

Walsall Healthcare NHS Trust

RBK

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)
RBK	Beechdale Health Centre	Trans Team	
RBK	Darlaston Health Centre	West Team	
RBK	Pinfold Health Centre	North Team	
RBK	Goscote Palliative Care Centre	Specialist Palliative Care Team	

This report describes our judgement of the quality of care provided within this core service by Walsall Healthcare 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 Walsall Healthcare NHS Trust and these are brought together to inform our overall judgement of Walsall Healthcare NHS Trust<Enter provider name>

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

In order to assess the level of service provided to end of life care patients, their families and carers we visited team bases and health services and spoke with nursing staff, doctors and managers about their work and how they were supported.

We accompanied staff on home visits to enable us to assess the service provided and to talk with patient's families and friends in their home environment.

We spoke with a total of 12 staff and 18 patients/carers and we also spoke with six patients by telephone.

We looked at 18 patient health records and other records and documents about the provision of the service, training and management of staff and provision and maintenance of equipment.

We liaised with colleagues in our Adult Social Care directorate who inspected the Hospice Service at St Giles Walsall Hospice . We did this to see how effective care was when patients moved between services.

We compared what we found against national guidance and best practice.

The World Health Organisation (WHO) define end of life care as: 'an approach that improves the quality of life of

patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.'

The National Institute for Health and Care Excellence (NICE) Quality Standards QS [13] provide 16 quality standards on which health care providers are encouraged to base their services and so provide patients with a seamless, first class service.

The National Clinical Guidance Centre, published a consultation document Care of the Dying Adult, in July 2015, outlining 67 recommendations in relation to the provision of care for dying adults. The guidance was commissioned by NICE.

Our judgement of the service provided in the community by the trust, fulfilled the WHO definition and met the NICE guidance. Areas of guidance contained in the Care of the Dying paper which were not already part of the service were under consultation. In some respects the service was very good. However, we did identify areas where the service could improve although the areas concerned did not impact on patients or their families.

Summary of findings

Background to the service

The trust had two dedicated Specialist palliative care teams, an acute team who worked within the Walsall Manor Hospital and a community team. Both teams were managed by the same senior managers and the services operated so that patients moving between community and acute services were identified and received appropriate care.

This report refers to the community based services only. There may be references to the hospital based services where these have had a direct impact on the community based services.

The Goscote Community Specialist Palliative care team were based in the same building as the St Giles Walsall Hospice. Whilst the hospice was operated by an independent provider, the services worked closely to ensure patients who were eligible and required hospice services were able to move between community and hospice services with the minimum of disruption.

End of life care is available to all patients who were assessed as being in their last twelve months of life. In common with many areas of the country, cancer patients form a high proportion of the trust's end of life care patients. Between April 2014 and May 2015 the trust's

specialist palliative care team received 1,549 referrals. Around 65% of these patients were cancer patients and 35% had other life limiting conditions. The proportion of patients identified with a non-cancer diagnosis had risen from 33% during the previous twelve months.

The community specialist palliative care team specialised in assisting patients with conditions which could not be cured but in many instances, with appropriate care and interventions patients could continue to live with their condition for many years. As a result, the team had often built up close relationships with patients and their families by the time they had been identified as end of life.

The service supported between 40 and 60 patients per month to die in community settings, either at home or in care homes or hospice settings.

Walsall Healthcare NHS Trust provided end of life care in Walsall Manor Hospital. Information regarding the hospital service is outlined in a separate report however, management of Specialist Palliative Care services was coordinated by the same senior management team and as such, there may be some areas of the reports which cross between acute and community.

Our inspection team

Our inspection team was led by:

Chair: Professor, Juliet Beale, CQC National Nursing Advisor.

Team Leader: Tim Cooper, Head of Hospital Inspections, Care Quality Commission.

The team included a CQC inspector, an End of Life Care Nurse and a Specialist Palliative Care Nurse.

Why we carried out this inspection

We undertook this inspection as part of the comprehensive combined acute and community health services inspection programme.

Summary of findings

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 held about the core service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by the trust and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit from 8 to 10 September 2015.

What people who use the provider say

Patients and family members were very complementary about the end of life care provided. Nursing staff on the palliative care and district nursing teams were particularly well liked. Comments such as: "they are all angels", "they can't do enough for you" and "absolutely brilliant" showed the depth of feeling.

Therapy staff, doctors, volunteers and counsellors were all described in glowing terms.

Good practice

The complementary therapy team at the Walsall Palliative Care centre had produced outstanding results using a form of auricular acupuncture, reducing sweats and flushes for patients and improving their quality of life. A reduction from 95 episodes in a month to five episodes, with corresponding less intensity were recorded.

The multidisciplinary approach to counselling with psychologists, bereavement counsellors who engaged with patients, family members and in particular children prior to as well as following bereavement were outstanding.

Identifying the need for support for patients and families in relation to social aspects of their lives and housing, the Citizens Advice Bureau Service is provided within the Walsall Palliative Care Centre.

Areas for improvement

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

- The trust **SHOULD** ensure that end of life guidelines is available for staff to follow to ensure patients are protected from the risk of inappropriate or unsafe care and treatment.

- The trust **SHOULD** ensure staff have sufficient training and time to enable them to assist patients and/or family members in completing the care plan document.

Walsall Healthcare 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 this domain as good. Incidents were reviewed and learning shared within and across teams.

Staff had received appropriate training and were managed in a way which ensured they understood how to keep people safe from abuse and how to report or escalate concerns.

Staff were seen to follow good practice in relation to prevention and control of infection. In people's homes, treatments were only provided if staff were satisfied the environment was suitable. Where any doubt existed, patients were offered treatment in clinics or hospital day beds so that the risk of infection was reduced.

