Leicestershire Partnership NHS Trust

RT5

Community end of life care

Quality Report

Trust Headquarters, Lakeside House, 4 Smith Way,
Grove Park, Enderby,
Leicester LE19 1SS
Tel: 0116 225 6000
Website: leicspart.nhs.uk

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RT5YG	Loughborough Hospital	Loughborough Hospital	LE11 5JY
RT5YD	Coalville Community Hospital	Coalville Community Hospital	LE67 4DE
RT5YL	St Luke's Hospital	St Luke's Hospital	LE16 7BN
RT5PH	Feilding Palmer Community Hospital Charnwood Mill	Feilding Palmer Community Hospital Charnwood Mill	LE16 7BN

This report describes our judgement of the quality of care provided within this core service by Leicestershire Partnership 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 Leicestershire Partnership NHS Trust and these are brought together to inform our overall judgement of Leicestershire Partnership 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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Overall summary

Overall rating for this core service Requires Improvement l

We rated this core service as requires improvement because:

- Staffing levels were adequate at the time of our inspection but staff told us that they had been short staffed for some time and that there were a number of vacancies. Staff told us that the trust were recruiting for their vacancies and they hoped to have a full complement of staff in the coming months.
- Mandatory training provided to Advanced Nurse Practitioners did not cover end of life care, and these professionals received little support from trust doctors with a specialism in palliative care. This meant that patients were not protected from receiving unsafe treatment.
- Following the national withdrawal of the "Liverpool Care Pathway" the trust has developed an alternative care plan; however this has not yet been implemented.
- Staff were unable to show us evidence of clinical audits or the basis of evidence based practice in end of life services.
- Computer systems were not shared across GP surgeries so information sharing did not happen effectively.
- Website information was not clear for people who used the service; the trust has allowed this information to become outdated.
- We saw that Advanced Nurse Practitioners were completing Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms having completed their training to do so; however we saw that these forms were not countersigned by a doctor or consultant. The trust confirmed after our inspection Advanced Nurse Practitioners used a DNACPR form which had been agreed within NHS East Midlands.
- The service was responding to complaints and implementing systems following these, however the trust waited for these complaints to prompt improvements in the service. The trust had no auditing system to measure performance in order to improve the service.
- Staff explained that the figures collected around preferred place of death were collected as these were requested by the clinical commission group (CCG), although these figures were collected for services in the community; the ward based palliative care figures were not collated.
- Services based in community hospitals did not admit patients close to weekends due to issues with verification of deaths over weekends, and the access to doctors.
- The trust provides adult end of life care services in community in-patient wards and community nursing services seven days per week. However staff did not appear to be fully aware of services provided and told us there were plans to implement a seven day service in end of life care.
- The trust had no end of life strategy as the previous one had expired and no replacement had been developed.
- The trust confirmed staff delivering end of life care were involved in bi-annual record keeping, safeguarding and clinical supervision audits. However there was no evidence of clinical audits or monitoring of the service in order to improve care provided to patients and staff were unable to talk about this to inspectors.
- Staff received little support from trust specialist doctors in palliative care and contacted the local hospice run by a charity for support.

However:

- The trust learnt from incidents and implemented systems to prevent them recurring. Staff were aware of the reporting policy and procedure and could give examples of when this was carried out.
- Records were stored securely and well managed by staff to ensure that sensitive information about patients was protected.
- Medication management systems were in place and followed to ensure that medicines were stored safely. Where patients took medicines home with them, staff ensured that they understood their use and storage.
- We saw that consent was gained from people in relation to their care and future wishes.

Summary of findings

- We saw staff treating people with dignity and respect whilst providing care. Staff empathised where a person had a negative experience and offered support where necessary.
- Staff at St Luke's Hospital had arranged bi-monthly meetings to involve patients and visitors in the news and actions happening on the ward.
- Palliative care nurses conducted holistic assessments for patients and provided advice around social issues, for example, blue badges for disabled parking.

Summary of findings

Background to the service

Background to the service

At Loughborough Hospital on Swithland ward there were two palliative suites (containing kitchenette facilities and relative sleeping area), and two side rooms which can be utilised for palliative care if necessary. Swithland ward was a 24 bedded sub-acute rehabilitation unit.

Feilding Palmer Hospital, Coalville Community Hospital, and St Luke's Hospital had one palliative care suite each, also with kitchenette and relative sleeping facilities.

At Charnwood Mill the Hospital at Home team are based with the MacMillan nurses.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett

Team Leader: Julie Meikle, Head of Hospital Inspection (mental health) CQC

Inspection managers: Lyn Critchley and Yin Naing

The team included CQC managers, inspection managers, inspectors and support staff and a variety of specialist and experts by experience that had personal experience of using or caring for someone who uses the type of services we were inspecting

The team that inpected this core service included two CQC inspectors and a Specialist Palliative Care nurse.

The team would like to thank all those who met and spoke to inspectors during the inspection and were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health 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 between 9 and 12 March 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 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.

