Good

Kent Community Health NHS Trust

Quality Report

The Oast
Unit D, Hermitage Court
Hermitage Lane
Barming
Maidstone
Kent
ME16 9NT
Tel: 01622 211900
Website: www.kentcht.nhs.uk

Date of inspection visit: 9th-13th June 2014,
Unannounced Visit: 19th June 2014
Date of publication: 02/09/2014

Core services inspected	CQC registered location	CQC location ID
Community health services for adults	Trust Headquarters	RYYE3
Community health services for children, young people and families	Trust Headquarters	RYYE3
Community health inpatient services	Livingstone Hospital	RYYZ1
Community health inpatient services	Queen Victoria Hospital Herne bay	RYYC3
Community health inpatient services	Whitstable and Tankerton Hospital	RYYY7
Community health inpatient services	Sheppey Hospital	RYYC7
Community health inpatient services	Gravesham Hospital	RYYY3
End of life care	Victoria Hospital (Deal)	RYYCH
End of life care	Sittingbourne Memorial Hospital	RYYC8

Summary of findings

This report describes our judgement of the quality of care at this provider. It 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.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for community health services at this provider	Good 
Are services safe?	Good 
Are services effective?	Requires Improvement 
Are services caring?	Good 
Are services responsive?	Good 
Are services well-led?	Good 

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 5

The five questions we ask about the services and what we found 6

Our inspection team 10

Why we carried out this inspection 10

How we carried out this inspection 10

Information about the provider 11

What people who use the provider's services say 11

Good practice 11

Areas for improvement 12

Detailed findings from this inspection

Findings by our five questions 15

Action we have told the provider to take 35

Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

We found that the provider was performing at a level which led to a judgement of Good.

The Board provided clear leadership to its staff despite currently undergoing a considerable reorganisation. The culture of the organisation varied across the services and where change in service provision was being transformed some staff felt excluded from decision making.

There were elements of good practice across a range of units and teams within each core services. The Trust staff were caring and there was good practice to ensure safe and responsive care. The organisation was well led. However the Trust needs to improve the effectiveness of the care given.

We found that some policies and procedures that should have ensured that all staff delivered a similar safe, caring, effective and responsive service were not consistently applied across the county.

The provider did not always ensure that all people receiving a service were protected from potential harm due to inconsistent reporting of incidents and learning across the whole service.

It is our view that the trust is providing a good service overall but needs to take steps to improve the effectiveness of its services and ensure the quality of their services is good consistently across all areas of the county.

We will be working with them to agree an action plan to assist them in improving the standards of care and treatment.

Summary of findings

The five questions we ask about the services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Patients were kept safe through robust safeguarding arrangements and the Trust worked well with partner agencies to protect vulnerable people from abuse.

Services provided to children, young people and families were safe, and arrangements were in place to minimise risks to children and young people receiving care and staff working alone in the community.

The Trust had processes in place to report and record safety incidents, concerns, near misses and allegations of abuse. However, not all managers could access the systems and there was a degree of under reporting of safety incidents such as falls, pressure ulcers and missed visits.

Whilst we judged the majority of services to be safe staff were not familiar with the Trust policy on the use of Do Not Attempt Cardiopulmonary and there was examples where these had not been adequately reviewed or updated to reflect the appropriate actions for patients at the end of life.

Recruitment and retention of staff was a problem in some areas of the county with some teams reporting vacancies for over a year. Many of these vacancies were being covered by agency staff and these vacancies posed a risk to the safe care in these few areas.

The Trust was moving to an electronic system to record care and support teams. However where the paper based systems was currently in use these were not always fully completed by staff and did not give assurance that risks were always identified, assessed or monitored.

The provision of equipment, particularly beds and mattresses to assist in the prevention of pressure wounds for people was inconsistent acoss the county that impacted on the timely provision to some patients and increased the risk of compromised skin integrety.

There were arrangements for the safe management of medicines. However, we identified weaknesses in medicine management procedures at Livingstone and Gravesham Community hospital.

Summary of findings

Are services effective?

Requires Improvement

Policies and care reflected current guidance such as that provided by the National Institute for Health and Care Excellence (NICE) and there were systems to review new guidance and to disseminate this to staff.

In -patients experienced integrated care that was planned by multidisciplinary teams. This ensured that treatment was delivered by staff with the appropriate, qualifications, skills and experience.

Services for children and young people were evidence based and focussed on the needs of children and young people. We saw some examples of very good collaborative work and innovative practice. Specifically the multi-disciplinary approach at Valance school and the focussed Chlamydia screening target.

The Trust had provided training and development opportunities but the distances to travel, the time required to undertake the training and the lack of resources in certain teams meant that not all staff had undertaken the necessary training to enable them to carry out their job effectively.

People received kind and compassionate end of life care from committed staff. However, the End of Life care Strategy was not implemented as it had only recently been approved; some staff were unaware of it and the care we observed and discussion with staff revealed that care planning and delivery was not meeting all the indicators of the National Institute for Clinical Excellence (NICE) Quality Standard 13:End of Life care for Adults.

Are services caring?

Good

All the patients we spoke with told us how pleased they were with the care and treatment provided by Kent Community Health NHS Trust and told us that the staff were kind and caring supporting them in their needs.

People were mostly involved in making decisions about their care and treatment. People were encouraged and supported to manage their own care where possible and to maintain their independence. People had appropriate emotional support and were helped to keep in touch with their family and friends.

Every hospital had a specific information book outlining the management arrangements and the services offered and other useful information. Each patient had a named nurse.

Patients could access emotional support from ward staff or chaplaincy service which operated at each hospital. For those requiring specialist input a referral could be made to counselling or psychology services

Summary of findings

Community team leaders and colleagues supported staff whenever problems were identified and this led to a 'can do' culture' where staff wanted to ensure that they provided care they were proud of.

Are services responsive to people's needs?

Good

The Trust was responsive in meeting the complex needs of the people of Kent in the community setting and the commissioning of services. The Trust was forward looking to improve the health of patients and improve their experience of healthcare through various initiatives such as the chronic knee pain programme and a new integrated discharge pilot. These programmes of work demonstrated that the Trust was proactive in working to improve patients' experience of healthcare and implementing new best practice initiatives.

There were inconsistencies in the provision of some services to children and young people across Kent. A contributing factor was the lack of sufficiently commissioned specialist posts to aid in the assessment of children referred under the National Institute for Health and Care Excellence Autism Pathway. Some services within specific localities were failing to respond to the needs of the local population and were failing to ensure that children and young people could access the right care at the right time.

The end of life service was developing and improving care through improved service planning linked to the strategy but there remained gaps in provision where people had less than optimal care.

Are services well-led?

Good

Staff told us they felt valued and supported to give high quality care by their managers, supervisors and the Trust Board. We found that staff were motivated and happy at work and felt confident to raise any concerns. We were told that matrons and managers were visible and available and executive team members visited the Community Hospitals.

Overall in patient services were well led. Staff in the Community Hospitals were aware of the Trust vision and we saw examples of local philosophies of care being developed. However in Children and Young People's Services staff were not always able to identify or relate with them. We also identified that the leadership in inpatient therapy services needed strengthening.

The Trust had been through a sustained period of change and reorganisation leaving certain staff groups feeling disaffected. However the majority of staff we spoke with said they felt valued and supported by their managers and were proud of to work for the Trust. Staff from teams affected by the most change told us that the

Summary of findings

leadership did not listen and 'imposed change' without listening. The Trust was aware of poor leadership in certain areas and communication issues and was working to address this through supporting managers and finding practical solutions where possible.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Carolyn White, Director of Quality/Chief Nurse

Derbyshire Community Health Services

Team Leader: Sheona Browne Inspection Manager Care Quality Commission

The team of 34 included CQC senior managers, inspectors and analysts, doctors, nurses, pharmacist, patients and public representatives, experts by experience and senior NHS managers.

Why we carried out this inspection

Kent Community Health NHS Trust was inspected as part part of our comprehensive community health services inspection programme we are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

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?