Clear records were maintained in relation to all aspects of the service including patient health records. Some duplication of health records occurred as copies had to be retained in patient's homes for use by visiting healthcare professionals. This was achieved by use of duplicating sheets which ensured all records contained the same information.

Incident reporting, learning and improvement

- It was practice across the trust for each community nursing team to meet every morning to discuss patient

needs and staff workloads. This included discussions concerning patients who received end of life care and also patients who received palliative care and when their condition deteriorates, may require end of life care in the near future. We were told how issues, including any learning from incidents were also discussed. Staff told us they saw these meetings as one of the reasons the teams were so effective.

- Incidents were reported at divisional level with community end of life patients sitting under the medicine and long term conditions divisional reporting figures. We saw in January 2015, long term conditions, which included inpatient areas, had reported a total of 164 incidents.
- 58 incidents were reported by the community specialist palliative care team between June 2014 to September 2015. 54 were classed as no harm or low harm and four were classed as moderate harm. Two 'moderate' incidents related to implementation of care and ongoing monitoring and review. One related to treatment and one related to self-harming behaviour. We were told appropriate measures had been put in place to support the patient's behaviour with self-harm.

Are services safe?

- Weekly Combined Specialist Palliative Care MDT meetings and Monthly Specialist Quality Palliative & EoL Care Group meeting took place during which information from around the trust, including learning from incidents, was shared. We saw minutes to support this.
- Community services had a periodic 'Learning Lessons' newsletter produced by the trust Patient Safety team. The April 2015 newsletter identified how five incidents had been reported by staff relating to patients not receiving insulin injections in a timely manner. Whilst not all these patients were end of life patients, all staff in the community were able to learn from the issues.
- We saw how actions had been put in place to prevent or reduce the incidents. For example, allocation procedures had been reinforced to prevent appointments being missed. Staff had been tasked with ensuring out-of-hours contact numbers were available within patients records so they knew who to contact if their appointment had not taken place as expected.

Safeguarding

- The trust had a safeguarding lead based at Walsall Manor Hospital; Staff in the community were aware of the lead and understood how they could be contacted if advice was required.
- Staff understood their role with regards to keeping patient's safe and reporting any issues. Staff were able to describe the different types of abuse and how they would respond if they encountered abuse.
- We saw an example of how a district nurse had safeguarded a young person from emotional harm. They demonstrated a good awareness of the safeguarding process and managed what they described as a 'challenging situation' well.
- All staff who delivered palliative and end of life care received safeguarding training in line with their role. 100% of nursing staff had received both adult and children's safeguarding training to level 2. One of the two bereavement councillors dealt directly with the children of deceased or seriously ill patients. They had received additional training to level 3.
- Patients and their relatives were encouraged to tell staff if they had concerns and we saw safeguarding posters

displayed in prominent areas in clinics and bases with up to date contact details. One relative told us they felt their relative was safe because of the monitoring and dedication of the nurses.

- All staff employed by the trust had been subject to disclosure and barring service (DBS) checks. DBS checks help to ensure only people of good character are employed in certain occupations.

Medicines

- The end of life care teams worked in liaison with primary care services which meant medicines were prescribed by the patient's GP.
- Most patients self-administered their medication or were assisted by their carer's. District nurses and end of life care nurses undertook medication administration and maintained syringe pumps where this was required. Where nurses administered medication we saw they had completed medication records appropriately and had received up-to-date medication training.
- Some patients who received end of life care were prescribed anticipatory drugs. These were provided to patients who were at risk of exacerbation of symptoms, for example: nausea, anxiety and constipation. This could include going into crisis at short notice, or it may be in anticipation of serious deterioration of health. Having anticipatory drugs available in the home allowed qualified staff to attend and administer drugs which may stabilise a patient or reduce pain and anxiety and prevent the need for an emergency admission to hospital. In the absence of anticipatory drugs, doctors are usually called which may involve a delay during which patients may be in pain or discomfort or may deteriorate to the point where they need to be admitted to hospital.
- Lockable medicine boxes were available and on loan to patients who needed to keep controlled drugs in their home, this meant that children and other vulnerable people in the home were kept safe.

Environment and equipment

- Staff told us and we saw they did not experience any issues obtaining or maintaining equipment for patients with end of life care needs.

Are services safe?

- Walsall Palliative Care centre provided a number of services on site for patients who received palliative and end of life care, including specialist equipment available for the treatments. We saw equipment was well maintained and serviced regularly.
- Maintenance records were in place. Specialist equipment was also ordered for the centre to meet patient's needs for example, specialist breathing equipment. The centre manager explained that this had been delivered specifically for one patient and unfortunately the patient had been unable to attend and therefore the equipment was to be collected and returned to store. The equipment included oxygen cylinders all within their service dates.
- The centre had one resuscitation trolley; the trolley was properly stocked and was checked regularly to ensure it was ready for use. We saw notices on the walls of treatment rooms around the building to remind staff of the location of the trolley.
- The trust had developed a care guide document for end of life patients and their families. The document was designed to allow families or patients to complete information which was important to them as an individual. Details of likes and dislikes, preferences and information about their history which helped staff understand the patient and provide care in way which met their needs. We were told the trust had developed a replacement of the Liverpool Care Pathway which was removed nationally more than 18 months previous. The new document was called The End of life Individualised Care Plan and the aim was to roll this out to acute, community, Hospice care, and Nursing homes in 2016.
- We saw the current document in use across community end of life services, The care guide document was an effective tool to use, until the new document was launched.
- Not all patient health records contained completed care documents.