Summary of findings

What people who use the provider say

We were unable to talk to patients in ward based palliative care services due to the nature of their illness. However other patients said:

"Excellent organisation by staff and discharge nurses at LRI"

"Outstanding and great team, big thank you"

"I'm living now, not dying"

"X got their wish to die at home with dignity"

"Excellent nurses, 10/10"

"Unable at times to get through to community nurses via the single point of access; terrible system"

Good practice

- The Hospice at Home team were effective at a local level and strived to improve the care provided to patients that used the service.
- St Luke's Hospital nurse managers were innovative in seeking feedback from patients and staff. We saw that they had won awards from the trust for this.
- The trust target for providing care in a patient's preferred place of care was 80%; the trust Hospice at Home team provided this for 92% of patients in their care.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must implement the alternative care plan developed after the withdrawal of the Liverpool Care Pathway.
- The trust must develop and follow an end of life care strategy.
- The trust must ensure that effective medical supervision is arranged for staff working within end of life services.
- The trust must ensure that mandatory training includes Duty of Candour and end of life care training for Advanced Nurse Practitioners.

Action the provider SHOULD take to improve

- The trust should ensure staffing vacancies are appropriately covered and recruited to provide safe, effective care to patients.
- The trust should ensure IT and computer systems are streamlined across the trust and with local GP practices to ensure patient information can be shared in a timely and appropriate manner.
- The trust should implement an auditing system to monitor the provision of services in order to improve.

Leicestershire Partnership 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 rated safe as good because:

- We found the trust learnt from incidents and implemented systems to prevent them recurring. Staff were aware of the reporting policy and procedure and could give examples of when this was carried out.
- Records were stored securely and well managed by staff to ensure that sensitive information about patients was protected.
- Staff were aware of safeguarding, had received training, and were able to follow the policy to report incidents.
- Medication management systems were in place and followed to ensure that medicines were stored safely. Where patients took medicines home with them, staff ensured that they understood their use and storage.
- Staff had access to four wheel drive vehicles for use in inclement weather to ensure that the service was not interrupted, and that staff remain safe and patients receive care they required.
- We saw that all ward areas were clean and schedules were in place to ensure areas were not missed. Equipment was serviced and tested regularly so that it was maintained in a safe condition.

However:

- Staffing levels were adequate at the time of our inspection but staff told us that they had been short staffed for some time and that there were a number of vacancies. Staff told us that the trust were recruiting for their vacancies and they hoped to have a full complement of staff in the coming months.
- Not all staff were aware of the Duty of Candour and what this meant in their practice.

Detailed findings

Incident reporting, learning and improvement

- Staff told us about the electronic incident reporting system which is used by the trust. Staff in each area we visited told us about this process and told us that their line manager would follow up any incidents.
- Staff told us that they did not always get feedback from incident reports, but they told us that if they asked their line manager they would be updated about the outcome.
- There were no reported incidents relating to end of life care where there was an outcome of harm to staff or patients.

Good

Are services safe?

- We were told about examples where systems had been put into place following learning from an event by nurses working in the palliative care teams. We heard examples where checking systems had been put in place to keep people safe in relation to medicines.
- The Hospice at Home team explained an event where a ward had discharged a person home without all of the necessary support systems in place. The Hospice at Home team investigated this issue and discovered that the nurse in charge of the ward was on holiday and other staff did not know what was required. As a result of this learning the team developed a discharge checklist for staff to use as a prompt to ensure the safe discharge of patients in the future.
- We were told that any incident or near miss is reported on the electrical system
- If there was an issue with a reported maintenance issue; the ward staff often have to submit this as a risk on the computer system in order to speed up the process of having the issue repaired. For example; we were given details about a break in flooring in a corridor which created an infection risk and a trip hazard. Staff were concerned about the length of time it took for this to be repaired and submitted it on the computer system, it was then repaired within days.
- Staff told us that incidents were discussed at monthly Patient Satisfactory Experience Group (PSEG) assurance meeting, and investigations of accidents that had been reported on the electronic system were discussed. Each ward area also reported pressure ulcer figures, and other incidents, near misses and items on the risk register.
- There were good examples of local level learning, but we were not given examples of trust wide learning or the sharing of information across the trust.

Duty of Candour

- At Loughborough hospital staff told us that they were aware of the changes in the Health and Social Care Act (2014), and of their duty to report issues relating to care and to be clear with patients if something did not go to plan.
- Staff were unable to give examples of when this had been carried out. Staff in other areas were not aware about Duty of Candour and what it meant.

Safeguarding

- Staff had completed mandatory training in safeguarding. Staff were able to describe the process for reporting safeguarding incidents, and gave examples around when this had been carried out.
- Palliative care nurses showed us prompt cards they carried which contained details around how to report safeguarding issues.
- The trust safeguarding policy was clear to staff about the procedure to follow, however information provided on the trust's website for patients and visitors was dated 2012.
- On ward areas we noticed signs for patients, staff and visitors to inform them of the process to report a safeguarding incident.
- We saw that review systems were in place at monthly PSEG meetings to review safeguarding investigations and feedback learning to other areas of the trust to ensure patients were protected from the risk of abuse.