The inspection team inspected the following four core services at the Kent Community Health NHS Trust:

- Community health services for adults
- Community health services for children, young people and families
- Community health inpatient services
- End of life care

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups (CCG), Monitor, NHS England, Local Area Team (LAT), Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

We carried out the announced inspection visit between 09 and 13 June 2014 . This included an out of hours visit to Livingstone Hospital to assess how it was run out of hours and the levels and type of staff available and the care provided.

We held focus groups with a range of staff in the trust, including nurses, doctors, therapists, administrative and clerical staff, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff in community hospitals and in their homes. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' records of personal care and treatment.

We carried out an unannounced inspection on 19 June 2014. Where we visited Gravesham Hospital to see if this location was providing safe, effective, responsive care, and was well led.

Summary of findings

Information about the provider

<Information goes here>

What people who use the provider's services say

- Scores for the Family and Friends test were variable across locations.
- In the National Bereavement Survey the Kent Community Health NHS Trust is under the Kent and Medway team which was in the bottom 20% of local area teams for a number of indicators.
- The number of complaints received about Kent Community Health NHS Trust during 2013/14 has been steadily rising although this could be the result of Kent Community Health NHS Trust providing better access to the complaints process.
- Community Nursing remained the service with the most complaints. Though there has been an improvement in the number of complaints relating to missed visits from community nurses.
- Kent Community Health NHS Trust had reviews from patients on the NHS Choices website. It scored a 5 star rating overall. Livingstone Hospital had the lowest overall star rating of three stars. Comments and reviews via NHS Choices are mixed. They praised the Trust for the friendly patient service from staff and the cleanliness of environment and fast and efficient services. However they commented that some staff were rude.

Good practice

We saw some good and outstanding practice including:

Community health services for children, young people and families

- Services that were evidence based and focussed on the needs of children and young people.
- The Trust was identified as an "Exemplar Organisation" by the Kent Safeguarding Children Board during their 2012/2013 review of safeguarding processes.
- There were many examples of good collaborative working within the multi-disciplinary team (MDT). Staff worked well together; there was effective communication between staff; and healthcare professionals valued and respected each other's contribution to the planning and delivery of children and young people's care.
- The multi-disciplinary approach adopted at Valence School
- Staff were compassionate and respectful and parents and carers were supported and involved with their children's treatment.
- Staff undertaking home visits were dedicated, flexible, hardworking, caring and committed.
- Chlamydia Screening
- The trust has consistently met the Health Visiting Programme target.

Community Inpatient Services

- Staff were passionate about their work and the difference it made to patients.
- There was a commitment to a multi-disciplinary approach to care and an ethos that promoted autonomy and independence.
- A positive approach to safety management. All staff knew their responsibilities with regard to safety.
- Staffs understanding of the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) was robust.
- At Livingstone and Gravesham Hospital we found that there was an effective falls reduction programme which has resulted in the number of falls with associated fracture reducing by one third in a year.

Adult Community Services

- There were robust safeguarding arrangements and the Trust worked well with partner agencies to protect vulnerable people from abuse.

Summary of findings

- The Trust's infection rates were low when compared with national benchmarks. This indicated good infection control practices were employed across the service.
- The patients we spoke with were all happy with their nurses' and therapists' standards of hygiene. They told us how the nurses used sanitizing hand gel and/or used their own hand washing facilities during visits to their home.
- During our inspection we observed good hand hygiene and infection prevention practice within the district nursing clinics and by staff in patients own homes. We saw that staff throughout the Trust used personal protective equipment such as gloves and aprons and adhered to the 'Bare below the elbows' guidance to ensure that lower arms were kept clear of clothing and jewellery to help prevent cross infection.
- The service was using technology to improve care. Cardio-respiratory nurses were using remote blood pressure monitoring equipment which enabled staff to check on patients observations in the own home whilst back at base. This was helping patients to stay independent in their own homes and self-manage their condition. Community nurses visiting patients at home using computer tablets which were being used to take pictures of wounds and then send them to the specialist tissue viability nurses for advice on treatment. Staff told us this improved the accuracy of patient's observations and reduced errors.
- Patients told us, and patient feedback received by the Trust, showed patients felt were treated with kindness, care and compassion and staff made time for them.
- The Community teams told us that accessing interpreters was not a problem and the Dover team had an interpreter permanently on the staff as they provided health care to a large Eastern European community. Patient information leaflets were available in a variety of languages, including Czech, Slovakian and Turkish.
- There was good multi-disciplinary and cross boundary working which meant that patients were assured of receiving the right care by the right team. The specialist services were especially praised for the support they gave not only to patients but the teams and wider health and social care community.
- Learning from safety incidents was disseminated through bulletins, on the StaffZone, minutes of meetings and staff meetings
- When we accompanied the district nurses and attended outpatient clinics we saw that patients were all asked their permission before any treatment or procedure took place and that where necessary consent forms were signed. Staff gave examples of best interest meetings being held in order to support families and patients in unsafe situations.
- Qualified staff told us that there were lots of personal development opportunities available in the Trust. They told us about further training and qualifications they had gained such as foundation

End of Life Care

- The involvement of the equality and diversity team in the development of all aspects of end of life care policy.The commitment of staff to providing an equitable service to all was commendable.
- The passion of staff working directly with patients and their commitment to providing good care.
- Local relationships with other end of life care providers were good and meant most people had access to palliative care expertise.

Areas for improvement

Action the provider MUST or SHOULD take to improve

There were also areas of practice where the Trust needs to make improvements.

Action the provider MUST take to improve

- The provider must ensure that all staff are familiar with the Trust policy on the use of Do Not Attempt Cardiopulmonary Resuscitation orders and that the use of these documents is monitored to ensure staff are adhering to the policy in clinical practice.

Summary of findings

Action the provider SHOULD take to improve

- Review the efficacy of its recruitment.
- In relation to care planning, the provider should provide further training on the principles of holistic, rather than task orientated, care planning.
- Regularly audit and review the quality of care planning to ensure patients always benefit from specific, measurable care interventions that commence with an initial comprehensive assessment, that meet all their identified needs including those in relation psychological, emotional and social support, takes account of their preferences and which is updated periodically.
- All community matrons have the skills and qualifications in prescribing to ensure patients in acute pain receive prompt medication.
- Review its arrangements for the provision of equipment to ensure that appropriate equipment is available in a timely fashion to support patients and staff to prevent an adverse effect on patient outcomes.
- Review the timescales in relation to the roll-out of electronic systems that support and record care to ensure that there is assurance that risks are always identified, assessed or monitored using an effective system.
- Introduce standardised record keeping across the service to improve standards of record keeping and to minimise the risks associated with records.
- Review the systems and processes in use, including those for allocating visits, with the aim of minimising the transcription of information from one system to another to reduce the risk of transcription errors.
- Review the current workforce establishment in children's and young people services to ensure that there are sufficient numbers of skilled and experienced staff to meet the needs of the service. Where deficits are identified, appropriate action should be taken to resolve the issue without delay.
- Review the leadership and culture of the service to ensure staff are fully engaged with the Trust's core vision as well as ensuring the Children's and Young Peoples Directorate has a clear future strategy.
- The provision of equipment through a third party contract is monitored effectively and that shortfalls in the provision are addressed in a timely manner.
- That staff providing end of life care are suitably trained and supported to do so in line with current best practice guidance.
- That where a competency framework is being introduced, the staff leading the introduction should be competent and supported to assess other staff.
- That care planning for end of life is both holistic, considering the wider needs of people using services and personalised.
- The provider should improve the auditing of end of life care and use the information gathered to improve the provision in both the community and the community hospitals.
- Ensure staff can access systems to report incidents
- Review vacancies to manage workforce deployment effectively
- Review equipment procurement to ensure community patients have timely access to equipment in all areas of the trust
- Review medicine management procedures in Livingstone and Gravesham Community Hospital
- Ensure all staff have access to the necessary training to enable them to carry out their job effectively.

