

Gloucestershire Care Services NHS Trust

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)
R1JX2	North Cotswolds Hospital		
R1J06	Cirencester Hospital		
R1J13	Stroud Hospital		







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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Requires Improvement

We found the end of life service to be safe, caring and responsive to patients' needs and requirements, particularly in the last days of life. Patients and carers told us how good the care was and that staff were kind, caring and considered the patients' dignity. However we found the service required improvement in the effective and well led domains which resulted in our judgement of requires improvement overall.

A commissioned report into the end of life services resulted in the development of an action plan to address points raised, however there was no strategic plan in place for end of life care. There was no plan in place for the end of life service to be accredited to best practice in

alignment with the gold standards framework. There was no recognition of this work having been commissioned and undertaken by the medical lead for end of life care. There was very little evidence of audit to support effects of some of the work having been undertaken. This meant there was a lack of systems and processes to help identify people entering the last 12 months of life.

It was unclear as to how patients' mental capacity had been assessed particularly in relation to documentation of the 'do not attempt cardio-pulmonary resuscitation' (DNAR CPR) forms. The only provision for seven day specialist care was in the form of a 24 hour advice line being managed by another organisation. Although this was easily accessible to staff there was no provision for patients or relatives to get advice out of hours.

Summary of findings

Background to the service

Information about the service

Palliative and end of life care encompasses all care given to patients who are approaching the end of their life and following death. It includes nursing care, specialist palliative care, bereavement support, and mortuary services. The definition of end of life includes patients who are approaching the end of life when they are likely to die within the next twelve months; patients whose death is imminent; those with advanced, progressive and incurable conditions, general frailty and co-existing conditions that mean a patient is expected to die within the next twelve months; existing conditions if they are at risk of dying from a sudden acute crisis in their condition; and life threatening acute conditions caused by sudden catastrophic events.

End of life care within Gloucestershire Care Services (GCS) consisted of a specialist palliative occupational therapy team providing a service but only to a small number of patients. This team consisted of three part time occupational therapists. Care was delivered to end of life patients within a community hospital and within patients' own homes by community nurses.

On this inspection we visited two patients receiving care in their own home. We visited five wards and spoke with two patients and four relatives we also spoke with 17 staff, one doctor and one chaplain.

Our inspection team

Chair: Dorain Williams, Assistant Director of Governance, Bridgewater Community Healthcare NHS Foundation Trust

Team Leader: Mary Cridge, Head of Hospital Inspections, Care Quality Commission

The team of 34 included CQC inspectors and a variety of specialists: district nurses, a community occupational

therapist, a community physiotherapist, a community children's nurse, a palliative care nurse, a sexual health consultant and specialist sexual health nurse, a health visitor, a child safeguarding lead, a school nurse, directors of nursing, an ex-chief executive, a governance lead, registered nurses, community nurses and an expert by experience who had used services.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme.

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 23 – 26 June 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked

Summary of findings

with people who use services. 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.

What people who use the provider say

We spoke with four patients and relatives. All spoke in the most positive and glowing terms about the kindness of the staff and the service they had received. These comments included,

- A patient we spoke with told us “I feel very safe here and know they are doing their best.”
- We were told by relatives that drinks had been offered to them during the drinks round and

- “it was an amazing place” and how their relative had been “treated with dignity and respect and all care needs were met which was fantastic.”
- Another person said they: “feel as they can take a breath now as [the patient] was being well looked after.

Areas for improvement

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

Action the provider **SHOULD** take to improve

- Ensure all learning from incidents relating to end of life care is disseminated across all areas of the trust.
- Monitor and audit patient outcomes of those receiving end of life care.
- Develop an end of life five year strategy.
- Strengthen the executive lead for end of life to ensure recognition of the service at trust board level, as well as identify an overall lead to take service forward and maintain responsibility for the provision of the service.

Action the provider **MUST** take to improve

- Ensure that all documentation relating to the ‘do not attempt cardio-pulmonary resuscitation’ (DNA CPR) include the completion of a Mental Capacity Assessment, to ensure that the patient’s consent and decisions around best interests are served. Forms must include reference to discussions with patients and relatives and must be stored in such a way as to ensure all staff providing care are alerted to them.

Gloucestershire Care Services 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

We have judged the safety of end of life care as good.

The senior nurses regularly reviewed incidents and shared the findings with individual staff and at team meetings. We were, however, unable to find evidence of this learning being shared trust wide.

Guidance was followed by staff to provide medicines safely both within hospitals and the community in order to manage end of life pain and symptoms for patients. Risks assessments were completed by staff and the shared care record was being used appropriately. The shared care record was a document used when patients were identified as being in the last few days of their life.