Medicines management

- In all ward areas we saw that medications were stored appropriately in locked cabinets.
- Controlled drugs were securely stored. The person in charge of the ward had the keys. We saw controlled drug record books and saw that checks were carried out each night to ensure that the log was correct and medication was not missing.
- We checked two different controlled drugs held at Feilding Palmer Hospital and St Luke's Hospital, and saw that the correct details were in the controlled drug log book. Medications held in the cupboards were in date, and clearly labelled with contents in their original packaging.
- We were told of an incident where a patient was transferred from a hospital ward to a palliative care suite in a community hospital and their syringe driver had been disconnected before the transfer. The patient did not receive medication for some time during their transfer, and this was further delayed due to staff in the community hospital having to obtain a prescription and to reconnect the pump. As a result of this ward staff told us they telephone wards to ensure systems are in place before the patient is discharged.
- Patients taking medications home had the use and storage details of the medications explained to them by hospital staff, and where "just in case" drugs were sent

home with a patient they were given advice on the storage to ensure they were kept secure. Palliative care nurses advised patients on returning unused medication to their pharmacy for disposal.
- Medications which must be kept cold were stored in locked fridges, and we saw records of temperature checks that the staff completed daily to ensure that medications were stored at optimum temperatures.
- We saw laminated guidance and trust policies for medication administration in clinic rooms, and syringe driver guidance was available for nurses when they were drawing up medications.

Safety of equipment

- Palliative care teams told us that they did not stock equipment to be loaned to people in their homes, but that the district nursing teams were able to facilitate this.
- Ward areas had systems in place to ensure equipment was serviced and electrically tested. We saw equipment was labelled with testing dates which were current, and staff told us about the procedure in place to clean equipment between patients.
- On wards equipment was stored appropriately and oxygen cylinders were stored securely upright to eliminate the risk of them falling. Store rooms were organised and boxes were safely stacked.

Records and management

- We saw that most records were held on an electronic system. This system is shared across the majority of the trust, but Specialist Palliative Care Nurses told us that some general practitioners (GPs) do not have the same system. This caused issues with data sharing.
- For example, the trust uses paper forms for "do not attempt to resuscitate" (DNACPR) as some GPs could not access this information from the system. The trust told us that they were aware of this issue with the computer system and were working on resolving it.
- During our inspection we saw that a computer screen displays were not left open at any time whilst they were not in use. The offices were used by many different staff, and this meant that records would not be seen by people who were not required to have access to this information for their work. We noted that the offices of the palliative care teams and MacMillan nurses were not accessed by members of the public or people who used the service.
- The palliative care team told us that they have access to their electronic system remotely, which enabled them to access data in various locations and update records without returning to the office. This system relied upon an individualised secure log-in system so that data was protected from any other person accessing the laptop.
- In ward areas we saw that paper records were stored securely and were not left unattended on desks. Bedside records did not contain sensitive information, and closing folders were used so that information was only visible once the folder is opened, and not on display for example on a clipboard.

Cleanliness, infection control and hygiene

- Offices and ward areas were kept clean and free from clutter. Patient areas had adequate space and facilities to enable them to be cleaned properly, and bins and waste areas were emptied regularly.
- Bathing facilities were adequate, some were dated but no chips or splits were present in the furniture so that dirt was not trapped or created an infection risk.
- We saw cleaning schedules in place in ward areas, and staff told us that night staff have responsibilities for cleaning tasks during the night and that a schedule was followed.
- All areas of end of life care completed hand washing audits and infection control audits. The "ten point" infection control audit we saw was not comprehensive; however it was used as a basis to improve the cleanliness of ward areas.
- We attended a visit with a nurse from the MacMillan nursing team and saw they washed their hands before and after working with the patient. Our observations of this staff member showed they had an understanding of infection control procedures and took steps to keep people safe from the risk of infection.

Mandatory training

- We were told that all staff were compliant with the trust policy for mandatory training.
- At Loughborough Hospital staff told us that newly qualified nurses complete induction training for a year. During this year nurses completed training in various competencies including administering intravenous medications, venepuncture, cannulation, syringe driver and catheterisation training.

Good

Are services safe?

- Newly qualified nurses were supported in their new role. Nurses on their preceptorship shadowed nurses in different parts of the service to get a full appreciation of the way the service worked.

Assessing and responding to patient risk

- At Loughborough hospital we were shown the variety of risk assessments in place for patients in the ward. These included moving and handling, skin integrity, nutrition, falls, and bed rails. These risk assessments were used as the basis for planning care for people and ensuring that people were safe.
- At Loughborough Hospital staff told us about an "electronic board" system which the trust planned to implement. This system will be programmed by nurses to prompt staff to carry out assessments and reviews and ensure that care is delivered corresponding to the risk assessments entered on the system.

Staffing levels and caseload

- At Loughborough Hospital a senior nurse told us "I don't feel like I'm a nurse" because of the high work load and lack of time they felt they had to be able to do their job properly.
- We were told that 50% of shifts are not able to be covered by ward staff so they are requested from the bank and agency, as the ward had vacancies for three full time nurses.
- Staffing levels at Swithland Ward in Loughborough Hospital were two registered nurses in the day, two at registered nurses at night, five health care assistants in the morning, three health care assistants in the evening, and three health care assistants at night.
- Staff told us that the palliative care suites were not usually both used, and at times both were empty. Should both of these rooms be required staffing levels may be low to ensure that adequate care was provided to all the patients, including those in the palliative care bays.
- Staff told us that they were not aware of any dependency tools in place to evaluate the number of staff required to ensure the ward is staffed to a safe number.
- Staff at Loughborough Hospital told us that they are on the trust's risk register as they are short of staff. We were told that the trust is working to recruit staff and has rolling job adverts and is streamlining recruitment procedures to allow quicker recruitment of successful staff.
- In each area of the trust with exception to the palliative care teams and MacMillan nursing teams; staff told us that they were short staffed and had been for some time. This meant we could not be sure that staffing levels were maintained at a safe level.
- At Loughborough Hospital staff told us that they had heard there were plans to remove the medical support the hospital received from Doctors altogether. Staff were unsure as to how this would work as there were issues with the lack of 24 hour cover from doctors in the current system. The trust confirmed there were no plans to remove the medical support to Community Hospitals.
- Market Harborough and Lutterworth palliative care nurses cover a large area and hold a caseload of around 34 patients each. We were told that this does not fall below this, but that the team manager reviews caseloads with staff to prioritise the workload. This acted as a peer review process and enabled the manager to oversee the care provided to patients.
- The staffing levels at St Luke's Hospital were not safe prior to our inspection; as a result the trust merged two wards into one. This meant that the service provided at St Luke's Hospital was not sustainable.