Action the provider COULD take to improve

- Strengthen leadership in therapy services.
- Work with commissioners to ensure the provision of services to children and young people across Kent facilitate the assessment of children referred under the National Institute for Health and Care Excellence Autism pathway. To ensure that children and young people can access the right care at the right time.
- Review strategic plans to ensure that the service meets the demands of the population to which it was commissioned to serve.
- Review the use of the National Early Warning Score to ensure that appropriate escalation actions are understood and taken when patients are identified as at risk of deterioration.
- The provider could consider how the reports of deteriorating patents using the SBAR system could be recorded consistently.
- Ensure that the contents of Patient Safety Alert NPSA/2011/PSA002:Reducing the harm caused by misplaced nasogastric feeding tubes in adults, children and infants are implemented.
- Consider the provision of training in relation to the dietary needs of those with difficulty swallowing.

Summary of findings

- Consider how the effectiveness of pain-relief, especially that given on an 'as required' basis is evaluated. The provider could consider how those patients with cognitive impairment have their pain levels assessed.
- Review its care environments to determine the extent to which they could be considered 'dementia-friendly'.
- Review its processes to minimise the numbers of out-of-hours transfers to community hospitals, and the levels of transfer back to acute care.
- Review and strengthen the leadership and management arrangements for therapists within community hospitals.
- Provide greater assurance that radiography services provided by other organisations as part of a service level agreement are compliant with the requirements of the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).
- Review the prescribing arrangements for the community hospitals and increase the use of independent nurse prescribers to maximise the access have to palliative medication.
- Ensure that the sufficient numbers of nursing staff working in the community hospitals were trained to insert cannulas so that patients were able to be hydrated and receive intravenous drugs without recourse to external teams.

Kent Community Health NHS Trust

Detailed findings

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Patients were kept safe through robust safeguarding arrangements and the Trust worked well with partner agencies to protect vulnerable people from abuse.

Services provided to children, young people and families were safe, and arrangements were in place to minimise risks to children and young people receiving care and staff working alone in the community.

The Trust had processes in place to report and record safety incidents, concerns, near misses and allegations of abuse. However, not all managers could access the systems and there was a degree of under reporting of safety incidents such as falls, pressure ulcers and missed visits.

Whilst we judged the majority of services to be safe staff were not familiar with the Trust policy on the use of Do Not Attempt Cardiopulmonary and there was examples where these had not been adequaltely reviewed or updated to reflect the appropriate actions for patients at the end of life.

Recruitment and retention of staff was a problem in some areas of the county with some teams reporting vacancies for over a year. Many of these vacancies were being covered by agency staff and these vacancies posed a risk to the safe care in these few areas.

The Trust was moving to an electronic system to record care and support teams. However where the paper based systems was currently in use these were not always fully completed by staff and did not give assurance that risks were always identified, assessed or monitored.

The provision of equipment, particularly beds and mattresses to assist in the prevention of pressure wounds for people was inconsistent acoss the county that impacted on the timely provision to some patients and increased the risk of compromised skin integrety.

There were arrangements for the safe management of medicines. However, we identified weaknesses in medicine management procedures at Livingstone and Gravesham Community hospital.

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

Our findings

Incidents, reporting and learning

- The Trust reported no Never Events in the last twelve months. A never event is classified as an incident so serious that they should never happen.
- The Trust provided CQC with a list of 84 incidents which were reported as serious incidents which required investigations, as defined by the NHS Commission Board Serious Incident Framework 2013, dating from 18 March 2013 to 20 March 2014.
- We saw that learning from safety incidents was disseminated through bulletins, on the StaffZone, minutes of meetings and staff meetings. For example, in response to a series of insulin related incidents the trust had undertaken an investigation and put an action plan in place to help improve staff practice and to avoid any further errors in the administration of insulin.
- The action plan in the board minutes of February 2014 identified that where possible the day staff should administer insulin, a diabetic nurse consultant would be appointed, patient information would be updated and additional training would be put in place. This information was dispersed throughout the Trust at team meetings, in staff bulletins and through the Trusts intranet to help ensure all staff were updated and given the opportunity to learn from past issues.
- Most staff teams were knowledgeable about the process for gathering data as part of the NHS Safety Thermometer initiative. This tool monitored improvements in patients subjected to pressure ulcers; falls; venous thromboembolism (VTE's) and catheter acquired urinary tract infections with the aim of improving clinical care.
- Information gathered for the Safety Thermometer was fed back to senior managers and directors of the trust who used the information to inform them of the current risks and plan strategic priorities. However we noted that in one area, the data collected for the safety thermometer for May did not correlate with the incidents recorded on the online reporting system.
- Managers and staff were aware that slips, trips and falls were the hospitals' biggest safety risk. We saw that focussed work streams had been introduced to address the risk. An example of this was at Livingstone and Gravesham Community hospitals where patients assessed as at risk from falls were identifiable by the use of coloured risk bands. We saw that an audit of falls undertaken in February 2013 showed that 100% of community inpatients had been risk assessed for falls.

Cleanliness, infection control and hygiene

- Clinical area were clean and well maintained. There were systems to monitor cleaning standards monthly and we saw the results of these audits. Any deficiencies were identified on an action list and we saw that these issues had been addressed promptly and re-checked. A Patient Lead Assessment of the Care Environment (PLACE) in 2013 found the Kent Community Hospitals average score for cleanliness to be 89.08% (range 68.75-99.45%). However this is below the national average of 95.7%.
- Staff demonstrated a good understanding of infection control precautions. The clinical procedures we observed in the community setting were consistent with the Trusts Standard Infection Control Precautions document dated 1 September 2012.
- Infection control systems and practices and found that the trust's infection rates were low with new urinary tract infections among patients with a catheter below the England average for the year ending April 2014. The trust's infection rate of C. difficile reduced from 14 to 8 incidents in the previous year with zero MRSA bacteraemia rates for the second year running. This indicated good infection control practices across the trust. However, we noticed poor hand hygiene on some occasions at Sittingbourne and Victoria Hospital, Deal.

Maintenance of environment and equipment

- The majority of locations were child friendly and welcoming. Toys were available in many of the clinics we visited and consulting rooms, treatment rooms and waiting areas were, in the main, decorated in bright colours with age appropriate pictures on walls.
- We found that each ward area had emergency equipment located that was easily accessible to staff and ready for use. This included items such as defibrillators and emergency medicines. We saw completed checklists that demonstrated this equipment was checked daily to ensure that it remained ready for immediate use.

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

- We noted that ward environments were fit for purpose and well maintained. However, at Queen Victoria Hospital (Herne Bay) we found that lack of storage facilities meant the ward appeared cluttered.
- Staff told us about some of the difficulties that the design and layout of the buildings presented. For example, in the Westcliff Community hub the open plan nature of the building meant it was difficult to maintain confidential conversations. Although there were small side rooms available on a day to day basis having confidential conversations on the phone with patients or discussing issues within the team was difficult.
- The Trust was contracted to provide beds and other equipment within 7 days of the order being received. There was no provision for prioritising people needing equipment for end of life care within the contract but the Trust had subcontracted to an external supplier and included a much shorter timescale for bed and mattress delivery. Community staff particularly in the east of the county, told us there were frequent delays in obtaining mattresses and beds for their patients. Where there were delays they were required to complete an incident report. The Head of the service told us they were aware of the problems and staff were being provided with tablet computers to order directly and reduce the problem of lost or incorrectly completed forms.
- Clinical staff we spoke to said that patients care was sometimes prejudiced because of the lack of equipment. They said that it was the community nurses responsibility to chase orders and that this took a significant amount of time each week, which impacted on the time they had available to provide care. The impact on pressure wound prevention and management was concerning for example a person who had been cared for on their usual mattress for a week after the need for a pressure relieving mattress was identified. This had resulted in skin breakdown.

