and have 'tightened up and improved standards'.
- Introduction of the SBAR template for handover and the use of Smart Board are expected to give ready access to essential information about patients.
- Staff were encouraged to bring their ideas forward and they try to action those where appropriate. For example, where families did not understand discharge issues they were encouraged to come and stay overnight to get an understanding of what they would be expected to manage when the patient returned home.