Managing anticipated risks

- Palliative care nurses told us that staff had access to four wheel drive vehicles to use when snow or inclement weather made travelling in personal vehicles dangerous. The trust had a system in place to anticipate risks to staff safety and provision of the service to patients.
- Weather forecasts were monitored in advance of poor weather so that plans could be made in advance.
- Risk assessments were in place for patients at Loughborough hospital which included moving and handling, tissue viability, nutrition, falls, and bed rails. We were unable to view these as the ward did not have a person in the palliative care facility at the time of our inspection.
- Staff working in the community told us that they had a "buddy system" where they check in with their buddy at the end of their shift. If staff were worried about a particular visit they will call their buddy before and after the visit so their whereabouts were known.

Good

Are services safe?

- There was no system in place to support palliative care nurses in advising on medication doses of patients provided by the trust. Staff telephoned the hospice for guidance around clinical matters and advice.

Requires improvement

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We rated effective as requires improvement because:

- Following the national withdrawal of the "Liverpool Care Pathway" the trust has developed an alternative care plan; however this has not yet been implemented.
- Staff had completed verification of death training but some were not able to put this into practice or explain why they were unable to do so.
- Staff were unable to show us evidence of clinical audits or the basis of evidence based practice in end of life services. The trust confirmed staff delivering end of life care were involved in bi-annual record keeping, safeguarding and clinical supervision audits. However there was no evidence of clinical audits or monitoring of the service in order to improve care provided to patients and staff were unable to talk about this to inspectors.
- Computer systems were not shared across GP surgeries so information sharing did not happen effectively.
- Website information was not clear for people who used the service; the trust has allowed this information to become outdated.

However:

- We saw that consent was gained from people in relation to their care and future wishes.
- We saw that Advanced Nurse Practitioners were completing Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms having completed their training to do so; however we saw that these forms were not countersigned by a doctor or consultant.

Detailed findings

Evidence based care and treatment

- Following the national removal of the "Liverpool Care Pathway" (LCP) staff told us about a replacement that is being implemented called Last Days of Life. We looked at documentation in all areas we visited, including on home visits and did not see an example of this paperwork being used.
- The Hospice at Home team attended meetings with the regional End of Life Care Group and East Midlands Group to ensure that latest evidenced based practice is shared and disseminated throughout the teams.
- The trust confirmed the Diana Community Children's Service had operational and strategic representations at the East Midland Palliative Care Network and presented at an annual multiagency palliative care training programme.
- Other areas of the trust, in particular the units with palliative care suites, were not involved in the end of life care networks or training. This meant that standards were inconsistent throughout the trust.
- The Diana Team provide a service for children receiving end of life services. They used a specific care plan designed for children to ensure that best practice is approached in their care. We saw evidence that this plans is communicated across other teams to ensure the treatment plan is followed.
- The trust had no policy for care after death, so nurses had created a checklist to prompt them when caring for a deceased patient.

Approach to monitoring quality and people's outcomes

- The trust confirmed staff delivering end of life care were involved in bi-annual record keeping, safeguarding and clinical supervision audits. However there was no evidence of clinical audits or monitoring of the service in order to improve care provided to patients and staff were unable to talk about this to inspectors.
- We saw an electronic patient care assessment form. This included a section to enter where people preferred to receive their care, for example; if they chose to stay at home during their last days of life. We were told that these questions were asked sensitively, and at an appropriate time. This meant that the trust could monitor the number of people that realised their preferred place of care, and it allowed staff to know at an early stage what people's wishes were.
- The Hospice at Home team told us about the targets they measure in order to provide the best care they can. The team used the electronic system to record where

people prefer to be cared for and if this is achieved. The team have a target of 80% in facilitating people to be cared for in their preferred place, and met this with 92% of patients.
- However in ward areas we saw that this system was not in place and staff told us they did not record preferred place of care other than in the patient's care file. This meant that data from people cared for in a ward setting was not collated, so figures on the electronic system are not trust wide.
- At Loughborough Hospital staff told us they audited instances of pressure ulcers that occur on the ward and investigated each occurrence in order to improve practice for future patients. Their reporting board displayed that they had not had a pressure ulcer on the ward for 470 days. This meant that there was a system in place to protect people from pressure ulcers.