Medicines

- There were systems in place for the safe administration of medicine in the community including readily available policies and procedures
- Following guidance being sent out nationally from the National Patient Safety Agency (NPSA), the Trust had identified that some of the ambulatory syringe pumps their staff used to deliver drugs posed a potential risk when patients moved between staff teams or from community to community hospitals. There had been a corporate decision to standardise syringe drivers across the county to a single type. New guidance was provided and training had been available to all staff, in conjunction with the hospices.
- Overall we found that there were adequate arrangements for the safe supply, storage, administration and disposal of medicines. However, we found concerns about medicines management at Livingstone Hospital and Gravesham Community Hospital.
- At Livingstone Hospital we identified a number of concerns relating to medicines management. This included the following which were not in accordance with the trusts own policy. Medicines were not stored safely in the medicines fridge. Medicines stocks were not monitored and replenish and those, including insulin, not in current use were not discarded. Frequency of controlled drug checks did not comply with the trust's policy and the time of medicines administration was not always documented, including the specific time of pain relief.
- At Gravesham Community Hospital we had concerns reacting to controlled drugs management, including clarity of stock records, methods and recording of their records, and prescriptions. We had concerns that the stock management systems for controlled drugs were not clear. We noted that delivery notices were not adequately reconciled and there were no formal mechanisms for monitoring stock levels and usage.
- We found there was a lack of awareness of risks associated with medicines management at the Livingstone hospital with no evidence that these had been mitigated against. We saw minutes of a staff meeting which showed no changes had been made in response to issues highlighted around medicines management.
- At both hospitals we saw that when part doses of controlled drugs were administered there were no processes to dispose of the unwanted portion of the medicines. We saw that part doses were taped into their original sealed packets for re-use, but were also told by other staff members that part doses were 'wasted' and were placed in the medicines disposal bin.

Safeguarding

- The Trust was identified as an "Exemplar Organisation" by the Kent Safeguarding Children Board during their 2012/2013 review of safeguarding processes.

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

- The Trust had a Safeguarding Declaration which had been revised in April 2014.
- There was a Named Doctor and Named Nurse who were appointed as the professional safeguard leads.
- The Trust had a Safeguarding Assurance Group which was chaired by the Director of Nursing; the remit of the group was to review all Serious Incidents related to safeguarding and adult protection alerts to ensure they are managed in a timely manner.
- There were proper procedures for child protection planning, investigations and outcomes of safeguarding concerns.
- The Trust had in place policies and procedures to safeguard vulnerable adults together with key contact numbers. We saw terms of reference and minutes of meetings which demonstrated that through the Kent Safeguarding Vulnerable Adults Board (KSVAB), the Trust worked in partnership with statutory agencies such as the local authorities and police to safeguard vulnerable adults. The trust had named safeguarding nurses and specialist safeguarding advisors within designated safeguarding teams.
- We noted that since registration 45 safeguarding incidents relating to adults had been raised for the Trust. The majority of safeguarding concerns raised involved the trust not acting promptly on a patient's deteriorating condition. From the minutes of the Adults Operations Quality Meeting we noted that safeguarding was a standing item on the agenda and any issues were discussed together with action plans. We found the Trust had robust arrangements in place to safeguard vulnerable adults.

Records

- The Trust told us that they were introducing an electronic system of care documentation. We spoke with nursing and therapy staff who told us about the move to electronic records. Some of the staff we spoke to had misgivings about the computer based records system as connectivity across Kent was problematical and many staff did not feel confident with the new technology. However other staff were looking forward to receiving the new IT equipment.
- One group of community staff told us how records sometimes went missing due to patients throwing them away or relatives taking them. They told us they were looking forward to the training to enable them to keep electronic records. We saw that the trust had put in place training for staff before the system was to go live later in the year.
- During our inspection we reviewed 20 sets of care records at varying locations across the Trust. We found the Trust relied heavily on paper based systems to plan and assess patients' needs and then document the care given to meet those needs and monitor the outcomes. In the community, care records were kept both in the patient's home with summaries held back at base with hand written copies in both locations. We found that the summary records kept at base did not reflect the care given and many had not been updated for some time. Many base held records were simply equipment requests and correspondence.
- We did identify some concerns about the correct use of Do not attempt Cardiopulmonary resuscitation (DNACPR) forms. Staff understanding around the correct completion process was limited and most staff had not completed training in the use of DNACPR process.
- We asked to see the records of three people who had a completed, current, DNACPR. In one file we found an expired DNACPR form that had been cancelled over a month previously. Staff were unclear why this person still had a DNACPR showing against their name on the printed handover sheet. They could not explain how the situation had persisted for over a month.
- In a different community hospital, an inspector was sufficiently concerned about the completion of two DNACPR forms that they asked the doctor to complete the forms appropriately. The form had no record of the decision having been discussed with the people or their families and no record of any involvement of the wider MDT. The people whom the forms related to both had capacity.
- No audits of DNACPR records had taken place across either the community hospitals or the community nursing teams.

Lone and remote working

- Lone working policies were in place and staff followed them.
- Staff told us of the Trust's protocols for arranging, and carrying out home visits.
- However we found that due to staffing pressures there were occasions when these policies had not been followed. For example, one of the out of hours teams we

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

spoke with told us that there was often three nurses on a shift rather than five which meant that they sometimes had to work alone when visiting a patient for the first time.

- Staff raised concerns about the lack of security in some of the neighbourhood team hubs at night. They said that they phoned each other through their shifts to let each other know where they were.

Adaptation of safety systems for care in different settings

- We noted that at the Windchimes Short Break Service, two bedrooms had been furnished so as to allow easy decontamination of the rooms. This included flooring which had been specifically chosen so that it was safe to walk across, even when wet.

Assessing and responding to patient risk

- The trust participated in the National Safety Thermometer scheme to measure and monitor avoidable patient harm. The results were widely disseminated and available for patients and staff to see. We reviewed the results for February and March 2014. We noted that the incidence of harm free care was 92.08% and 89.4% for these months. However, this is below the Trust benchmark of 95%.
- A range of risk assessments were utilised by the various clinical teams to assess and manage risk. Examples included risk assessments for children who were at risk of developing pressure ulcers, manual handling risk assessments, central venous line infections and for those children who were subject to a child protection plan.
- We looked at a wide variety of care records across the county in varying health settings and found that the majority of records were incomplete with risk assessments for falls, poor nutrition and the development of pressure sores not undertaken or updated on a regular basis. This meant that there was a risk that when a patient deteriorated this was not identified quickly and measures put in place to address the issues.
- We looked at the incident reports for the past year and found that there were incidents where pressure sores had developed or deteriorated due to changes to the patient not being identified promptly, communicated effectively or actions taken promptly. Poor risk assessments was an identified factor in many of the safeguarding alerts made involving pressure ulcers in the community. We found that the assessment of risks to patients was not always carried out in a timely or effective manner.
- The End of Life Strategy is the policy by which the Trust has identified and intends to respond to patient risks directly related to end of life care. This was dated March 2014 and is still very much an aspirational document with little evidence of impact to date.
- Community hospitals used the national early warning scoring system (NEWS) to identify patients whose condition was deteriorating. We reviewed observation charts and saw that these scores were routinely completed. However, we noted that escalation actions prescribed by the NEWS were not always followed.
- Where risks were identified, staff had access to support, guidance and equipment to help manage risks. However, staff working in the Continuing Health Care Team raised concerns that the Trust's equipment store did not routinely stock pressure relieving mattresses for people who weighed less than 25KG. We were told that whilst there were systems in place to source specialist equipment, they occasionally experienced delays predominantly associated with securing funding from third party Commissioners

Staffing levels and caseload

- The Trust acknowledged that recruitment and retention of staff was identified on the Trust's risk register. In December 2013 there were areas of the Trust which were working with a 13 - 20% vacancy rate and although this was improving there were still areas that had been chronically understaffed for some time. The situation was compounded by differing service provision and increasing demands with the seven CCGs. The Trust had a Nursing Recruitment Strategy Workforce Group with action plans in place to address the staffing issues.
- An investment of £444,000 had been set aside in the 2014/2015 budget to facilitate the improvement of staffing levels with the aim of providing a qualified to unqualified ratio of nursing staff to 65:35 and a 1:7 patient to nurse ratio. Matrons and ward managers we spoke with confirmed that this investment was translating into increased establishment.
- During our inspection we found that across the county the staffing situation varied from area to area and team to team. There were areas and teams that were fully

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

staffed, had low reliance on bank or agency staff and had manageable caseloads. Staff in these teams felt able to manage a heavy caseload as they were well supported by their team.