Quality of records

- Staff completed paper records in the patient's home so everyone who visited had an up-to-date record of multidisciplinary input. Duplicated record sheets were used so that one copy could be left in the home and one attached to the patient's main health records which were kept at the relevant team base.
- We looked at 18 records which showed symptom observations for end of life care were fully completed.
- We saw one instance where a patient was receiving treatment from a district nursing team at Beechdale Health Centre whilst resident in a care home. We looked at records held in the home in relation to the services provided by the trust; we then compared these with the main records at the base. We found the base records did not contain the latest drugs directive for the patient and had not been updated to reflect the patient's DNACPR status. This was highlighted to the district nurse manager and we saw this was corrected.
- We looked at audits and action plans which had been completed at the various locations we visited and in order to assess what staff and patients had told us, we checked several patients' health records both electronic and paper. We found the records were completed accurately and reflected what we had been told.
- We observed staff complete records during their time with patients and this often included an explanation to the patient of what the nurse had recorded.
- Patients told us they understood they could access the notes if they wished to do so. One family member spoke about medication and said: "I know I can go to the notes, but the nurse explains everything so I don't need to."
- Audits, staff rosters and training matrices were all completed in advance and maintained well.
- The palliative care link nurse at Darlaston Health Centre demonstrated a good audit process for records and record keeping.
- We saw monthly audits were completed. Three sets of notes were checked each month as a minimum, unless there had been less than three eligible patients in the location. Record audits at Darlaston District nurse base showed all required actions had been completed. The nurse explained how earlier audits had identified the subject of tissue or organ donation had not been discussed with patients and relatives. Tissue donation was now included in the managed care plan guidance

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used by staff. We were told this had led to additional training being provided to staff to help them understand how to broach the subject of tissue donation with patients and relatives.

- We reviewed a total of 18 sets of patient notes. We saw information contained within patient notes reflected the needs of individual patients. We saw records contained information about the individual patients which was designed to keep them safe and monitor their health over time. Health assessments and risk assessments were present which reflected updated risks of the patient and their condition. We saw evidence which included: pain assessments, waterlow assessments, nutritional assessments and falls assessments.
- Staff had described the managed care document which patients and their families were encouraged to complete. However, we saw the documents were not always completed. We saw staff had not encouraged families to complete the document or explain the importance of doing so.

Cleanliness, infection control and hygiene

- The trust had an infection control policy and all nursing and medical staff received training in infection control. We spoke with staff in the clinics and in home settings and we saw all the staff had a good understanding of infection control practices. There were no infection prevention control training figures available for the end of life care services.
- We observed staff as they used personal protective equipment such as aprons and gloves. We saw nurses washing their hand prior to and following patient contact. In patients' homes we saw how nurses prepared clean areas before opening sterile dressings or medication.
- Staff followed good practice guidance of being 'bare below the elbow' when providing care.
- Sharps bins were used for the disposal of contaminated dressings and sharps and the clinics we visited were all clean and tidy.
- Cleaning schedules were kept which outlined daily, weekly and monthly cleaning tasks and we saw evidence of these being audited. Cleaning schedules of clinics within the palliative care centre was the responsibility of the trust.

- The Walsall Palliative Care centre was a rented accommodation, however the furniture and fittings belonged to the trust.
- The facilities were shared by various services and many of the rooms are used for different clinics.
- We saw in June 2015 seven areas all used by Walsall Healthcare NHS staff within the Walsall Palliative Care centre, with the exception of St Giles Walsall Hospice, was audited. The results showed linen, personal protective equipment, hand hygiene, sharps and waste scored between 92% and 100%. Toilets, bathrooms and dirty utility areas scored 83%. The kitchen areas were RAG rated red with a score of 70% and environment and equipment was also RAG rated red with a score of 58%.
- We were told action plans were in place for all amber and red areas.

Mandatory training

- The trust target for mandatory training was set at 90%. We saw mandatory training rates in community services varied.
- Mandatory training was made up of a number of subjects, these included: conflict resolution, clinical update, equality and diversity, fire safety, patient handling, information governance and safeguarding children. Percentages were aggregated, such that individual members of staff might have completed some subjects and not others, so the figures for each discipline were added together to provide an overall level of compliance.
- We saw as of April 2015 100% of the palliative care management team had completed mandatory training. Rates for other areas included palliative care nurses scored 89.9%, complementary therapies team 90.2%, District nurse teams at Anchor Meadows was 69.8% and the Broadway team scored 82.4%. We saw the Brownhills team achieved 79.9%, the Central team scored 84.9%, the Darlaston team scored 81.9% and the Pinfold team achieved 77.1%.
- Staff booked themselves onto mandatory training. Training was available as e-learning and face to face courses.
- End of Life care training had consisted of a two day mandatory training course for all staff who provided end

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of life care. Staff told us the course had been excellent and it was based around the proposed new End of life Policy. The trainer had left the post the week before our inspection so we were unable to clarify the training and how this related to the draft policy. We were told the vacant training post was being advertised.

Assessing and responding to patient risk

- Risk assessments were completed in relation to both patients and their environment. We saw information was recorded which would assist staff or other health professionals to understand the patient's needs and provide care, treatment to identify, monitor and mitigate risks.
- Risk assessments were also completed in people's homes in order to keep staff safe and ensure equipment could be accommodated and used without it presenting a risk to the patients or staff. Assessments included malnutrition universal screening tool (MUST) scores, falls and mobility assessments, patient handling (sometimes referred to as manual handling) assessments and pain assessments.
- Any changes in a patient's health or vulnerability was recorded and any additional preventative measures were put in place for example, pressure relieving mattresses to reduce the risk of pressure ulcer development and mobility aids to reduce the risk of falls.

Staffing levels and caseload

- Caseloads were discussed each morning by each of the specialist palliative care teams. The needs of each patient, details of new patients, changes both expected and unexpected to the patient's health or circumstances were discussed which then allows an appropriate response to be planned from the most suitable member of staff.
- The Specialist palliative care nursing team consisted of nine specialist nurses who worked a variety of full and part time hours and an operational manager who also managed other teams within the SPC service'
- The team worked collaboratively with the occupational therapy, physiotherapy and complementary therapies teams and other health care professionals at the centre and also with the five locality district nurse teams.