The specialist palliative care occupational therapist team cared directly for patients at the end of life; this was a small team who managed their workload well. The community nursing teams also cared for patients nearing end of life and prioritised the care for patients who were unwell and on the end of life pathway.

There was good access to out of hours support and advice for nursing staff.

Detailed findings

Incident reporting, learning and improvement

- Staff we talked with across the trust, community hospitals, community nurses and specialist occupational therapy team, were able and knew how to report incidents using the reporting system. They received feedback from their line manager if they requested it. If there was some learning involved for the individual this was not always shared across the teams. We did not find any evidence of shared learning from incidents across the organisation.
- We reviewed a report concerning a drug related incident. An explanation and apology was made to the family but there was no evidence concerning learning or training needs for the staff involved.
- Staff were aware of the new duty to be open and honest with people. A new regulation for the provider came into force in November 2014 about dealing with serious incidents. The Duty of Candour explains what providers must do to make sure they are open and honest with patients and their families when something goes wrong with their care and treatment. Staff were able to demonstrate an understanding of this and senior nurses

Are services safe?

were able to describe how the Duty of Candour was part of their working practices. The process they followed was firstly a verbal and then written apology and explanation.

Safeguarding

- Staff were trained to recognise and act upon abuse or suspicions of abuse of vulnerable people. The staff we spoke with had received safeguarding training during their induction and had completed their online training. A community nurse we spoke with was aware of the reporting process. They recognised the potential vulnerability of the patients in their care.

Medicines

- An anticipatory prescribing medication chart was available for use and linked to the trust's shared care record for the expected last days of life. This chart was prepopulated with the four most common symptom and pain relieving medicines, with guidance of dose and frequency. There was additional space on the chart for other specific medicines to be added to meet individuals needs as required. Anticipatory drugs are an important aspect of end of life care, they are prescribed drugs in order to control symptoms such as nausea and pain, it is considered good practice to have this in place. However, anticipatory drug auditing was not undertaken by the trust, auditing is important in order to ensure patients receive the correct drug at the correct time in order to relieve symptoms.
- Ward stocks contained commonly used end of life medicines so they were available for prompt use when patients were admitted.
- We observed staff renewing a syringe driver (a pump used to deliver pain relief to a patient through their skin for a specific period of time) in a patients' home. The district nurse made all the relevant checks such as: checking the skin where the needle was inserted, ensuring the correct drug and dose was given against the prescription, and finally the correct numbers of drugs remained. A check of the syringe driver was carried out to ensure that it was functioning correctly and that there was sufficient battery life.

- A community nurse explained how controlled drugs were secured in patient's homes to prevent risks to vulnerable people such as any children living in or visiting the patient's home.

Environment and equipment

- The provider was using appropriate equipment. The NHS National Patient Safety Agency (an agency established to improve patient safety in hospitals) recommended in 2011 that all Graseby syringe drivers (a device for delivering medicines continuously under the skin) should be withdrawn by the end 2015. The McKinley T34 syringe driver had been introduced into the trust. Records showed nursing staff throughout the trust had been trained in its use, through online training and assessment of their competency. Staff we spoke with confirmed this. Staff were able to access a syringe driver and equipment whenever required. A comprehensive policy and guidelines on the use of syringe drivers were in place (2013) for staff to access. The homes we visited had sharps containers to allow for the safe disposal of objects such as needles, syringes and glass ampoules.
- Nursing staff in the community told us that there were no issues with ordering or obtaining equipment promptly for patients who were receiving end of life care. This included pressure relieving mattresses for patients with a risk of developing pressure sores.
- Renovations to some single rooms were being planned in order to make them less clinical for those patients entering the final days of life. These changes were being made in Stroud hospital. North Cotswold hospital had mostly all single rooms, they also provided facilities for relatives to stay overnight and 'put up' beds to enable them to stay in the patients room if required. The relatives had access to their own room and facilities to make themselves snacks and drinks.

Quality of records

- Risk assessments and patient records were well completed in relation to their end of life care. In January 2015 Gloucestershire Care Services launched the 'shared record for the expected last days of life' (the shared care record). This documentation was designed to promote best possible clinical care and make documentation accessible to professionals, patients, families and carers in order to improve communication.

Are services safe?

The shared care record included risk assessments of patients' nutrition, pain, mobility, and skin integrity. Risk assessments were documented and were reviewed and the documentation we reviewed was being used appropriately and completed fully. The shared care record was initiated appropriately in the last days of life.