- However there were also teams which had been understaffed for many months. We heard of nursing posts that had been vacant for over a year. Staff in these teams told us they were exhausted and demoralised. They told us of incidents where they felt unsafe and pressured to deliver care outside of their area of competence. They told us that they did not take lunch breaks, that any non-urgent work would be 'Put off for another day'.
- Staffing difficulties were seen to be a common theme on the Children and Young People's Risk register. There were a total of 8 risks logged within the register specifically relating to staffing levels.
- Senior staff within the Specialist Community Children's Nursing Team, Residential Short Break Service, Safeguarding Team, Universal Speech and Language Service, Sexual Health Team, Continuing Care Team and Community Paediatrics all raised concerns that the recruitment and retention of skilled and experienced staff was problematic.
- The Clinical Commissioning Groups (CCGs) across the county all mentioned some level of concern about the staffing levels and excessive reliance on temporary and agency staff. One CCG reported concerns about task focussed care being provided, which mirrored our own observations. At Victoria Hospital, Deal for example, one patient wrote on a comment card that, "The care was very regimented, nothing was forgotten. All very organised". Concerns were also raised by the CCGs that care was very tasked focussed, which could be indicative of inadequate staffing levels.

Deprivation of Liberty safeguards

- Staff received training as part of the trust mandatory training programme. Staff we spoke with demonstrated a sound and confident knowledge of the principles of the Mental Capacity Act and the Deprivation of Liberty Safeguards.
- We saw examples of applications being made to the supervising authorities with regard to the deprivation of liberty of individual patients. We tracked applications and saw that the process had been followed in line with statutory requirements and the trust policy. We noted in one case that while authorisation was awaited suitable interim arrangements had been put in place.
- We saw clinical records that demonstrated staff had undertaken capacity assessments for specified decisions and the rationale for any decisions made on the patients behalf in their best interests was made explicit.
- When we accompanied the district nurses and attended outpatient clinics we saw that patients were all asked their permission before any treatment or procedure took place and that where necessary consent forms were signed. Staff gave examples of best interest meetings being held in order to support families and patients in unsafe situations.

Managing anticipated risks

- The Children and Young People's Directorate operated a directorate wide risk register. In addition, each locality service managed local risk registers which contained risks applicable to their own location. Each risk entry contained a description of the problem, the risks posed and the underlying cause. We found that each risk was scored according to a nationally recognise risk scoring system, and then subsequently RAG rated. Key Controls were listed to assist staff with managing the risk, and summaries of action plans were included to demonstrate how the risk would be resolved. Each risk was assigned with a "Risk Owner" and there were dates when risks required reviewing.
- The Trust maintained risk registers which were discussed at the monthly management meetings between the director and the head of service. We asked managers in adult community services how they managed the risks within the team and we found this was managed differently through the Trust. Although some managers had IT access and were managing the team risks effectively others told us that they did not know what was on the risk register and could not access the system.
- We spoke with managers who did not use IT or electronic spreadsheets but held paper based documents in lever arch files. We reviewed these files and found they were not always kept up to date, did not

Good

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

include risk assessments or action plans. One 'Risk Register' consisted of a list which included 'Missed visits' and 'Unsafe discharge' without any further information or action plan.

- We had concerns that staff with the direct responsibilities for managing risk did not have the information or tools to do so effectively. For example although 'Missed visits' were included on the risk register the manager was unable to tell us how many there had been in the last month and did not know the frequency. This was the same with complaints management which we were told was in a 'protected' area of the trust's shared drive which could only be accessed by the Head of Service.

Major incident awareness and training

- Staff we spoke with were aware of the trust's major incident plan and business continuity plans.
- Incident procedures were available to staff in prominent positions.
- During recent flooding events during the winter of 2014 the Trust's business continuity plans had been tested and proved to be effective.
- We were told that the Kent Community Health NHS Trust had several high profile locations where major incidents may occur such as the ports, international rail links, Channel Tunnel and airports. We were told how regular training took place on responding to major incidents alongside of other emergency services, health and social care providers. Managers told us how proud they were of the way staff always responded to requests for help during any major incident alert.

Are services effective?

Requires Improvement

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 of findings

Policies and care reflected current guidance such as that provided by the National Institute for Health and Care Excellence (NICE) and there were systems to review new guidance and to disseminate this to staff.

Services for children and young people were evidence based and focussed on the needs of children and young people. We saw some examples of very good collaborative work and innovative practice. Specifically the multi-disciplinary approach at Valance school and the focussed Chlamydia screening target.

In -patients experienced integrated care that was planned by multidisciplinary teams. This ensured that treatment was delivered by staff with the appropriate, qualifications, skills and experience.

The Trust had provided training and development opportunities but the distances to travel, the time required to undertake the training and the lack of resources in certain teams meant that not all staff had undertaken the necessary training to enable them to carry out their job effectively.

People received kind and compassionate end of life care from committed staff. However, the End of Life care Strategy was not implemented as it had only recently been approved; some staff were unaware of it and the care we observed and discussion with staff revealed that care planning and delivery was not meeting all the indicators of the National Institute for Clinical Excellence (NICE) Quality Standard 13:End of Life care for Adults.

Our findings

Evidence based care and treatment

- Children referred to the Integrated Therapy Children's Service were assessed by the most appropriate therapist, ranging from speech and language, physiotherapy and occupational therapy. The Assessment of needs were carried out by qualified staff who utilised nationally recognised, age specific assessment tools and resources such as, but not limited to the Oxford Muscle Strength Scale, Gross Motor Function Measure, Peabody Developmental Motor Scales, Beighton Scores, Pre-school Language Scales, Pre-school Clinical Evaluation of Language Fundamentals, Clinical Evaluation of Language Fundamentals and Derbyshire Language Scales.
- The Trust adopted the National Institute for Health and Care Excellence (ASD) Clinical Guideline 28 – Autism diagnosis in children and young people: Recognition, referral and diagnosis of children and young people on the autism spectrum.
- The Trust had a range of policies and clinical guidelines available for staff. These were held on the Trust's intranet and readily accessible for staff in the community. The policies were up to date and based on current best practice guidelines such as NICE (National Institute for Health and Care Excellence). Staff told us about Best Practice Forums where staff met to discuss current guidelines and any new initiatives. We saw minutes of meetings where new guidelines were discussed and how to implement them in the community setting. This demonstrated that the trust was proactive in working to implementing new best practice guidelines.
- We found that the trust had appropriate guidance, policies and procedures in place but there were few monitoring systems in place to provide assurance that staff worked according to the evidence based guidance.
- The majority of staff we spoke with were unfamiliar with the End of Life Strategy. Some told us they knew there was one but had not read it; other staff told us they didn't know anything about it and were unaware of the content of the strategy.
- We saw examples of national guidance being implemented. For example in the area of nutrition we saw that guidance from the NICE relating to screening for malnutrition was in place, saw initiatives such as DAFNE (Dose Adjustment For Normal Eating) and DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) were being implemented and noted that menus at Whitstable and Tankerton Community Hospital the patients' menu had been reviewed by the dietician team to meet the latest 2013 guidance. We other aspects of NICE guidance such as Falls Management and Care of People Living with Dementia were being implemented.

Pain relief

- The Trust supported patients with chronic pain through the Integrated Clinical Assessment and Treatment

Are services effective?

Requires Improvement

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.

Services (ICATS) based in East Kent. The team consisted of a multi-disciplinary team of clinicians specialising in the treatment of long term chronic pain. The service was delivered through local outpatient clinics at locations across East Kent and aimed to support patients in achieving self-management of their pain thereby reducing dependency on healthcare services. This service was not reviewed during our inspection.