Competent staff

- At Loughborough Hospital staff told us that they did not routinely carry out specialist training when caring for people in end of life suites. The manager told us that they had attended an advanced communication course, but other staff on the ward had not completed any further training beyond the trust's mandatory subjects.
- Ward based staff in different areas told us that they had completed training in verification of death so that they could shorten the length of time this process usually takes. At Loughborough Hospital staff told us that they were not yet permitted to use this training, and that this was frustrating for them as they were waiting for out of hours doctors to come in to perform this task. We found staff in other hospitals were using this training; we found an inconsistency in the trust approach.
- All of the senior staff we spoke to told us that they had attended advanced communication training which taught them to effectively manage difficult situations and gave them confidence to know when it was appropriate to discuss sensitive subjects.
- The Hospice at Home team carried out monthly supervision for the nurses with prescribing qualifications to ensure that practice was up to date and monitored. The team had seven prescribers which enabled the team to provide a quicker service to people who may be in pain.
- The team told us that they received monthly training in symptom management and syringe driver use to ensure they remained competent in these areas.
- Staff have been encouraged to study professional funded courses, for example a "Health and Professional Care" degree. A nurse told us, "We have been allowed to develop and turn our innovations into practice."
- The trust had not implemented specific end of life training for staff working in end of life services, any courses provided to staff were based on interest and a heavy reliance was placed on the local hospice for training requirements.
- End of life care services had minimal bank and agency staff usage.

Multi-disciplinary working and coordination of care pathways

- The Hospice at Home team told us how they work with other professionals to provide a holistic service. They told us that they work closely with MacMillan nurses, district nurses, Marie Curie nurses, general practitioners, hospices and wards where patients may be receiving end of life care.
- The Hospice at Home team told us that they had provided some training to local care homes to improve understanding of end of life care and the services available. The team told us that they planned to provide more of this training in the future.
- Multidisciplinary meetings were arranged every six weeks to review patients and treatment plans. Staff were unable to tell us why this did not happen more often.
- Gold Standard Framework (GSF) meetings were held at a GP surgery, but staff reported that they could not always attend this meeting because of a high workload. One palliative care nurse told us that they cover nine GP surgeries in one area, and 14 more in another.
- We were told that the current bereavement service consisted of a letter posted to the family or carer of the patient some weeks after the patient had died. This letter contained signposting information but there was no service to meet with people or call them to ensure that they had access to counselling if necessary. This meant that the trust had not provided a complete service for these people.

Referral, transfer, discharge and transition

- Referrals can be made to the palliative care team by any professional, and patients that have previously been seen by the team are able to call up and refer themselves back into the service.

Requires improvement

Are services effective?

- Hospital staff told us that MacMillan nurses attended the ward to visit patients who were on their caseload, or to provide support on transfer of their care when they were going home into the community. We were told that patients were able to ask for their MacMillan nurse to be contacted, however this was not routinely offered to patients.
- The trust had a "rapid discharge team" which was instigated in 2010, in partnership with the University of Leicester and the Loros Hospice. This service facilitated a safe discharge for patients by enabling care packages and equipment to be put into place to ensure the patient was able to receive care in their chosen place.
- The Hospice at Home team completed daily handovers by telephone with the night team so that the transfer of care between the teams was smooth. This meant that relatives of patients do not have to repeat issues to the different teams.
- Calls were also made to district nursing teams to inform them that they are on call should they require support with their case load.

Availability of information

- Staff told us that the computer systems they use are not shared with all GP surgeries. This meant that there was an issue with information sharing with some surgeries. The trust was aware of this but staff were not aware of a plan to solve the issue. Staff told us that they had to telephone surgeries to hand over information, and this meant spending long periods of time getting through to the surgery. There was also the risk of information not being recorded accurately by the person taking the call. The trust confirmed work was ongoing with external partners and key stakeholders to resolve these issues.
- Staff told us that they found it difficult to navigate the trust online directory to find information. This meant that care plans and other documentation were not always available to staff to carry out their work.
- The data collected by the trust on preferred place of care for the clinical commissioning group did not cover patients in wards in the community hospitals; this meant information was not a true representative of the trust's performance.
- The Hospice at Home team had information packs to give to patients so that they had access to contact numbers and other services provided by the trust.
- At St Luke's Hospital staff told us that relatives had commented in their feedback sessions that the trust website was not clear and did not contain up to date information about the ward. Staff arranged for the details to be changed to reflect the service; however it is not clear if the trust have updated information on the website for all areas.

Consent

- All of the staff we spoke to explained to us how they obtained consent from patients to carry out care and manage information.
- We saw documentation that people signed advanced decisions for their care, and staff told us about the process for making best interest decisions where patients were deemed to have fluctuating or reduced capacity. This meant that staff understood the requirements of the Mental Capacity Act (2005).
- We looked at "do not resuscitate cardio pulmonary resuscitation" (DNACPR) forms in use in the trust. We saw that the trust was proactive in arranging these forms to be completed early in a patient's care.
- We reviewed five forms and saw all of these had been completed fully, however we noticed that the form the trust used did not have an area in it for staff to document or tick a box to reflect that a multidisciplinary discussion had taken place. This meant that it was not clear as to which professionals contributed to the discussion around DNACPR for the patients.
- We saw that Advanced Nurse Practitioners were completing DNACPR forms having completed their training to do so; however we saw that these forms were not countersigned by a doctor or consultant. The trust confirmed after our inspection Advanced Nurse Practitioners used a DNACPR form which had been agreed within NHS East Midlands.

Good

Are services caring?