- In a completed care record we reviewed we found clear and concise documentation and a recorded discussion with family members about the end-of-life wishes of their relative.
- We received a draft documentation audit completed by the specialist palliative care occupational therapist. The audit compared results to one year ago and although the results had much improved there were still areas for improvement; however the action plan had not been completed at the time of the inspection.
- We reviewed six Do Not Attempt Cardio Pulmonary Resuscitation (DNAR CPR) forms on three hospital wards and in two patients' homes. These were yellow stickers attached to notes. According to the policy these should be attached to the unwell patient form. We found no evidence of this and there appeared no standard place for them in a patient's records. In some notes it was difficult to find them. The meant there was a risk to communication from one healthcare professional to another, resulting in the risk of wrong decisions being made about patients in an emergency situation.

Cleanliness, infection control and hygiene

- There were infection prevention and control systems in place to keep patients safe. The ward areas we visited were visibly clean. There were sufficient hand gel and hand washing facilities available. There was sufficient provision of single rooms to protect people who were more susceptible to infection and to protect others.
- On a patients' death we were told by staff that they had a contract with a local undertaker they were able to use if the patient or relatives had not stated a preference. We were told and there was a protocol 'last offices in hospital' (however this was three years out of date), advising staff to inform undertakers of any relevant infection control risk.

- During visits with community staff to patients home we witnessed good hand hygiene and the use of personal protective equipment, such as disposable gloves and aprons, when administering care to a patient.

Mandatory training

- Staff we spoke confirmed they had undertaken their mandatory training, although there was no specific end of life component for any staff group.
- We saw data showing evidence of the specialist nurses and health care professionals having completed the mandatory training.

Assessing and responding to patient risk

- Patients' risks were assessed and responded to well. The shared care record in the last days of life incorporated regular reassessments of patients' needs to minimise risks and maximise symptom control. The regularity of assessments was based on the impact of symptoms on patients. We saw that risk documents had been reviewed appropriately to look for changes and where care needed to be adjusted
- There was a 24 hour advice line for professionals to access out of hours. The advice was given by specialist palliative care nurses or palliative care consultants based at the local hospice. Other out of hours support was supplied through the local ambulance service. This service employed doctors to attend to patients when required. The trust had a system in place to alert the out-of-hours services where a patient's condition was deteriorating.
- The trust's 'unwell/potentially deteriorating patient plan' (UP) form was being developed at the time of our inspection. When this is put into practice, each plan will state the maximum level of interventions a patient would or would not have in the event of deterioration in their condition. We saw the policy relating to this but did not see any of these forms in use. This would be for use of patients both in a community hospital and at home.

Staffing levels and caseload

- End of life care was provided by community nurses who worked across the county. The specialist occupational therapists provided care to palliative patients through a referral system again across the county.

Are services safe?

- The specialist palliative care occupational therapy team consisted of 1.3 whole time equivalent occupational therapist (three therapists) covering a five-day working week. When we met with them they were caring for 42 palliative patients. It was not clear how establishments had been calculated. All three therapists worked on Tuesdays which enabled them to meet together to reflect and debrief on their patients, practice and cases. The team was fully established with no long term sickness or other unplanned leave. There was a waiting list of eight patients, although three of these patients were still in hospital so receiving inpatient care.
- Community nurses provided seven day working from 8am to 10pm. Outside of these hours one team consisting of four nurses covered the county.
- Medical cover for each hospital was provided consistently by allocated GPs. In Stroud General Hospital four mornings per week were covered by a GP with specialist background knowledge of palliative care. Out of hours medical cover for both the hospitals and community was provided through the local ambulance service.
- The trust had a bad weather policy but this did not identify how end of life patients, in particular, would be cared for in these circumstances.

Managing anticipated risks

- A lone worker policy was in place giving good guidance to staff. Staff told us risk assessments were completed on the first visit to a patient's home; however we did not ask to see evidence of this in use.

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 judged the effectiveness of end of life care as requiring improvement.

We reviewed six 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms. These are forms recording a discussion with a patient or their family/carer about their wishes around resuscitation in the event of a cardiac or respiratory arrest. These forms should also record an assessment of a patient's mental capacity to make their own decisions. Explanations for the reason for the decision to withhold resuscitation were not always clear. Records of discussions with patients and their relatives, or of reasons why decisions to withhold resuscitation were not documented in five of the six records we reviewed.

Patients with long-term conditions who might have been in the last year of life were not consistently recognised by staff throughout the trust. Where patients were identified with end of life care needs, they had their needs assessed and reviewed and had pain and other symptoms managed effectively. The trust was providing care in line with national guidance.

Detailed findings

Evidence based care and treatment

- Evidence based care had been implemented, but not necessarily for all patients who were in the last year of their life. In line with NICE guidance (QS13 End of Life Care for Adults) use of the Liverpool Care Pathway had been phased out in 2014 and replaced with the 'shared care record', although this has yet to be audited to determine if it was effective.
- The trust had implemented the five core recommendations for care of patients in the last few days and hours of life in the Department of Health's End of Life Care Strategy 2008. It had also implemented recommendations of 'One chance to get it right' published by the Leadership Alliance for care of the Dying people 2014. As a result unnecessary investigations, blood tests and continued use of medicines were regularly reviewed.