- Patients told us that their pain was adequately controlled. They said pain relief was provided regularly or as needed. They told us they could request pain relief when they needed it. One patient said, "I sometimes ask for extra pain relief during the day and it is provided." We looked at medicines administration records which confirmed patients received pain relief as prescribed on both a regular and as prescribed basis.
- The lack of community matrons with prescribing meant that there was sometimes a delay in patients in acute pain receiving prompt medication.
- A pilot medicines chart for use by the wider team caring for people who were dying in the community included brief guidance on pain management and escalation of analgesia.
- Staff in the community felt pain relief was good but were not aware whether this had been audited. A Trust wide audit of pain relief was in progress; On 31 March 2014 data was still being collected by the end of life nurse consultant.
- We did not see any evidence of non-pharmacological approaches to pain relief, and staff told us these techniques were not routinely used.

Nutrition and hydration

- Patients reported that there was a choice of food and drink available, that any special diets could be catered for although we found there was not always sufficient information about these. There was the facility to order food off-menu if this was required at most hospitals. Patients also told us that they were encouraged to drink adequate fluids and that hot drinks were available throughout the day and night. One person said, "The food is wonderful."
- We observed patients being helped to eat and drink. The wards operated a protected mealtime policy and this was advertised on the ward, but in practice this was only partially implemented. For example we saw medicines rounds that clashed with mealtimes, and not all staff were focussed on helping people to eat at mealtimes. We saw various systems that identified those who required special help with feeding to staff, for example a red tray scheme or discreet symbol displayed above patients' beds. We did not see any pictorial menus to help those with dementia or learning difficulties make food choices.
- Children and young people attending Valence School underwent care planning meetings with health care professionals, the pupil, parents and key workers. As part of the care planning meeting, the eating and drinking requirements of each pupil were assessed and care plans were developed to ensure staff were aware of each pupil's individual requirements.
- We found that not all staff were fully aware of the requirements of patients with difficulty swallowing and requiring modified diets, in March 2013 an audit of dysphagia patients in seven community hospitals found 14% of patients to be on a modified diet or enteral feed; 100% had been assessed by the Speech and Language Therapist. 25 thick pureed meals were audited against the Dysphagia Diet Food Texture Descriptors. Four meals (16%) failed the standards. Adaptations to the puree diet training for catering were recommended as a result of this audit.

Patient outcomes

- Data provided by the Trust for March 2014 demonstrated that the number of 3-4 month peri-natal mental health assessments had increased to 67.4% against a benchmarked target of 60% (Green rated).
- Data provided by the Trust for March 2014 demonstrated that the number of antenatal visits carried out by the health visiting teams had reached 177 visits. This again was rated as green.
- The Trust was seen to offer 100% of eligible cases a Universal New Birth visit, 3-4 month maternal mood assessment and a 1 year and 2-2 ½ year developmental and family review. However, it was noted that the update of those services was variable, with 70% of eligible cases up taking the offer of a universal new birth visit in April 2014.49% of eligible cases up took the offer of a Universal 1 year family and development assessment in April 2014 despite 100% of eligible cases been offered the service.
- The care and treatment provided usually achieved positive outcomes for people who used the service. We spoke with 46 patients during our inspection and

Are services effective?

Requires Improvement

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.

reviewed details of patient feedback including satisfaction surveys. We noted that much of the care delivered was task orientated and this was reflected in the care records kept.

- Staff told us that it was difficult to meet patients' expectations when time was a factor as clinical tasks took priority. Although when we accompanied community nurses on their visits we observed good care, staff did not always have time to deal with the patients holistically.
- Staff in the Out of Hours teams told us that there was sometimes a breakdown in communication which led to either missed or inappropriate calls. They gave the example of visiting a patient's home to find they had died earlier in the day.
- Our intelligent monitoring of the trust indicates that outcomes for patients are in line with national expectations.
- Across the Trust the incidence of pressure damage is below the average for England. In March 2014 the community hospitals the rate of pressure damage was 9.32% above the Trust benchmark of 4%.
- For the incidence of falls with harm, the Trust performs below the national average with community hospitals reporting a rate in March 2014 of 0% below the trust benchmark. However, in February the rate had been 0.42%.
- The Trust rate for catheter associated urinary tract infections is below the national average. In February 2014 the rate in community hospitals was 0% and 1.27% the following month. This is against a trust benchmark of 0.25%.

Performance information

- Performance information about community health services was included in the Trust's Integrated Performance Report. This included information about patient safety, incidents, infection prevention and control, and patient experience such as complaints and serious incidents.
- The Trust had an annual clinical audit programme which was made up from clinical audit projects undertaken within each of the trust's clinical directorates. Each directorate agreed its own clinical audit topics for example departmental records audits and national audits such as the stroke audit. We saw that some audits were undertaken in response to local concerns such as why patients did not attend outpatient appointments and others were in response to safety incidents.
- An end of life care audit was undertaken between November 2012 and January 2013 which considered whether patients received care that followed national best practice guidance. The information gathered showed how the Trust was performing during this period and formed a basis for the newly appointed nurse consultant to develop the End of Life Care Strategy from.
- Key findings from the End of Life Audit 2012-2013 showed that 64% of patients had anticipatory medication prescribed for five symptoms likely to be experienced in the last few days of life.
- Not all end of life care patients were identified as such. 24% of patients who received end of life care were not listed on the GPs palliative care register. This meant that there was potential for people approaching the end of their life to have care that was not co-ordinated effectively.

Competent staff

- 35 doctors who had a prescribed connection to Kent Community Healthcare NHS Trust in 2013. Of those 35, 31 (89%) had undergone an appraisal in the first 12 months of revalidation as compared with the national average of 76% across England for 2012/2013. The trust provided an assurance report to the board of the trust highlighting the reasons why the four remaining doctors had not received an appraisal.
- 66% of doctors who had a prescribed connection to the Trust had taken part in a 360 degree appraisal which included them receiving feedback from colleagues, peers and patients. The assurance report provided by the trust indicated that no significant concerns had been reported as part of the 360 degree appraisal programme.
- 85% of staff reported receiving job-relevant training, learning or development in the previous 12 months, in the 2013 staff survey. This compared with a national average of 83% for community trusts.
- 41% of staff reported having a well-structured appraisal in the last twelve months. This compared with 35% the previous year and was seen to be higher than the benchmark rate of 37%.

Are services effective?

Requires Improvement

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.

- The Trust reported in April 2014 that 86% of staff had had an appraisal in the last year, against the Trust wide target of 85%.
- The Trust provided training opportunities for staff from induction and mandatory training to funding for bespoke specialist training. The training was monitored by the team managers who used a computer based training matrix. We were told that although the trust provided the training and managers oversaw their teams training needs, it was the individual's responsibility to attend the required training.
- Staff told us that the training situation had improved recently and that new staff received a good induction to the Trust. There were concerns raised about the induction and support that existing staff received when they were promoted. Several newly promoted managers and senior staff told us they had not received any induction or support when starting in their new role. One manager told us how they struggled as a result.

Use of equipment and facilities

- Equipment and facilities were generally fit for purpose.
- Some delays in the provision of individually adapted mobility equipment from another provider were identified, and this issue had been escalated to the Commissioners for the service.
- One team told us of delays of over 10 days in providing pressure relieving equipment. Another team told us that they routinely had to wait for several days and spend much time on the telephone chasing up the supplier. A carer told us how they had to wait three days for specialist pressure relieving equipment for their relative who had a terminal condition. We heard that on occasion the delay in accessing equipment had led to the patient's condition deteriorating.
- The Head of Integrated Equipment Serves told us that the Trust now had 40 stores around the county where staff could get some equipment from immediately. No electrical items were stored in the stores but some had nebulisers and suction machines as these items were considered critical for getting people home.
- Stores and community nursing teams all had lightweight, inflatable pressure relieving mattresses for use as out of hours provision for patients identified as at risk of developing pressure damage.

Telemedicine

- Community matrons and nurses from the specialist teams told us about the introduction of telehealth, in some areas of the community. For example, cardio-respiratory nurses were using remote blood pressure monitoring equipment which enabled staff to check on patients observations in the own home whilst back at base. This was helping patients to stay independent in their own homes and self-manage their condition.
- The Trust told us that they were rolling out the use of telemedicine with the community nurses visiting patients at home using computer tablets which were being used to take pictures of wounds and then send them to the specialist tissue viability nurses for advice on treatment. Staff using the new equipment were pleased with it saying it improved the accuracy of patient's observations and reduced errors.