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

Summary

We rated caring as good because:

- We saw staff treated people with dignity and respect whilst providing care. Staff empathised where a person had a negative experience and offered support where necessary.
- Staff at St Luke's Hospital explained to us that patients can be anxious when they are admitted to their ward, and as a result of identifying this they had developed a "meet and greet" service and information sheets to manage initial expectations and provide information about their service.
- Staff at St Luke's Hospital had arranged bi-monthly meetings to involve patients and visitors in the news and actions happening on the ward.
- Palliative care nurses conducted holistic assessments for patients and provided advice around social issues, for example blue badges for disabled parking.

Detailed findings

Dignity, respect and compassionate care

- We saw signs were stitched onto curtains at Feilding Palmer Hospital around bed bays to remind staff that care is being carried out behind the curtains. The manager told us that this was in order to preserve the dignity of the patient receiving care and remind staff not to enter bays when curtains were drawn.
- We were told that this system had been recently implemented following a dignity champion drive, and that so far the results were positive, although this was not formally audited.
- The Hospital at Home team told us examples where they had attended to care for people in their own home and had respected the wishes of that person. For example, staff told us that they often removed shoes to enter, and to follow cultural wishes they had worn head scarves to cover their hair when attending patients.
- Staff also told us that they had close links with the Muslim Burial Council so that they were able to facilitate burials in line with patient's beliefs.
- At Feilding Palmer Hospital staff told us that they had admitted a young patient to their palliative care suite because they were the parent of a young child who was scared of hospital environments. The suite was close to the entrance of the hospital and meant that the family could spend time in a homely environment and maintain the patient's dignity.

Patient understanding and involvement

- Staff told us that they had access to interpreters by telephone or in person where patients spoke a different first language than English, to ensure that patients understood their care and could communicate without breaking confidentiality with the use of family members or carers to translate.
- We saw leaflets and information packs that staff gave to patients to inform them of other services they have access to in the trust. This meant that patients could contact other services when they felt they required support and had access to the numbers to do so.
- An Advanced Nurse Practitioner we spoke to at Coalville Community Hospital explained the importance of looking after the patient and the relative or carer. They "make sure the relative and patient has the best experience possible and families are accommodated."
- St Luke's Hospital initiated bi-monthly meetings with patients and their families to involve them in ward meetings. Comments from the meetings were recorded and actions put in place to rectify issues.
- For example people said call bells took a while to be answered, so staffing allocation was altered to improve this at a specific time of day. At a following meeting staff revisited this subject for feedback and found that things had improved. This process was recorded in the minutes of the meeting, and a brief synopsis was displayed on the wall in the ward.

Emotional support

- At St Luke's Hospital we were shown a "meet and greet" service that had been implemented following the staff recognising that patients and their carers were often distressed following their diagnosis.
- Staff noticed that patients were overwhelmed with information on admission, so they appointed a health

care assistant to champion the meet and greet process. Staff told us that when a person is admitted the "meet and greet" form is completed with the patient and their carer.

- This provided patients and their carers with information leaflets about the ward, staff introductions, and a "getting to know you" form where patients were encouraged to document their preferences. We saw that relatives had written on the bottom of these forms thanking the staff for the warm welcome to the ward.
- Staff told us this initiative had enabled the ward to address concerns of people and had reduced complaints in the unit.
- St Luke's hospital had staff that spoke to patients on a one-to-one basis, and during quieter periods patients can have "pamper weekends" where their nails were painted. This time enabled staff to interact with patients and provide emotional support on a one-to-basis.
- The palliative care specialist nurses told us about the counselling service available at the local hospice run by a charity. There was a waiting time of six weeks for this service and patients had to attend the hospice to access it. The trust did not have a counselling service of its own to offer patients.
- St Luke's Hospital had a Chaplain who provided access to all faiths if necessary. The hospital had six volunteers that assisted in visiting patients and provided access to support. The trust confirmed all community hospital in-patient wards have access to a Chaplain.
- A specialist palliative care nurse showed us the holistic assessment that was completed for patients. This included asking what the patient preferred to be called, explaining their role and how often they would be visiting, requesting consent to add the patients details to the computer record system, review of medical history and medication to ensure records are current.
- The nurse also provided support around obtaining a blue badge for parking in disabled spaces, and explained to the patient that they would arrange this for them.
- We were told that the current bereavement service consisted of a letter posted to the family or carer of the patient some weeks after the patient had died. Currently there was no service to meet with or call families or carers to ensure that they had access to counselling if necessary. The trust confirmed other bereavement services were provided by the community nursing service and Hospice at Home teams.
- We observed the nurse speaking to patients and their carers with respect, and being empathetic when a relative relayed a poor experience they had had with another service.
- We spoke with relatives of a patient on end of life care. The relatives told us they were pleased with the care their relatives received.

Promotion of self-care

- The Hospice at Home team told us that patients were facilitated to go home to be cared for if they wished, and that equipment could be supplied with the assistance of other agencies. This meant that patients were able to be as independent as they wished in the end stages of their life.

Requires improvement

Are services responsive to people's needs?