- End of life care within the hospital was focused on the recognition of patients who might be approaching the last few days and hours of life. The Department of Health's End of Life Care Strategy (2008) and NICE quality standards for end of life care (2011) included recognition of end of life care for patients with advanced, progressive, incurable conditions thought to be approaching the last year of life. Clinical staff on the wards we visited did not demonstrate this understanding that end of life could cover an extended period, or that patients might have benefited from early discussions and care planning.
- The trust was not currently working towards accreditation of provision of end of life care. Many trusts and hospices are currently working towards the Gold Standards Framework as this is considered to be best practice.
- Staff were aware of the Advanced Care Plan (ACP) but we did not see any evidence of its use. ACP is a key part of the Gold Standards Framework Programmes. It should be included consistently and systematically so that every appropriate person is offered the chance to have an advance care planning discussion with the most suitable person caring for them.
- Advance Care planning is a key means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live and die in the place and the manner of their choosing. The main goal in delivering good end of life care is to be able to clarify peoples' wishes, needs and preferences and deliver care to meet these needs.

Pain relief

- Patients' pain relief was well managed. The relatives of a patient told us that doctors and nurses had been regularly reviewing and altering the dose of pain relief. This was in order to get the optimal dosage to manage the patient's pain. When extra pain relief was required the nurses were prompt in providing this following the

Are services effective?

patient's prescription. They checked the patient following administration to ensure it had been effective. One patient we met was also given extra pain relief prior to being assisted out of bed.

- We saw evidence of a pain management care plan with clear entries for managing intermittent pain and the effectiveness of the analgesia used.
- Patients identified as requiring end of life care were prescribed anticipatory medicines. These 'when required' medicines were prescribed in advance to be given to allow promptly management of any changes in patients' pain or other symptoms. Palliative medicines (which can alleviate pain and symptoms associated with end of life) were available at all times. Wards and community nurses had adequate supplies of syringe drivers (devices for delivering pain medicines continuously under the skin) and the medicines to be used with them. Staff were trained to set up this equipment.

Nutrition and hydration

- Nutrition and hydration was well managed. We observed a nurse discussing the menu with a patient for the following day. The patient was not keen on eating but had been offered nutritional drinks and could ask for one whenever they wanted.
- Screening tools were used to determine how best to support patients. A patient in receipt of palliative care, for example, had been assessed using the Malnutrition Universal Screening Tool (MUST). This had led to a referral to the Speech and Language Team due to difficulties the patient had with swallowing.
- We saw evidence of daily fluid charts in use and recorded appropriately.
- If patients at home were recognised as in need of rehydration they could be admitted to hospital for an overnight stay to manage their fluid intake. In other cases, nursing staff were able to provide subcutaneous fluids to help a patient absorb fluids.

Technology and telemedicine

- In most areas, but not all, the trust had introduced an electronic patient record system. The specialist palliative occupational therapy team had adopted this system well. They had been able to have it adapted to

suit their individual and patient needs. We saw evidence of this being used at several locations. Access to the system was easy. Staff were given individual log in details to maintain information security. Once staff were logged into the system there was a clear chronological record of patient visits, clear and concise professional records, and completion of risk assessments

- In other areas of the trust paper documentation was being used; however there was a roll out plan for the electronic patient record system to be introduced in all areas.

Patient outcomes

- The trust did not contribute to the Royal College of Physicians National Care of the Dying Audit 2014. The standards of care evaluated in this audit are based on the End of Life Care Strategy (DH, 2008) and reflect recent national policy guidance. However, we were told the trust was taking part in 'Voices': a National Survey of Bereaved people. This was a survey which collected the views on the quality of care provided to a friend or relative in the last three months of life. It was commissioned by the Department of Health and NHS England, with data collection due to commence in September 2015.
- Not all patients were able to die in their preferred place. The trust did not have a process of measuring outcomes for all patients against their preferred place of death. This data was only provided in respect of deaths in community hospitals and not for patients in other setting. For community hospital patients, only 42% of deaths recorded in hospital were at the patients' preferred place.
- The trust was not working towards an independent accreditation standard, within the community hospitals, such as the gold standards framework, nor were staff using an end of life quality assessment tool. The Gold Standards Framework (GSF) is a model that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis. It is a way of raising the level of care to the standard of the best. Through the GSF, palliative care skills for cancer patients can be used to meet the needs of people with other life-limiting conditions. The GSF provides a framework for a planned system of care in consultation with the patient and family. It promotes better

Are services effective?

coordination and collaboration between healthcare professionals. The tool helps to optimise out-of-hours' care and can prevent crises and inappropriate hospital admissions.