- District nurses provided a range of care and treatment to people in their homes and we saw a proportion of their caseload involved the provision of end of life care. Medical oversight was provided by the Community Palliative Medicine Consultant based at the Goscote Walsall Palliative Care centre and worked part time.
- We saw recognised tools were used to assess staff levels and skill mix in all the locations we inspected. Staff in all areas we visited during the inspection told us they were busy, but they felt they had sufficient time to provide a meaningful and quality experience for their patients. Patients told us that with very few exceptions staff were unhurried and willing to spend time explaining procedures and health issues to patients and their carers/families.
- Care for end of life patients in the community was provided jointly by the specialist palliative care team and the district nurses. Each area district nurse team had a palliative care link nurse on the team. The link nurses had received additional training and liaised closely with the main specialist palliative care team. They were able to disseminate good practice and supported the local teams. We saw district nurses had good relationships with the palliative care team. This was demonstrated when we saw how the two teams worked together, discussing a patient's needs during a home visit.

Managing anticipated risks

- The trust had a lone worker policy; staff told us they understood how to keep themselves safe when working in the community. All staff carried mobile phones provided by the trust and details of all visits were recorded at each base which meant staff could be traced.
- End of life patients were identified to out-of-hours services and to ambulance services so appropriate advice or treatments could be given if patients deteriorated and to identify when patients had expressed a desire not be admitted to hospital were possible.
- Anticipatory drugs were discussed with GPs in relation to patients in their care and these were kept in people's home if prescribed so suitably qualified staff could

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administer the drugs to prevent delay in reducing pain or other symptoms as they arose. We saw advice was provided to GPs regarding potentially beneficial drugs and how these were then prescribed to prevent delay.

- Nurses we spoke with told us teams do not have pre-selected anticipatory drugs. The drugs were prescribed based on patient's individual needs.
- We observed the process for liaising with GPs and obtaining drugs during a home visit. A patient had been identified by a specialist palliative care nurse as requiring a particular drug. The nurse contacted a number of pharmacists in the local area to identify which had stock of the particular drug. The information about the patient's condition, the requested medication and the location of the pharmacist was faxed to the GP.

A prescription was written which was sent electronically to the pharmacists. The patient's relative was given the details of the pharmacist concerned and went to collect the drugs.

Major incident awareness and training

- The trust had major incident plans which included strategies to relieve pressure on acute services by increasing early discharge and care at home for patients. Community based staff were aware of the plans and how their role supported the trust.
- Staff told us major incident plans had been put in place in January 2015 for a short period as a result of the pressure on the hospital. This had increased workload for community staff during the period of the major incident and for some weeks after.
- We were told and we saw that staff were aware of what actions to take during adverse weather conditions.

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

The effectiveness of services overall was judged to be good.

End of life care in all areas of the trust's community services was centred on the individual patient, but also included support and guidance for carers and family members.

Facilities were provided in people's homes and supported by district nurse clinics in health centres which people could access in their local area. The facilities of the Goscote Walsall Palliative Care centre were also available.

Staff were encouraged and supported to keep up to date with their mandatory training and were also encouraged to develop personal skills which would complement or enhance the team's ability to provide holistic care to patients and support to their families.

Evidence based care and treatment

- End of life care in the trust had previously been provided in line with the Liverpool Care Pathway (LCP). The LCP was withdrawn nationally in July 2014. The pathway was withdrawn as it had been possible for misinterpretation of some aspects of the pathway which could lead to suffering for patients.
- In order to ensure their patients received appropriate end of life care, Walsall Healthcare NHS Trust introduced a managed care plan for patients with end of life needs. This centred care on individual needs rather than following a set format. We reviewed the care plan and saw it contained the monitoring elements for example, pain management, breathlessness and nausea with guidance on eating and drinking, bowel and bladder function and spirituality. We saw the care plan had an overview of the draft end of life pathway as an aide-memoire for staff to refer to.
- The trust in partnership with the CCGs had produced a draft end of life guidelines. This had been shared with other healthcare professionals, patient advisory bodies and groups in the area. This was in place to ensure all interested parties had an opportunity to comment and

suggest amendments or alternatives. This process had involved long review periods which had meant at the time of our inspection the trust had not ratified end of life guidelines.

- We were able to see the draft end of life guidelines and we saw it followed the NICE guidance, was patient focused, and ensured patient needs, physical, mental and spiritual were all considered. The guidelines included issues of consent and involvement of families, friends and interested parties in making decisions for patients who could no longer communicate their own preferences. Whilst the guidelines had not been approved, we were told staff training in end of life care was based on the guidelines. Staff we spoke with understood the guidelines and we observed the systems and processes in practice during our home visits.
- NICE Quality Standard on end of life care was published in 2011 but was amended in 2013 following the removal of the Liverpool Care Pathway (LCP). Quality standard QS13 outlines 16 quality statements to assist providers of adult health care to develop care pathways appropriate to their role. Not all 16 quality standards are applicable to all areas of adult care. We could see the trust's managed care plan reflected the NICE guidance in relation to the relevant quality standards.
- End of life care teams worked closely with GPs, the majority of whom used the National Gold Standards Framework for Palliative Care. In addition, staff used other tools to assess and monitor patients, such as the Macmillan care support guide.