Multi-disciplinary working and working with others

- There were many examples of good collaborative working within the multi-disciplinary team (MDT). Staff worked well together; there was effective communication between staff; and healthcare professionals valued and respected each other's contribution to the planning and delivery of children and young people's care. This work was underpinned by sound implementation of approved care pathways, for example, within the Integrated Therapy and Care Co-ordination Service for Children with Disabilities.
- We found that there were close working relationships between the children's residential short break service and the local county council.
- The Children's Community Nursing Team attended multi-agency safeguarding meetings which were attended by representatives from Social Services and Kent Police. Furthermore, the children's community nursing team and continuing health care team had developed strong links with the local children's hospice in order that they could provide timely, flexible and consistent care to the children and families they supported.
- We were told about a pilot involving care homes which aimed to reduce hospital admissions. This was a team looking into reducing hospital admissions from care homes. We heard that the team was successfully reducing admissions from a small band of care homes

Are services effective?

Requires Improvement

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.

that were finding it difficult to cope with more complex patients however we were told that this service had not yet been audited. The team consisted of district nurses but did not include therapists.

- We found many examples of good multi-disciplinary working both within the trust and with outside organisations. For example, staff told us that the long term conditions team attended meetings with the local acute trust to discuss safe discharge and integrating care, a representative from the local hospice attended the MDT meetings in Canterbury and there was always a representative from social services at the MDT meetings.
- There was very good joint working with all three hospice provider organisations.
- Many patients, particularly those requiring complex symptom control were under the care of the hospices, who took the lead in managing and co-ordinating the care of these patients. Hospice community palliative care nurse specialists visited patients in their home and ensured that best practice was followed.

Co-ordinated integrated care pathways

- The Integrated Therapy and Care Co-ordination service for Children with Disabilities was made up of Occupational Therapists, Physiotherapists, Speech and Language Therapists, Therapy Assistants and Keyworkers. The ITACC service was provided from a range of community based health centres to ensure they were easily accessible to the local population to which they served. The Keyworker service engaged with a range of health and social care professionals to ensure that parents and carers could access the most appropriate help, support and treatment for their child.
- We spoke with staff who described the patient centred model of care and how they worked collaboratively with the health and social care coordinators. We saw that patients followed integrated care pathways where appropriate. This was a plan of care written and agreed by a multidisciplinary team and designed to help patients with a specific conditions move progressively through the clinical experience. These worked particularly well in the rehabilitation teams.
- The care planning we saw in the community hospitals for people approaching end of life was, in some cases, poor. The documentation was very general in nature and care planning was not personalised. Care was task focussed and failed to address the holistic needs of each person. This finding mirrored concerns raised by some of the CCGs who suggested that there was a lack of holistic assessment and care planning leading to very task orientated care. One person we saw had very severe contractures but there was no plan of care to minimise the discomfort and disability that this caused. National Institute for Clinical Excellence (NICE) Quality Standard 13:End of Life care for Adults Standard 3 says that , "People approaching end of life are offered comprehensive, holistic assessments in response to their changing needs and preferences, with opportunity to discuss, develop and review a personalised care plan for current and future support and treatment.
- We found an example of an orthopaedic care pathway was in use at Queen Victoria Memorial Hospital. However, staff expressed concerns about its content and use. They told us about six patients who they felt could be discharged with a care package, but the pathway dictated they should remain as in-patients.

Good

Are services caring?

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

Summary of findings

All the patients we spoke with told us how pleased they were with the care and treatment provided by Kent Community Health NHS Trust and told us that the staff were kind and caring supporting them in their needs.

People were mostly involved in making decisions about their care and treatment. People were encouraged and supported to manage their own care where possible and to maintain their independence. People had appropriate emotional support and were helped to keep in touch with their family and friends.

Every hospital had a specific information book outlining the management arrangements and the services offered and other useful information. Each patient had a named nurse.

Patients could access emotional support from ward staff or chaplaincy service which operated at each hospital. For those requiring specialist input a referral could be made to counselling or psychology services

Community team leaders and colleagues supported staff whenever problems were identified and this led to a 'can do' culture' where staff wanted to ensure that they provided care they were proud of.

Our findings

Compassionate care

- Patients who used the service were treated with kindness and compassion.
- Patients were positive about the staff that provided their care and treatment.
- The Trust seek feedback from patients and parents using a range of different methods. We found that the ITACC services utilised a system called "Meridian" to seek feedback. Data for May 2014 demonstrated that the combined ITACC patient experience score was 92% and was therefore within the RAG range of Green.
- All the patients we spoke with without exception, told us how pleased they were with the care and treatment provided by Kent Community Health NHS Trust. We were told about the kind and caring community nurses and therapists who were more 'like a friend coming'. Every patient that we spoke with spoke highly of the kindness of the nurses and therapy staff. One patient summed up the views of all the patients by saying, "All the staff are good, some are excellent".
- At Victoria Hospital, Deal we met a person who was being cared for as an inpatient. They had been admitted with their spouse because they needed end of life care but was also the person's carer. This compassionate and kind arrangement meant the couple could spend time together in the final days of their long marriage and that both received good care.
- The Trust had introduced a system of intentional rounding (comfort rounding) to promote high standards of fundamental nursing care. We saw that this system was in place and saw records of that indicated that this practice was used across the community hospitals. However, a comfort round audit carried out in November 2013 found low compliance (25%) with suggested best practice and concluded intentional rounding was not fully embedded in hospital practice across the trust although 91% of patients questioned felt it improved their hospital stay.

Dignity and respect

- The staff interactions with children and their parents we observed on all the home visits were positive, respectful and centred on the child.
- Patients said that they were always treated with dignity and respect and gave examples where nurses had taken time to explain things to them, not making them feel silly or rushing them but treating them with respect and compassion.
- All newly appointed staff received two hours training in meeting the needs of every person equally regardless of their religious, cultural and sexual preferences or any disability. We were told by the equality and diversity team that respect for individuals and personalisation was key to providing good care. Other training was provided for more experienced staff from all areas of the Trust. There was currently 91% compliance with staff attending training and this level of take up was increasing.
- Patient Led Audit Care Environment (PLACE) in 2013 gave an overall score of 81.53% for Privacy, Dignity and Well-being with a range of 67.11 – 89.8%.

Good

Are services caring?

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

Patient understanding and involvement

- We found parents had an understanding of their children's care and treatment that the service provided. This was supported in all areas we inspected but was especially commendable at Valence School. Examples included a pupil who was being fitted with new splints; the pupil was supported to be engaged in the process, including staff obtaining the necessary consent from the individual, as well as promoting them to self-care for the splints. Information was provided to the pupil on how to care for the splints and this information was also provided to the carers.
- We saw that throughout the Trust there were information leaflets available on various conditions, accessing services and they types of support available. The leaflets were available in other languages, including Czech, Slovakian and Turkish. When we spoke with the community teams they told us that accessing interpreters was not a problem and the Dover team told us they had an interpreter permanently on staff.
- We spoke with a hospital volunteer who helped in the Friends café and provided a trolley shop to inpatients. This volunteer was also a member of the patient experience group. They told us they had been involved in auditing call bells monthly and also asked to look at staff uniforms. Members of the patient experience panel had been invited to take part in food tasting session twice a month and give feedback. Menus had changed as a result of the comments the group had made.

Emotional support

- We found the Trust delivered good emotional support within all the children and family services.
- The parents we spoke with told us that there was effective communication from staff and any concerns were addressed quickly and appropriately.
- Chaplaincy arrangements were a positive feature of the community hospitals. We spoke with several chaplains who visited regularly and were known to all the staff. The regular chaplain were Anglican but we were assured a Catholic and Free Church minister also visited frequently. The chaplains were able to arrange a visiting minister from other non-Christian faiths, if necessary.
- The records we looked at did not include assessing patient's emotional needs or include care plans that addressed this. However in practice we found that the community teams supported patients emotionally although this was not documented.