Competent staff

- Each area we visited had an enthusiastic end of life lead/champion. This was a member of the nursing staff who were involved in teaching sessions and planning further learning. The champions explained how they were able to access advice from specialist palliative care teams from the local acute hospital and local hospices.
- Staff we spoke with were committed to providing good end of life care. We spoke with two nurses who had or were completing the certificate in end of life care; other staff were aware of and had completed the end of life online training.
- Online training modules for the syringe driver used in the trust were available and we saw evidence that most registered nurses had completed this training.
- Gloucestershire Care Services commissioned an independent report in September 2014, to investigate how the trust was delivering high quality, responsive, efficient, effective and equitable end of life care for adults. An action plan was developed to address the findings. The action plan stated the following training sessions would commence after a training needs analysis had taken place:
 - Communication / Dignity
 - Difficult Conversations
 - Pain control / Syringe Drivers / Abbey Pain Tool / Medications
 - Spirituality
 - Religions – End of Life 'Rituals'
 - Advanced Care Planning
 - Shared Care Records
 - Fast Track
 - Multi Agency Working
 - Mental Capacity Act
- Ten staff (all either registered nurses or healthcare assistants) had been funded since June 2014 to attend short courses or study days at either the local hospice or university. These included courses such as the patient centred approach to end of life care.
- We spoke with a Training and Education facilitator who had a planned training programme which included some aspects of end of life training. We saw evidence of 40% of staff in Stroud community hospital having completed training on the shared care record. We asked to see how this was evaluated, however the trust were not able to provide us with that data.
- Staff in both the community hospitals, as well as community nurses, continued to receive informal training and guidance in end of life care management by colleagues as part of peer support and one-to-one on-site training.
- A ward sister at Cirencester Hospital told us they were able to access free courses and education at the local hospices. We saw evidence that 50 staff across the organisation had attended some end of life training at local hospices over the previous 12 months.
- Some registered nurses had been trained in verifying the death of a patient in certain circumstances (such as when the death was expected) and there were plans to increase the numbers of staff qualified to complete this training and competence.
- We saw evidence of a comprehensive induction plan for a specialist palliative occupational therapist. This included a local induction at the base in the local hospice and a completed mandatory training spread sheet for this group of staff; the appraisals for this team were up to date. Objectives were also set, including commencing a university based specialist palliative care course.

Multi-disciplinary working and coordinated care pathways

- Patients received care that was multiprofessional and coordinated to meet their needs.
- The Specialist Palliative Care Occupational Therapist attended multi-disciplinary meetings held at the hospice for end of life patients in their care. Community nurses were invited to the GP Gold Standard Frameworks meetings; however attendance was reported as poor due to pressure of workloads.
- Patients at the end of their life were identified for fast-track discharge if they wished to transfer their care to their home or to an alternative service. The fast track discharge was coordinated by the continuing healthcare

Are services effective?

team (CHC). Staff said these patients had their funding assessments and care packages completed promptly. There were, however, no records or audit information available to confirm this. Responding to patients' choice for their preferred place of care is part of national best practice guidance.

Referral, transfer, discharge and transition

- Access to in-patient beds for all patients across Gloucestershire was managed by Single Point of Access (SPA). This contributed to patients at the end of their life being in their preferred place of care when being discharged from an acute hospital or admitted from home via their GP. All the trust's community hospitals stated they provided end of life care but there were no designated end of life beds.
- The specialist palliative occupational therapy team was available to all adults with life limiting illnesses who were registered with a Gloucestershire GP. Referrals were completed by the GP through an electronic referral form on the trust website or through verbal communication with other health care professionals. Referrals were prioritised by the occupational therapy team depending upon the needs of the patient.
- Equipment and care packages were put in place in a timely manner through the continuing health care fast track system. This was accelerated for those patients preferring to die at home. Families were involved in discharge planning and were able to attend meetings to discuss plans and address any concerns. The community hospital staff had good relationships with the community nurses and were able to discuss discharge plans via the telephone. The community nurses did not have a waiting list for end of life patients. Rapid discharge from hospital was facilitated by community nurses prioritising their workloads.
- The trust did not have an adolescent service to support the transition of children into adult services. However at the time of the inspection new pathway was at the time being developed. There was some end of life knowledge within the children's community nursing team but they were supported by adult community nurses especially in the use of syringe drivers. This was supported by a discussion held with a community children's nurse.
- We observed good use of the electronic patient record system. This was accessible to all staff including those working out of hours. Care records were available for external care staff, such as care agencies and hospice nurses, visiting patients at home. At the time of inspection one third of GPs had access to the electronic patient record system
- Staff had access to the trust intranet page. This held up to date information leaflets for families and patients and a link to the local acute hospital trust palliative care web page where guidelines for symptom control were available.
- We were told there was no countywide single point of access for patients and families to obtain end of life information. This was, however, an action to be completed in the end of life action plan.
- There was a 24-hour advice line for health care professionals to access specialist palliative care support and advice. This was provided by community palliative care nurses with consultants employed by the hospice. Staff we spoke with appreciated the support of the specialist palliative care nurses (SPCN) for out of hour's advice and support. A member of staff told us "I have learnt a lot from the clinical nurse specialist about complex symptom control, especially nausea and agitation management."
- We were told by a children's community nurse they were able to access information and support by the Children's Hospice. When a syringe driver was required the children's nurse would 'buddy up' with an adult community nurse for support and advice in setting this up.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff asked for patients' consent prior to delivering any care. This was recorded on the electronic patient record system. Patients were also asked to give consent for their information to be shared with other healthcare professionals such as GPs and specialist palliative care nurses
- A nurse we spoke with was able to discuss the pathway for decisions around resuscitation. This included discussion with the patient and family and if the