Pain relief

- Pain relief formed an important part of the service's function. Patients in the community who received end of life care remained under the care of their GP who was responsible for prescribing their medication. However, consultants were available within the end of life care teams to provide advice and guidance to GPs on the most effective treatments.
- The Specialist Palliative Care team supported patients by liaising with GPs and district nurses regarding best practice in relation to care and treatment, including

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pain management. We reviewed 18 sets of patient records. Patients had all received pain assessments which was evidenced in their notes. Patients confirmed their pain was managed well. They described how staff had liaised with GPs on their behalf and medication had been adjusted to meet their needs. Where appropriate patients had syringe pumps. A syringe driver is a small, battery powered pump that delivers medication through a soft plastic tube, into a syringe with a needle which is placed just under the skin of the patient's arm, leg or abdomen. The continuous dose of medication is used to treat symptoms such as: pain, vomiting, seizures and agitation.

- We saw qualified nursing staff on the community teams were trained in the use of syringe pumps. Staff explained that syringe pumps were readily available within the trust.
- Support services such as occupational therapists or physiotherapists were available to patients in all areas and complementary therapies, specifically with massage treatments to help to reduce pain; this was delivered at a Walsall Palliative Care centre or on request, in patients' homes.
- We were told how a complementary therapy had assisted patients who due to their condition experienced hot flushes and sweats. A form of auricular acupuncture was used. We saw audit results from 2014/2015 which showed how the treatments had resulted in a dramatic reduction in the frequency and intensity of patients experiencing flushes. An example being a reduction from 95 episodes in a month to five episodes per month.

Nutrition and hydration

- Patients were encouraged by staff to maintain a healthy lifestyle, this included advice on diet and drinking. During their interaction with patients we saw staff discussing diets and reminding patients to drink plenty of fluids to stay hydrated.
- We saw staff contact dieticians and speech and language specialists (SALT) who specialised in eating and drinking disorders, to obtain up-to-date information so they could relay this to patients. Any patients who required more specialist support were referred to the dietician or SALT directly.
- During home care assessments, malnutrition universal screening tool (MUST) scores were completed which

helped staff identify patients at risk of malnutrition. For patients who were assessed as being 'at risk' of malnutrition, food and liquid intake was recorded and patient weight was monitored more regularly.

- Some patients were given medication to reduce nausea and enable them to eat without feeling ill.
- Where patients are unable to take food or drink by mouth, it is important to maintain oral hygiene. We did observe one instance where a nurse discussed difficulty swallowing and good oral health care; however, they referred to the use of lemon/glycerine mouth swabs. Whilst these are available as over the counter remedies, these swabs are no longer recommended for evidenced based care as the swabs had been shown to increase oral drying and loss of saliva due to temporary over-stimulation of the salivary glands, and osmotic effects of glycerine. Frequent use can also cause softening of tooth enamel.

Patient outcomes

- The trusts managed care plan for end of life patients had an overview of the whole end of life pathway as an aide memoire for staff to refer to.
- We saw records which showed assessments and comprehensive reviews of patients medical needs including; waterlow score which evaluates a patient's risk of developing pressure ulcers, pressure ulcer body check, level of continence, mobility, malnutrition universal screening tool (MUST) score which identifies patients who were or may be susceptible to malnourishment or obesity; other assessments included: pain, personal care, and sleep. Records showed how these areas were reviewed periodically or in response to changes in health and/or wellbeing.
- Care plans were reviewed to meet people's changing needs, one example being comprehensive medical notes detailing changes to pain medication and the introduction of a syringe driver for administration of drugs as a patient deteriorated. The notes were concise and signed and dated to show when and by whom the decisions had been made.
- Last offices is the term used to describe the procedures medical or nursing staff need to complete following the death of patient. National guidance is provided on all aspects of care following death and includes options to take account of cultural and religious beliefs of the

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deceased or their relatives whilst observing any legal requirements. All the staff we spoke with were able to describe the last offices processes and how they would support relatives and sign post them to other support services.

- Based with the SPC team at Walsall Palliative Care Centre were two bereavement counsellors, one of whom had received specialist training in counselling children whose parent had or was near to passing away. We saw this member of staff had also received level 3 child safeguarding training. Bereavement services support was available to patients and their families prior to death and continued with support for family members following a death.
- Although the trust participated in the National Care of the Dying in Hospital, this involved patients from the acute hospital and not the community end of life service. We saw the trust had listed 40 palliative care and end of life local audits in their 2015/2016 audit planner however, the audits directly related to the acute hospital and not the community end of life team.
- We saw evidence that in July 2015, a total of 63 patients had been identified as being end of life patients across the trust. Of those, 52 patients (82.5%) had died at home or at a hospice. We saw this was their preferred option and a good outcome for the patient and their family.

Competent staff

- Specialist Palliative Care Medicine Consultants were available for advice to trust staff and to other healthcare professionals. Home visits were completed in support of district nurses and GPs to advise on practice.
- Doctors told us they were supported to complete their revalidation. Revalidation for doctors was introduced in 2012; in order to maintain their licence to practice, doctors were required to demonstrate on a regular basis they were up-to-date and fit to practice. Study leave was provided and the service had a robust appraisal system which helped to support the revalidation process.
- We saw evidence at all locations we visited regarding training for nursing and healthcare workers. Specialist palliative care training included medicines training, syringe driver training and tissue viability training.

- Specialist nurses worked with specialist therapy teams and complementary therapists based at the Walsall Palliative Care centre and were also able to make home visits. Additional support was also available from a range of services, including psychologists.