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

Summary

We rated responsive as requires improvement because:

- The service was responding to complaints and implementing systems following these, however the trust waited for these complaints to prompt improvements in the service. The trust had no auditing system to measure performance in order to improve the service.
- Staff explained that the figures collected around preferred place of death were collected as these were requested by the clinical commission group (CCG), although these figures were collected for services in the community; the ward based palliative care figures were not collated.
- Staff told us services did not admit patients close to weekends due to issues with verification of deaths over weekends. The trust confirmed nurses have been trained in the verification of death and a protocol was in place.
- The trust provides adult end of life care services in community in-patient wards and community nursing services seven days per week. However staff did not appear to be fully aware of services provided and told us there were plans to implement a seven day service in end of life care.

However:

- We saw the Hospice at Home service had expanded and provided support for end of life care in the trust.

Detailed findings

Planning and delivering services which meet people's needs

- Staff told us that they received support from the local hospice for advice where needed.
- In Loughborough Hospital, Palmer Feilding Hospital, and St Luke's hospital the palliative care beds were overseen by Advanced Nurse Practitioners (ANPs).
- These nurses have completed courses to be able to prescribe anticipatory pain relief for patients. However we were told there was minimal medical support from doctors and out of normal working hours staff had to call out of hours doctor's services. This meant that people being cared for in the palliative care suites may receive delays in their care.
- Staff told us that due to the lack of medical cover there had been problems with staff obtaining verification of death over a weekend. We were told that admissions were not accepted before weekends because of this issue. We asked if this had been raised with management and staff could not tell us if it had or not. The trust confirmed nurses have been trained in the verification of death and a protocol was in place. – REMOVE THIS PART OF SENTENCE therefore nothing had been put in place to manage this.
- The team told us that they monitored types of calls so that they were aware of the emerging themes in their caseload. The manager told us this enabled them to plan ahead and provide care to meet the needs of the local population. This was developed by the Hospice at Home team and was not implemented by the trust across all the end of life services.

Equality and diversity

- The community hospitals we visited had access to quiet areas for people to reflect. These areas were not decorated to represent a particular religion so that patients felt comfortable regardless of their religion.
- Chaplains provided a service for any faith, and volunteers also worked at the service to assist in supporting patients to carry out their wishes.
- The palliative care nurses told us they aimed to find out patients' wishes and religious beliefs early in their care so they can document this and ensure their wishes can be carried out. For example staff told us that they have been able to assist a family in the early release of a body so that burial times were adhered to.
- Leaflets and information can be obtained in other languages for people who do not speak English as a first language, although these were not visible alongside English leaflets in the places we visited.

Meeting the needs of people in vulnerable circumstances

Requires improvement

Are services responsive to people's needs?

- We asked staff if they had care plans in place for people with dementia to make end of life choices early on in their illness.
- We were told that this did not exist in the trust; neither were care pathways in place for people with learning disabilities or other diagnosis which may require different services and support.
- The trust confirmed community services accessed and engaged with different trust services as appropriate to support people living with learning disabilities and dementia who were making end of life choices.

Access to the right care at the right time

- The palliative care team and MacMillan nurses told us they worked closely with other members of the multidisciplinary team, for example GPs and district nurses, in order to ensure patients received timely access to services.
- We were told about the rapid discharge system that could enable the discharge of a patient within four hours by arranging relevant care packages at their home and equipment.
- Staff were able to give us examples when this had been used to ensure a patient was able to return home as they wished, however we were not able to verify this with any patients that had used the rapid discharge service.
- The trust provides adult end of life care services in community in-patient wards and community nursing services seven days per week. However staff did not appear to be fully aware of services provided and told us there were plans to implement a seven day service in end of life care.
- The Hospice at Home team told us that their telephone system is manned 24 hours a day so that patients had access to clinical advice at all times. This meant that people had access to care and services at they required it.
- The Palliative Care Lead Nurse told us that a single point of access service was being developed so patients could call one number and press numbers on the keypad on their telephone to be put through to their desired service. However, this line would be manned by administration staff and not clinicians, meaning that patients would have to wait for clinical advice to be forwarded to them.

Complaints handling (for this service) and learning from feedback

- Staff sought feedback from visitors and service users from questionnaires so that feedback was provided about the service. The questionnaires were presented in a pack with a stamped addressed envelope so that patients could be confident that their feedback would be handled independently.
- A manager told us how they dealt with complaints and gave an example of an investigation they had recently carried out in relation to a complaint in another area of the trust. They told us that managers investigated complaints and incidents from other departments so that an independent view was taken.
- However, we were told that verbal complaints were managed at ward level and the findings were documented in the notes of the patient, and not logged on the ward or notified to the trust. This meant smaller issues may not be tracked and resolved by the trust as there was no auditing system in place for verbal complaints.

Requires improvement

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 requires improvement because:

- The trust had no end of life strategy as the previous one had expired and a replacement had not been developed.
- There was no evidence of clinical audits or monitoring of the service in order to improve care provided to patients.
- Staff received little support from specialist doctors in palliative care and contacted the local hospice run by a charity for support.
- In St Luke's Hospital we saw good examples of staff arranging meetings for patients to get involved with the news and plans for the ward; however this was not the case in other areas of the trust providing end of life care services.