Access to information

Are services effective?

patient's mental capacity had been assessed. Once the resuscitation form had been completed it was entered on to the end of life register. A hand held form stayed with the patient.

- We reviewed six Do Not Attempt Cardio Pulmonary Resuscitation (DNAR CPR) forms on three hospital wards and in two patients' homes. These were yellow stickers attached to notes. There appeared no standard place for them in a patient's records and in some notes it was difficult to find them. Therefore the form could easily be missed by healthcare workers.
- None of the DNAR CPR forms showed references to patients' mental capacity, and this was not easily found in other medical or nursing notes. It was not evident

from patients' records which patients had or did not have mental capacity regarding making decisions around resuscitation. This meant it was not possible for the trust to audit how decisions had been made; whether advance decisions had been respected; whether legal proxies had been consulted; or whether national guidance had been followed.

- It was not evident in those forms we reviewed that patients or relatives had been involved in the decision making process. While there may have been appropriate reasons for not having discussions, no explanations were documented in those records we reviewed.
- We noted verbal consent had been obtained for assessments and was clearly documented.

Are services caring?

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

Summary

We judged the caring of the service as good. We observed patients being cared for with dignity, respect and compassion. Patients and relatives we spoke with told us staff were caring and looked after them well.

Detailed findings

Compassionate care

- Patients were treated with compassion. During visits to patients in the community we found staff delivering high standard of care. They were kind and showed empathy, respect and compassion to the patient and their carers/relatives. We spoke with five patients receiving end of life care. They all spoke highly of the staff and felt fully supported in their environments and their needs were being addressed.
- During a visit to a community hospital we spoke with four family members. Some of their comments to us included: “it was an amazing place” and how their relative had been “treated with dignity and respect and all care needs were met which was fantastic.” Another person said they: “feel as they can take a breath now as [the patient] was being well looked after.” Relatives and carers said they were being kept fully informed of what was happening and communication from staff was good. They had a meeting planned to discuss future plans for the patient with the doctors and nurses.
- We spoke with a patient who told us the staff were all very nice and they had no complaints. When the patient required pain relief the staff acted quickly and checked on them later to make sure it had worked.
- We observed drinks were placed close enough to the patient for them to reach and the nurse was chatting to the patient about her food requirements for the following day.
- Nursing staff had a positive attitude towards caring for the dying patient and were keen to learn new skills and take the service forward.

- The trust Friends and family test undertaken by Gloucestershire Care Services showed very positive feedback, the average score for those who would extremely likely/likely to recommend was 94.3% of all responders

Understanding and involvement of patients and those close to them

- Patients and those close to them were involved with their care. We spoke with four relatives in a community hospital and one relative in a patient’s home. They told us they had been consulted about decisions and understood what was happening and why. Some family members had been invited to a multi-disciplinary meeting with staff to discuss future care needs for their relative.
- The patients we spoke with all acknowledged that they had been involved in their care, their wishes had been taken into consideration and they had an understanding of what was happening to them.
- A documentation audit completed by specialist palliative care occupational therapy team in May 2015 showed evidence that 97% of patients had been involved in their care planning. Although the audit had taken place an action plan from the results had yet to be completed.

Emotional support

- Community hospitals reported good links with local chaplains of various denominations. We spoke with a chaplain at Stroud General Hospital who was on call for 24 hours per day. The chaplain said “it was a good place to die.” They said they felt they were “a resource for staff and patients.” The chaplain was able to offer time to sit with patients and able to assist them with their worries and concerns. The EOL action plan suggested a work plan looking at spiritual care however at the time of inspection the chaplain, who had a vast amount of experience, had not been involved in ways to take the actions forward.
- Community staff contacted relatives of the deceased on the day to offer support and advice; they then followed this up one week later with a visit or a call to the

Are services caring?

relatives. The community nurses and community hospital staff were able to signpost relatives for further bereavement support to, for example, charitable organisations.