Multi-disciplinary working and coordinated care pathways

- The specialist palliative care team held daily team meetings. The awareness of patients and their individual needs were discussed each day together with details and needs of any new patients who required visits. The team identified on a daily basis who was best able to support each patient and how care and support might best be delivered. The team liaised closely with the district nurse teams and the palliative care leads on each team and with therapy staff.
- Psychologists, occupational therapists and physiotherapists were all based at the Walsall Palliative Care centre and provided clinics at the centre. They also provided home visits where required.
- The Citizens Advice Bureau (CAB) provided advice and guidance to patients and family members. Staff described how many patients often became anxious about how their condition would affect income and how they or their families would cope. The CAB advice service helped people understand what assistance was available and enabled people to concentrate on their health without having to worry about other issues.
- We saw how the teams interacted and supported each other in order to provide effective care to patients. For example, during one home visit, the district nurse advised us that a member of the palliative care team was due to attend the address that day, on our arrival the palliative care nurse was already in attendance. The two discussed the condition of the patient and confirmed each others plans. They reviewed the care plans and medication charts with the patient and discussed how additional medication had been requested via the GP. We saw how the changes to medication had been documented in the records.
- The SPC Team were based at the Walsall Palliative Care Centre and worked closely with the district nurses, all of whom supported people to remain in their homes

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rather than being admitted to hospital. The care was coordinated through the team leader who ensured appropriate services attended, this reduced duplication and unnecessary repetition of assessments.

- Staff at all the locations we visited were proud of the effectiveness of their multidisciplinary working. A constant thread throughout the inspection was that every member of each team felt engaged and aware of what their fellow colleague was trying to achieve for the patients.
- We saw how end of life care staff worked with staff in care homes and assisted district nurse teams by providing advice and guidance and links to other community based services for the provision of specialist equipment such as beds and mattresses to enable patients to remain in or return to the care home if this were their preferred place of care or death. End of life care staff also provided advice and guidance to care home staff.

Referral, transfer, discharge and transition

- The trust had a rapid discharge initiative 'Home to die' pathway. The initiative aimed to discharge patients who have made a preference to die at home, to be discharged from the hospital within four hours. This involved ensuring community based care was set up and available to meet the patient's needs.
- District nurses, palliative care nurses and community based consultants all understood their role in the process of enabling patients to receive end of life care which met their needs and wishes.
- The trusts Specialist Palliative Care Team and the support services shared a building with the St Giles Walsall Hospice. Clear protocols existed between the trust and the hospice which enabled patients to move between the trust and hospice services as their needs changed. Whilst the two were separate organisations they provided a seamless transition for patients.
- End of life care patients were able to attend the Fair Oaks Day Hospice, where they could take advantage of all the facilities and services in the centre. Where patients were too ill to attend the centre, referrals could be made and staff such as therapists, psychologists and counsellors visited patients in their homes.

- District nurses and palliative care nurses worked closely with GP services and care home staff to ensure end of life patients received appropriate medication and support.

Access to information

- All nursing and medical staff had access to the trusts computer systems when at their respective base. However, the trust did not have remote access to electronic systems; staff used duplicated case notes when visiting patients in community settings. This enabled one copy to be left with the patient notes in the home and a second copy to be placed with the main patient records held at the base.
- Guidance, policies, procedures and general information to assist staff was available through the trust intranet and internet systems.
- Copies of policies and audits were kept by managers and senior nursing staff at the various bases and were available to staff if they needed to view them.
- Staff had individual email accounts where they received information or messages directly affecting them.
- News items appeared on the trust intranet and electronic newsletters were circulated which we saw contained useful information and guidance regarding incidents and medical alerts.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Community specialist palliative care staff used a national Mental Capacity Assessment tool to assess the capacity of patients. We did not encounter any patients who did not have capacity during our inspection.
- The Alzheimer's Society describes deprivation of liberty standards as 'The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aimed to ensure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.'
- Do not attempt cardio pulmonary resuscitation (DNACPR) forms were checked across several sites. In all we reviewed six DNACPR forms; we found they had been completed appropriately. For example, patients had

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signed their consent, or where appropriate best interest meetings had been held with relatives or carers and medical staff. The DNACPR forms had been signed by GPs or hospital consultants.

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 end of life care staff to be good. We found staff were very caring when dealing with patients and their families. Staff were proud of how they cared for and supported people and strove to develop ways to improve the service they provided.

In any other discipline, the judgement for caring may have been outstanding. However, it is expected staff in end of life care teams will have the skills and personality to enable them to deal with the difficulties associated with the prospect of death. We found staff involved in end of life care whether they were managers, doctors or nurses, all showed great compassion and care. Patients and family members all described how well they had been treated and couldn't imagine how staff could do better or do more than they did.

Staff involved patients in their care, encouraged them to be independent and gave advice to carers or family members to help them assist with care when this was appropriate.

Emotional support was provided to everyone concerned including staff supporting each other and being supported by their teams and managers.

Compassionate care

- Staff believed it was important to establish a relationship with the patients and their families in order to help people understand and deal emotionally with the complexities and realisation patients are approaching the end of their life. We saw how the staff used managed care documents for patients receiving end of life care. These enabled staff to understand the wishes of patients and their families. We were told staff should encourage patients and their families to complete the documents.
- Throughout our inspection we were able to visit a number of end of life care patients in their homes and we saw how staff interacted with the patients they cared for. Staff were polite and courteous; patients appeared genuinely pleased to see staff. Staff were welcomed into people's homes and treated almost as family by patients and their relatives or carers.

- During one home visit we saw the patient and family were pleased to see the nurse but we also noted that the nurse was clearly happy in her role and this reflected in the interactions between her and the family. The care provided was patient focused, provided with empathy and compassion.

Understanding and involvement of patients and those close to them

- We spoke with a number of patients at the Walsall Palliative Care centre who were all receiving treatment in a Community Oncology Suite. Patients told us they preferred this method because they could chat with each other and with staff during the procedure. Patients told us this made the experience feel less clinical. They all told us they were fully informed about their condition and the procedures they would need. They said doctors were excellent and they were clearly at ease with the nurses who were present, joking and laughing with them. They said the nurses could not do enough for them and were brilliant. Many of the patients were accompanied by family members. The family members confirmed they had been able to attend consultations and had been able to join in the consultations.
- Staff told us they involved carers and relatives in discussions about care and support and how this involved helping them as well as the patient to understand and come to terms with their condition. We saw evidence of this involvement and support when we observed members of the team during home visits where patients, carers and other family members were present. We saw how staff were friendly and exchanged banter with patients and their relatives but were professional and caring in their practice.
- Patients told us their medication and treatment had been explained to them including any possible side effects and the benefits they might see from taking medication.
- We observed staff provide care and support, and noted how staff took time to explain what they were going to do, how they were going to do it and ensured the

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patient was happy for the procedure to be undertaken. They confirmed with patients they were still happy for us to be present and where appropriate, they were happy for relatives to be present.