Detailed findings

Service vision and strategy

- The Hospice at Home team had a clear strategy for developing end of life care. They had a five year plan for the service relating to increasing staffing, providing training to the team, and then facilitating training to other areas of the trust so that other teams were more aware of end of life care.
- We saw a trust palliative Care Lead Nurse who had developed an end of life care plan which was being implemented, however we did not see any of these care plans in place in people's homes or on wards where we looked at notes from people who had recently died.
- The End of Life Strategy the trust had developed had expired and there was no replacement strategy in place currently. This meant the trust had no plan in place to develop the service.
- The post of the "End of Life Care Facilitator" had been discontinued and not recruited into, staff told us this may be one reason that end of life care did not have a clear direction in the trust.
- Staff told us the new end of life care plan had been uploaded onto the trust intranet so that staff could access it to print when required. However, staff told us that care documents are usually stored in a folder named "working life balance" but in fact it was stored under "education". This meant that staff were unable to find the documentation, and clear guidance had not been given about its storage.

Governance, risk management and quality measurement

- At Loughborough Hospital, staff told us they did not carry out any audits specific to the patients cared for in their palliative care suites. We asked if the ward contributed to the trust's data collection on preferred place of care and we were told that they did not.
- Staff told us about the "Patient Safety and Experience Group" (PSEG) group assurance meetings which were held each month by the trust. Managers discussed current risks and the management in place for these, along with complaints, accidents and incidents, and other risk related points at Quarterly Performance Review meetings. This meant the trust had a system in place to monitor risk in departments and the opportunity to measure the quality of the service.
- We were told about different meetings that took place in the trust; ward meetings on a monthly basis, PSEG meetings, and "Introducing Quality Performance" meetings which were started in October 2014. However staff were unable to show us minutes from these meetings.
- The Hospice at Home team were involved in many meetings; professional nurse meetings, task and finish groups and service line governance. Staff told us that complaints, incidents, feedback from other meetings, and safeguarding issues were discussed at these meetings. This meant the Hospice at Home team had clear risk management systems in place.
- In other areas of end of life care these issues were adopted into medical wards and therefore the trust did not have a clear governance system in place for end of life care. The trust confirmed governance systems for specialist end of life care teams were integrated into the wider community services governance arrangements.

Leadership of this service

Requires improvement

Are services well-led?

- We met with the Palliative Care Lead nurse and discussed the trust plans for the future in end of life care. We saw the trust had developed a plan to develop aspects of the trust; however it was not clear how this would affect the end of life care services.
- Staff told us about a new system which had been implemented for staff appraisals, called uLearn. Staff had received training in this system, but they told us that they were not consulted in its implementation.
- Staff had received yearly appraisals, but supervision across the trust was less well managed, and in particular clinical supervision for managers was not effective.
- Many staff on the wards told us how supportive the local hospice was. They attended training with them and were able to call them for advice. However the trust had no system in place to provide this leadership for staff.
- All staff we spoke to told us that their line managers were supportive in the trust and they felt that they could approach them if they had problems.
- Senior nurses and managers told us that they did not know about any long term plans from the trust. We did not see evidence of trust leadership overall for end of life care services.

Culture within this service

- Staff in the Hospice at Home team told us that they felt listened to by the trust and where they had presented cases for improvement of the service by increasing staffing numbers the trust had acted.
- A nurse told us; "I feel valued as a member of team."
- In other areas of end of life care services staff did not feel so well supported and felt they had to work very hard to get heard. For example one nurse told us that she had to report environmental issues as risks so that the estates department would repair them.
- At a local level we saw managers had an understanding of performance management of the team they led.
- Staff told us that they were able to be open and honest with their colleagues, and they felt listened to by their line managers. However due to constant changes in the trust, managers were unable to say whether they felt listened to by trust senior management personnel.

Public and staff engagement

- At St Luke's Hospital the ward managers told us about an innovative project they had developed called "sisters act". This was a feedback system where staff were able to complete comment cards with prompts about what the comment was about, what the staff member thought would be a solution to the problem, and how they would like to receive feedback; on a one to one basis, in a staff meeting, or anonymously.
- We were told that this was the first stage of a system where staff will be able to give feedback on a computer system with a touch screen which patients and visitors will also have access to and be able to provide real time feedback. Staff told us that this would enable them to solve issues much quicker and before they escalated.
- Staff who worked in hospitals with palliative care suites were not involved or consulted around the new end of life care planning document. Pilots were not carried out in the trust for staff to trial this documentation before it was implemented.
- We saw examples where the trust had improved its service as a result of feedback or complaints; however the trust did not seek to engage patients and their carers in order to improve the service other than through questionnaires. The trust acknowledged these had a low return rate from people the questionnaires were handed to.

Innovation, improvement and sustainability

- The project "sisters act" at St Luke's Hospital, which encouraged staff to give feedback about the service and encouraged them to think about how it could be improved and to contribute to ideas in the department, had been rewarded by an award from the trust.
- However it was not clear if this has been adopted in other areas of the trust.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found the trust had not implemented the alternative care plan developed after the withdrawal of the Liverpool Care Pathway. This was in breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (1) HSCA 2008 (Regulated Activities) Regulations 2014 Person centred care. The trust must make sure the care and treatment of service users must be appropriate, meet their needs and reflect their preferences.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision We found the end of life care strategy had expired. This was in breach of regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance. The trust must make sure an end of life care strategy is developed and followed to assess, monitor and improve the quality and safety of the services provided. This was in breach of regulation 20 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

This section is primarily information for the provider

Requirement notices

The trust must make sure accurate, complete and contemporaneous records are maintained in respect of each service user.