- The specialist palliative occupational team were able to offer support via the local hospice and relatives had access to a carer's course held at the hospice.

- Some staff reported receiving debrief after patients death and the ability to discuss difficult situations at a one to one session with immediate line manager. Staff were given access to six free counselling sessions with 'Care First' in which they were able to self-refer.

Are services responsive to people's needs?

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

Summary

We judged the responsiveness of the service as requires improvement

The trust staff were responsive to the needs and requirements of individual patients. However we found the trust had not planned for the needs of the local population it serves.

There was a fast track discharge to enable patients to return home if they wished to die there. There were plans in place to refurbish side rooms in order for a 'less clinical' environment for patients and their relatives if the chosen place of death was a community hospital

The trust had commissioned a review of the services but actions had yet to be completed

Planning and delivering services which meet people's needs

- In September 2014 a report was commissioned to assess the end of life services for Gloucestershire Care Services. From this report an action plan/work stream was developed for community hospitals. There was work being carried out on the actions agreed but few had been completed. Due to the newness of the action planning there were no audits available to test its effectiveness.
- Facilities and arrangements were in place in the community hospitals for relatives wishing to stay overnight. These included 'put up' beds, designated washing facilities and a rest area where the relatives could prepare drinks and food for themselves.
- Discussions and research were taking place in order to enhance the ambience of some single rooms for end of life patients and their relatives. This involved refurbishment and access to ensuite facilities.
- At the three hospitals we visited car parking for patients and visitors was adequate. The hospitals we visited had quiet rooms to hold sensitive discussions with relatives and facilities for families who wished to stay with patients who were at the end of their life.

- We observed care being delivered in the community. We saw staff made every effort to ensure that people's needs were met, including medicines being delivered, equipment being provided and support for relatives being put in place.

Equality and diversity

- Translation and interpretation services were available through a contracted service. Any translated leaflets were saved for future use. There was guidance and support available on the intranet about how to contact the translation service. In the previous year there had been 677 requests for translation services, however we were unsure as to how many requests were made for end of life patients.
- We found no evidence of needs being met for black and minority ethnic groups
- We observed from visiting community hospitals access for disabled service users and visitors was good with slopes in and out of buildings and availability of lifts inside the building.

Meeting the needs of people in vulnerable circumstances

- Hospital and community staff had support and advice from a link nurses for people with dementia. The end of life link nurses worked with the dementia link nurses to provide care to those patients with both end of life needs and an encroaching dementia. There was recognition by staff that an individualised approach was needed to support patients with dementia as they approached the end of life.

Access to the right care at the right time

- The specialist palliative care occupational therapy team consisted of 1.8 whole equivalent (three) occupational therapists, the team were currently managing a caseload of 42 patients, there were eight patients on their waiting list but some of these patients were still receiving care from an inpatient environment. The case load was prioritised according to need with a clear referral pathway in place.

Are services responsive to people's needs?

- There was a fast track discharge to enable patients to return home if they wished to die there

Learning from complaints and concerns

- Two matrons we spoke with told us that they dealt with any concerns locally by speaking with the patient/relative concerned. The patient experience team would

be informed who would also contact the patient or family. One complaint received in the last year related to end of life care. This resulted in staff attending communication skills training for which a total of 16 nurses attended. Complaints related to communication were reflected in the end of life work action plan and had resulted in further training in communication skills.

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 have judged the leadership of the service as requiring improvement.

There was no strategy for end of life care and governance processes were inconsistent. There were few audits to demonstrate the effectiveness of the care being delivered.

The trust-board lead for end of life care was unaware of the action plan devised from the 2014 report commissioned into end of life care services. There was no one person in a position to take end of life care forward and maintain responsibility for provision of the service.

Individual teams demonstrated a commitment to deliver good end of life care and to develop end of life provision. The teams were well led by the matrons in the organisation. The staff we spoke with told us they had a high level of respect for their line managers and felt able to discuss and issues or problems with them.

Detailed findings

Service vision and strategy

- There appeared to be work being carried out on the action plan developed as a result of the report, but few actions had yet been completed.
- There was no evidence of an end of life strategy within the trust; however the action plan suggested a five year countywide strategy should be developed in the future.
- The trust had no plans for a formal accreditation in the form of the gold standards framework[TN1] .
- Staff both within the hospitals and community services recognised the importance of end of life care. The specialist palliative care occupational therapy team worked closely with the hospices' specialist palliative care hospice nurses in providing end of life care.
- The service was part of a local strategic board for the development of end of life care. The local Clinical Commissioning Group had set up an End of Life Care Strategy Board in May 2015 to develop a clear direction for services across Gloucestershire. The aim was to

ensure all adults with advanced, progressive and incurable illnesses, regardless of age, gender, disability, ethnicity, socio-economic status, geographical location or setting, live as well as possible until the end of their life. This group encompassed representation from the trust, the local acute hospitals, local hospices, the out of hour's services, Gloucester County Council, and a patient representative from Health watch.