Emotional support

- All end of life care patients were allocated a named nurse so that they had a single point of contact. Patients told us they had found all the staff either in person or on the telephone to be equally as helpful and friendly. Some patients did say that having a named nurse was reassuring to them.
- Bereavement counselling was provided by the trust from Walsall Palliative Care Centre. Two bereavement counsellors were employed, one of whom specialised in dealing with children who had a parent who had passed away or was expected to pass away in the near future.
- Quiet rooms were available for people to speak with bereavement or nursing staff in a friendly, less clinical environment. A play room was also used where small children could be engaged with games and activities whilst discussing their feelings.
- A multi faith prayer room was available where patients or family members could meet with chaplains for spiritual support or use to collect their thoughts. We were told how weddings and blessing services had been conducted in the room.
- We saw how staff encouraged patients to complete tasks for themselves to maintain their independence. We saw nurses encouraged patients to live as independently as possible, monitor their own health and to report any changes rather than wait until a scheduled visit took place.
- Discussions also took place with family members who were advised about possible complications or consequences of certain issues such as pressure sores from sitting or lying in one position for extended periods of time. We heard advice being given about changing position and monitoring for signs of pressure ulcer damage together with options for mattresses or cushions should the patient's condition deteriorate.

Are services responsive to people's needs?

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

Summary

The end of life team were responsive to people's needs and we judged the service in this area to be good.

Care was planned to meet the individual patient's needs; most services in the community were available during core hours between 8:30am and 8:30pm seven days per week, with some provision of overnight care following certain procedures such as blood transfusions.

Patients and relatives told us they had never had problems getting appropriate advice or services, regardless of the time or day they called.

Community end of life services enabled rapid discharge of patients from the acute hospital, providing support to meet patient's individual needs and wishes.

Planning and delivering services which meet people's needs

- The Walsall Healthcare NHS Trust had one defined service for end of life care patients regardless of where they resided in the area.
- The Specialist Palliative Care Team were based at Walsall Palliative Care Centre but travelled across the trust.
- District nurses worked from six community based locations. There were five teams but the East (South/East) team was split between two sites. Each district nurse team had an end of life/palliative care link nurse. This ensured a uniform approach took place across the trust.
- The trust did not have a dedicated end of life care ward although they worked closely with independent hospice services. Patients who were admitted to hospital or the hospice with end of life needs were supported to return home if this was their wish.
- Patients were discharged home or back to their care home to die where this could be facilitated in time. Figures for July 2015 showed 82.5% of patients who died whilst under the care of SPC did so in community settings and this was their choice.

- The trust had a community rapid response team. The team used offices within a local authority care home as a base. They operate between 8.30am and 10pm seven days per week. Part of their role was to respond to and support end of life care patients to prevent unnecessary hospital admissions. They responded within two hours of referral to provide a multidisciplinary approach to stabilise patients until other services such as district nurses or GPs could respond to the patient's needs. Referral to the rapid response team was via healthcare professionals, patients were not able to self-refer.

Equality and diversity

- Staff received training in equality and diversity as part of their mandatory training however, there were no training figures to support this.
- Staff we spoke with understood how to support patients who had particular religious or cultural preferences.
- We saw printed information leaflets provided to families were all written in English. Staff told us even though there was a diverse community with many ethnic minorities, the vast majority of patients spoke English. The main languages after English were South Asian and Polish. Staff assured us information leaflets were available and could be provided in any language required.
- A telephone interpreter service was available and face to face interpreters could be arranged if required

Meeting the needs of people in vulnerable circumstances

- Patients may require a discharge at short notice, usually due to a deterioration in their condition and their wish to return home. We saw a fast track discharge procedure was employed by the acute end of life teams.
- Wherever possible patients were transferred home if that was their wish, when it became apparent care at home was appropriate, or no further interventions were available in a hospital setting.
- We saw evidence of this during a home visit for example, a patient who suffered with a number of health issues had been taken to A&E by ambulance. On being

Are services responsive to people's needs?

assessed at the hospital it had been identified there was nothing further the hospital could do which could not be provided in the patient's home. Suitable equipment was ordered which enabled the patient to return home the same day. Palliative care and district nurses were both booked to visit and manage the patient's care at home.

- Staff told us how they liaised with ambulance services regarding end of life patients in order to prevent unnecessary hospital admissions. We were told due to the geographical areas covered by the trust they received support from a number of ambulance trusts.
- The Walsall Palliative Care centre included a day centre where palliative and end of life patients could meet socially; patients were very complementary of the day centre and told us how they used other facilities at the centre such as therapies or counselling whilst they were there. The day centre had its own team of nursing and health care staff who were able to support patients with their complex needs.

- The Walsall Palliative Care centre facilities included:

A Specialist Day Hospice Facility

Community Oncology and Chemotherapy Service

Specialist Community Palliative Care Service

Complementary Therapy Service

Specialist Therapies Teams

Cancer and Palliative Information and Support Services

Specialist Lymphoedema Services

Voluntary Services

Psychology

Bereavement Services

An Outpatients Department offering a range of consultation facilities

Benefits Advice

provided by WHT services.

