Kent Community Health NHS Foundation Trust

RYY

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)
RYYE3	Trust Head Quarters	Hospital Wide	ME16 9NT

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

Summary of findings

Ratings

Overall rating for the service

Are services safe?	

Summary of findings

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Summary of findings

Overall summary

Following the last inspection the Trust demonstrated that training programmes, guidance, advice and support in respect of do not attempt cardiopulmonary resuscitation had been developed and implemented across the community hospitals, adult community services and children and young people's services. In addition, the Trust provided evidence of on-going audit programmes in place to provide organisational assurance as well as learning and improvement in all the localities.

Summary of findings

Background to the service

A comprehensive inspection took place in June 2014 where the CQC rated the Trust's end of life care as requiring improvement. One aspect of this rating was that the Trust was found not fully compliant with Regulation 20(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. A requirement notice was issued. This is a form of enforcement action which demands that providers make the necessary improvements to meet the required standards.Following amended Regulations coming into force since the comprehensive inspection was undertaken, the non compliance, for the purposes of this report, now relates to regulation 17(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 To check that improvements had been made and the Trust no longer breached the regulation, we conducted a desk top review. This is where the Trust submits the necessary evidence which the CQC reviews to ensure that the terms of the requirement notice have been met. We found on the evidence provided that the Trust met the required standards. However, this focussed desktop review will not alter the 2014 rating.

Our inspection team

Our review was led by Sheona Keeler, Inspection Manager and included a CQC Inspector.

How we carried out this inspection

We contacted the Trust's Director of Clinical Governance and Quality who submitted evidence that included staff training records, the Do Not Attempt Cardiopulmonary Resuscitation policy, audit reports, meeting minutes and the Trust's service improvement plan.

Kent Community Health NHS Foundation Trust

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Detailed findings from this inspection

Are services safe?

By safe, we mean that people are protected from abuse

Summary

The services for end of life care safety requires improvement.

The Nurse Consultant in End of Life Care for the Trust had insufficient length of time in post to have made a significant impact on the care patients receive, although they had overseen the co-ordination of an End of Life Care Strategy that was approved in March 2014. Full implementation of the policy should result in significantly improved end of life care being provided by the Trust but that will take some considerable time to achieve.

The provision of equipment, particularly beds and mattresses to assist in the prevention of pressure wounds for people approaching the end of life, was inconsistent. Failure to deliver to the service level agreement by the sub-contractor had a significant impact on the quality of care for some people. An action plan had been created and the agreement was being monitored but the situation had taken an excessive amount of time to resolve and was still problematic.

In two community hospitals we saw some examples of poor infection prevention and control practice with staff failing to wash hands prior to providing direct care to patients. Trust policies on infection prevention and control were not always followed. Infection prevention and control within the community was well understood, with staff demonstrating a sound understanding of theory and practice.

Incident reporting, learning and improvement

- There were no serious incidents reported that related to the provision of end of life care.
- The Trust had not reported any never events in the year preceding the inspection.
- The Safety Thermometer displayed at Sittingbourne Memorial Hospital showed that during June 2014 there had been no reported incidents of falls, medicines errors, and hospital acquired infections or adverse comments.
- Staff in the community had a sound understanding of incident reporting and were able to give us examples relating to equipment where they had escalated concerns.
- The three designed palliative care beds at Victoria Hospital, Deal and two at Edenbridge Memorial Hospital were not providing specialist palliative care but, rather, more general end of life care. The criteria for admission

to these beds was unclear. The number of patients receiving end of life care in the community hospitals was very small as the primary focus of the community hospitals was on rehabilitation.

Environment and equipment

Quality of records

The Trust provided evidence to the CQC that a Do Not Attempt Cardiopulmonary Resuscitation (DNA CPR) policy had been introduced across all the localities and covered all levels of clinical staff. The Trust had an initial target to train 150 clinical staff. However, we saw that the Trust had exceeded this number with 245 staff trained across the community hospitals and community nursing. We were told that training was on-going with a further 29 staff trained in the last quarter.

The Trust provided records that confirmed that 100% of medical staff had undertaken the end of life care/DNA CPR training course by the end of 2014.

A monthly training schedule for clinical staff had been developed for 2014/15 as well as guidance that included where to find further advice and support. End of life care facilitators were appointed since the last inspection and their role is to support the Trust's end of life training programme and provide guidance and support to operational staff. Regular audits of the DNA CPR orders were introduced across the Community hospitals, Adult Community services and Children and Young People's services to give assurance that the quality of record keeping was meeting national standards and complying with the NICE Quality Standard [QS13]. This quality standard defines clinical best practice in end of life care and includes statements that cover documented assessments and discussions with patients, their families and carers regarding needs and preferences.

We reviewed the audits submitted together with improvement plans and gained assurance the teams were addressing any issues raised by the audits. The audit results were discussed at directorate quality meetings and matrons meetings.

This included the most recent six monthly audit of a sample of 105 forms undertaken January - February 2016. The results demonstrated an improvement or similar finding for most areas when compared with the previous audit. For example the answer to the question regarding how clear it was who had completed the DNA CPR form had improved from 92% in July 2015 to 95% in 2016. However, a few areas showed a worse result, such as how satisfactorily and with whom the discussions with the patient's next of kin had been recorded. This had dropped from 81% in July 2015 to 77% in 2016. The audits also identified on-going concerns regarding the legibility of some entries.

In addition, the end of life care facilitators undertook spot checks of forms on the wards as well as reviewing the DNA CPR form following a death. We were told that any identified issues would be raised with the doctor concerned at the time. The wide dissemination of the audit results and discussions held showed that the Trust continued to raise awareness of the importance of the process and to drive improvements.

The audit results and recommendations were reviewed by the Trust's Adults Quality meeting. This provided organisational assurance and ensured that patient safety in regard to the DNA CPR process was routinely monitored and reviewed.