Governance, risk management and quality measurement

- There was no specific risk register for EOL care. Any risks relating to EOL care were included within risk registers for each community hospital or service. Clinical governance meetings were generalised and not specific for end of life care
- Although there was an end of life action plan in place no auditing of any actions introduced had taken place, it was difficult to understand how the actions were being monitored.

Leadership of this service

- The director with responsibility for end of life for the trust was unaware of the action plan developed as a result of the commissioned report. The director also [TN2] reported feeling it unnecessary to have a specific end of life team within the organisation. The service was, therefore, fragmented without one lead person responsible for ensuring changes were out in place to take the service forward.
- Three service leads we met had priorities that were patient focused and based around delivering best practice within each service, however their approaches were not coordinated.
- Locally, individual teams were well led, Staff felt they were able to discuss any concerns with their line managers and felt well supported with good leadership.

Culture within this service

Are services well-led?

- Staff we met were committed to making a difference, encouraging learning and development, and sharing of knowledge in palliative/end of life.
- Staff we met both within community hospitals and working in the community felt well supported and valued in their roles. One nurse told us if mistakes were made there was no blame or criticism and staff were supported to learn and develop. One member of staff told us: “The best thing working in this organisation is the team I work in, the staff are supported and I feel supported both within my role and personal life.”
- We were told by nurses that there was an open and honest culture within the organisation.

Public engagement

- We were informed patient groups were invited to staff study days but found no evidence to substantiate this statement.
- We found no evidence of public engagement in specific relation to end of life care having taken place however there was a planned questionnaire (VOICES) to be sent to carers in September 2015 in order to assess the perceived support they received. The questionnaire had been developed together with the patient experience team, members of health watch and a bereavement charity.

Staff engagement

- The trust had commenced ‘Listening into Action’. Driven by the trust, this was a framework providing a comprehensive and joined-up approach to tackle

improvements in specific service areas, delivered through the direct engagement of staff. A senior nurse thought it had improved communication from “bottom to top approach.”

Innovation, improvement and sustainability

- The specialist palliative care occupational therapy team led the care of the end of life patient but also worked collaboratively with other services. This included working with colleagues from other community services, local hospice community specialist nurses and palliative consultants from both the hospice and acute trust. The patients we saw had their cases actively managed and well supported by the team. We observed an experienced and skilful occupational therapist working at an advanced level of end of life care in clinical practice, she was acting as the ‘key worker’ and through her speciality of OT she covered many of the specialist areas of a clinical nurse specialist. In many places, care normally co-ordinated through nursing staff which makes this service different and innovative from many other areas
- A deactivation policy for Implantable Cardioverter Defibrillator (ICD) was in place. This was a very new policy (May 2015) at the time of inspection, therefore it had not been discussed with staff. ICD’s are fitted to prevent sudden cardiac death; the presence of an ICD at the time of natural death can present problems. The European Heart Rhythm Association Expert Consensus Statement notes that ICD shocks for a patient in the terminal phase of any illness can be physically painful and psychologically distressing without prolonging a life of acceptable quality. The policy advised clinicians to discuss deactivation of the device as the patient entered into the terminal phase.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services</p> <p>Regulation 9: Person – centred care</p> <p>9(2) Providers must make sure that they provide appropriate care and treatment that meets people's needs, but this does not mean that care and treatment should be given if it would act against the consent of the person using the service</p> <p>In some cases, people's preferences for their care or treatment may not meet their needs. Where this is the case, and people lack capacity or are detained under the mental health legislation, providers must act in accordance with the mental capacity Act 2005</p> <p>9(3)(a) carrying out collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user</p> <p>9(3)(d) enabling and supporting relevant persons to make or participate in making, decisions relating to the service users care or treatment to the maximum extent possible</p> <p>The trust was not providing the following information in relation to DNA CPR through failing to:</p> <ul style="list-style-type: none">· Provide effective recording of decisions about CPR in a form that is recognised and accepted by all those involved in the care of the patient· Ensure effective communication with and explanation of decisions about CPR to the patient, or clear documentation of reasons why that was impossible or inappropriate

This section is primarily information for the provider

Requirement notices

- Providing effective communication with and explanation of decisions about CPR to the patient's family, friends, other carers or other representatives, or clear documentation of reasons why that was impossible or inappropriate
- Providing effective communication of decisions about CPR among all healthcare workers and organisations involved with the care of the patient.