Access to the right care at the right time

- The Specialist Palliative Care Team provided a range of interventions both in people's homes and in community settings enabling patients to receive treatments which historically might have only been available in hospital. These included blood and blood product transfusions, scans and medicines management and therapies. This was a diversionary treatment pathway in partnership with St Giles Walsall Hospice, which had been nominated for an international and national award.'
- Supported by the community district nurse teams, access to services was available throughout the day and night seven days per week. The community palliative care, end of life and district nurses worked between 8:30am and 8:30pm seven days a week, including all public holidays. The service also provided out-of-hours sitters who could spend time with patients allowing carers to rest for a few hours or in some circumstances overnight.
- Nurses told us patients were usually very understanding if they arrived slightly early or slightly late. Patients we spoke with said they had not been kept waiting, they had been able to contact the district nurse base if they had an issue and staff had responded quickly to their messages.

Learning from complaints and concerns

- Very few complaints were received by the service. This showed the service understood the benefits of listening to patients and had systems in place to help people raise issues in a non-judgemental way.
- No complaints were recorded during this period relating to the Walsall Palliative Care centre or their staff. During the same period the Specialist Palliative Care Team received 15 compliments.
- Managers and staff told us how details of complaints were shared amongst teams during handovers and team meetings. We saw minutes of management and team meetings where complaints were seen to be a standing agenda item.

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

Overall, we judged local management of services was good.

Clear management structures were in place for teams dependent upon which geographical area of the trust they worked.

Staff had confidence in their managers and believed they provided appropriate support and guidance; this was evidenced by training records, annual reviews and clinical supervision.

Audits were completed of all aspects of the service and learning was shared within teams.

Service vision and strategy

- Managers in all the locations we visited were very passionate about the service their teams provided. They were proud of the achievements that had been made and there was a clear wish to continue to improve the service for the benefit of patients.
- The trust had developed comprehensive end of life guidelines however, this was still in draft format at the time of our inspection. Guidance was available to staff within the managed care document, the guidance followed the information in the draft guidelines however, if agency staff had needed to be used they would have no definitive guidelines to refer to.
- SPC services across the trust were coordinated by the palliative care operations manager. We spoke with them and they described how the trust had been developing their end of life pathway. A working party had been set up to review end of life care which had resulted in the introduction of their 'One chance to get it right' action plan.
- The palliative care operations manager and the discharge team also introduced the Rapid Discharge initiative 'Home to Die.'

Governance, risk management and quality measurement

- We saw there was clear clinical oversight and involvement with patients throughout their care. Systems were in place which ensured managers understood their workforce and their workload.
- Weekly and monthly team meetings took place in all the teams we met with. Standing agenda items included incidents, complaints, praise and policy updates. Staff at all levels told us the meetings were a useful source of information and encouraged staff to engage with issues and enabled learning to be passed across the teams and the trust. We looked at minutes of meetings and saw what staff had told us was reflected in the notes.

Leadership of this service

- There were clear lines of accountability within the management teams. Teams worked in a well organised way and were all well-led. They knew what was expected of their role and respected the roles of managers and team leaders.
- Healthcare workers and nurses all told us they were supported by their line managers and department heads in all aspects of their work, including training and supervision of their work.
- We saw evidence at all the locations we visited of learning from incidents and complaints.
- Consultants told us they were supported by the trust and colleagues and had sufficient study time to enable them to re-validate their registration.
- The community district nursing teams were in the process of converting to integrated care teams, this involved bringing all the therapies and nursing teams into one coordinated unit. We were told the benefit for patients would be faster referrals and better multidisciplinary meetings with 360 degree feedback within teams. This meant staff from different disciplines could understand how their work complimented or impacted on other members of the team and ultimately

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the patient. This enabled self-reflection and learning. At the time of our inspection, one team had converted to this system and the other teams were scheduled to change.

Culture within this service

- There was a clear sense of pride and belonging amongst staff at all levels within the end of life care teams. Each person's role was seen as being equally as important as the next. Staff appeared to have a genuine respect for each other which allowed them to concentrate on their role within the team.
- Daily discussions about patients' needs and staff skill mix ensured that patients received the best possible response and staff were supported to provide it.
- Staff received weekly updates via the intranet from the head of the service relating to board level issues. Issues such as major incident status and the CQC inspection were shared with teams. Members of the team told us there was no hierarchy within the team and they felt they did contribute and influence the team during team meetings and discussions.

Public engagement

- The trust collated information from patients, families, carers and staff using the friends and families test, we also saw evidence of public engagement at trust level, in relation to changes to services. Following the removal nationally of the Liverpool Care Pathway, there had been controversy in the Walsall area regarding its use. For this reason the trust had been very cautious regarding the development of a replacement document. Public and healthcare professional engagement had meant progress to develop and implement definitive guidelines had been slow.
- Managers told us they felt this was appropriate to the region as they wanted to ensure patients, family members and all health care professionals both inside and outside the trust had total confidence in the final guideline.

- Individual end of life care teams provided information for patients and their families as and when patients came into their care. Guidance leaflets and information about health issues relative to people's diagnosis were available.
- Having been identified either in the community or in hospital settings as requiring end of life care, when they returned to the community, patients and their families were encouraged to discuss their treatment and care and could influence their own treatment and care. The managed care document provided an excellent opportunity for patients to provide this information.
- The trust used recognised sources of patient feedback such as complaints, compliments, patient advice and liaison service (PALS) and incident analysis. In addition, they used on-line review sites where patient experiences were posted and the trust were able to respond.

Staff engagement

- Staff engagement was primarily through team meetings, email and intranet services.
- Senior managers made frequent visits to community based locations. Staff we spoke with were able to name senior managers and told us they engaged with them during visits and appeared genuinely interested in their work and issues.
- Board level managers were less visible although staff told us they were approachable and pleasant when they did visit.

Innovation, improvement and sustainability

- The evolving of district services to integrated care services, sought to improve referral times for patients who require additional services.