Promotion of self-care

- Adaptations to physical environments had been made to help encourage children and young people to be as independent as possible. This included height adjustable vanity mirrors and remote control taps within the bathroom at Windchimes.
- There were systems in place to support patients to manage their own health and care and where possible to maintain independence. We saw that the specialist clinics undertook remote observations by telemedicine to help give patients confidence in managing their conditions. We saw that therapists visited people in their homes offering advice on lifestyle, diet, exercise and equipment.
- We saw examples of patients who were being supported to administer their own medication, and one patient told us about their positive experience of this. However, we noted that at Livingstone hospital self-medication was actively discouraged, and we saw staff meeting minutes which confirmed this.

Are services responsive to people's needs?

Good

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

Summary of findings

The Trust was responsive in meeting the complex needs of the people of Kent in the community setting and the commissioning of services. The Trust was forward looking to improve the health of patients and improve their experience of healthcare through various initiatives such as the chronic knee pain programme and a new integrated discharge pilot. These programmes of work demonstrated that the Trust was proactive in working to improve patients' experience of healthcare and implementing new best practice initiatives.

There were inconsistencies in the provision of some services to children and young people across Kent. A contributing factor was the lack of sufficiently commissioned specialist posts to aid in the assessment of children referred under the National Institute for Health and Care Excellence Autism Pathway. Some services within specific localities were failing to respond to the needs of the local population and were failing to ensure that children and young people could access the right care at the right time.

The end of life service was developing and improving care through improved service planning linked to the strategy but there remained gaps in provision where people had less than optimal care.

Our findings

Service planning and delivery to meet the needs of different people

- The Trust was looking to improve the health of patients and improve their experience of healthcare through various initiatives such as the chronic knee pain programme and a new integrated discharge pilot. These programmes of work demonstrated that the trust was proactive in working to improve patients' experience of healthcare and implementing new best practice initiatives.
- Provision was made for people who did not have English as their first language. Staff could access interpreter services and written information could be provided in other languages or in large print.
- We found that, due to variations in commissioning, children referred for assessment under the Autism Diagnosis pathway were managed differently depending on where they lived. For example, we found that implementation of the pathway was seen to be well adopted within the East Sussex region, with one parent stating how impressed they had been with the service, with their child being diagnosed with autism before the age of three; this allowed them greater access to support and therapy services.
- This was in contrast to patients in the Dartford, Gravesham and Swale service, where there was a waiting list of 173 patients who had been referred but had not commenced an assessment because there was insufficient numbers of commissioned speech and language therapists to carry out specific components of the ASD pathway assessment.
- We found that service planning in the Trust was complex due to the differing demands of the seven CCGs. For example, the Trust was moving toward centralised community nursing hubs in order to provide better support to the district nurses and community therapists. However this was supported by some CCGs and not others who preferred to have district nurses attached to their GP practices. The Trust worked to accommodate this and supported the district nurses by bringing them into the central hub on a daily basis.
- There was limited evidence of county wide service planning of end of life care. Good work was being done but was very dependent on local goodwill from staff and local relationships with the hospices.
- The Trust reported high levels of readmission to acute hospitals from community hospitals. This was up to 25% of all admissions in one of the community hospitals. A lack of anticipatory prescription and guidance for staff on symptom control meant people were transferred back when their condition deteriorated, despite them approaching the end of their life and DNACPR forms being in place.
- The community hospitals had a fixed number of beds. The majority of admissions were 'step-down' in nature from acute hospitals although some patients were admitted on a 'step-up basis' from community based care.

Are services responsive to people's needs?

Good

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

- Bed occupancy was around 90%, above the nationally recognised rate of 85% which allows for maximum efficiency. There were no facilities to open extra capacity in periods of peak demand. We were told that waiting lists for admission were minimal.

Access to care as close to home as possible

- Services such as the Looked after Children service were responding to client feedback and increased "Did Not Attend" results by amending clinic times so as to allow children and young people to attend Health Assessment Clinics after school.
- We spoke with staff in the various specialist clinics and most were able to see patients within the target times for the service. For example, new stroke patients were seen within 24 hours and two weeks for people discharged from hospital. However we were told of other services where non urgent patients were pushed further down the list by urgent cases until they 'Fell off the end' of the list and no longer required the service.

Access to the right care at the right time

- The network of community hospitals, support of the hospices and the commitment of the community nursing teams ensured that patients could be cared for as close to home as possible. People using the hospitals frequently mentioned to us that they felt safe in small hospitals closer to their homes and that it made it much easier for family and friends to visit.
- The rapid response team was felt by staff to be effective in reducing admissions to hospital and enabling people to remain in their own homes. A recent reconfiguration of the service resulted in teams of doctors, nurses and healthcare support workers working 3 shifts across the 24 hour period. Nurses on the team had completed training that allows them to certify an expected death.
- Some community hospitals had minor injury units (MIU) attached to them which enabled people to access urgent care without attending accident and emergency departments. We visited some of these units and found they were well utilised by local people. During 2013-14, all patients who attended the MIU were seen within the four target time set by the government.
- Staff told us there were challenges to achieving some performance indicators; in particular referral to treatment for speech and language therapy and the LAC service did not always achieve their initial assessments within the 20 day time scale or their annual review. During March, April and May 2014, the percentage of looked after children who underwent their annual health assessment within the required timescale was 85.6%, 86.5% and 85.4% respectively. This was below the Trust benchmark level of 90%.
- We heard stories from staff and patients about the timing of their transfer from acute care to the community hospitals. There was widespread concern that frail people were transferred late in the day, often after 10pm. We were told this was due to problems with non-urgent transport, or delays in the acute sector such as the availability of discharge medications.

Meeting the needs of individuals

- There were a range of information leaflets available in the locations we visited from the GP clinics to community nursing hubs and community hospitals. We saw that leaflets were available in a variety of languages including Czech, Slovakian and Turkish.
- When we spoke with the community teams they told us that accessing interpreters was not a problem and the Dover team told us they had an interpreter permanently on staff as they provided health care to a large Eastern European community.
- We found there were arrangements and facilities to meet the needs of individual patients. We saw that there was adequate equipment such as adapted bathing facilities, disabled toilets and moving and handling equipment to safely care for people. We also saw that there were adequate supplies of mobility aids and therapy equipment to enable staff to provide rehabilitation. Staff told us they could access specialised equipment for very heavy (bariatric) patients and that patients would not be admitted until this equipment was in place.
- Care at the community hospitals was good but lacked personalisation; the routine remained task focussed.

Moving between services

- Handover arrangements were in place for those children and young people moving between services.
- We found that the Trust looked for ways to ensure that patients were safety transferred and discharged into the community. For example discharge from an acute hospital was seen to be complex resulting in delays of transfer. The Trust analysed the process and identified

Are services responsive to people's needs?

Good

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

areas of duplication and improved the discharge process. Staff told us about the hospital integrated discharge team which worked together with the acute trusts to ensure safe discharge.

- We identified an issue with one acute hospital transferring people back to the community who were in significant pain because the syringe driver used to administer opioid analgesia was removed from them prior to transfer home. Hospital staff administered a bolus of pain relief that should be adequate for the journey but there were sometimes delays in discharge or traffic disruption which meant they went an excessive time without a top up to their analgesia. This situation sometimes prevented discharge and meant people were in hospital for longer than necessary. The community nursing teams used pragmatic workaround solutions to overcome this most of the time but admitted to not always being successful. A more cohesive end of life care strategy should address this situation.
- We were told that patients in the community hospitals experienced delayed transfers of care. The most common reason for these discharges was local authority or continuing NHS funded healthcare funding or the availability of suitable care home vacancies. Both of these areas are outside of the direct control of the trust. In April 2014 6.21% of available community hospital bed days were lost due to delayed transfers.

Complaints handling (for this service) and learning from feedback

- We found the service had systems in place within all its teams for learning from experiences, concerns and complaints, and these systems were generally effective in all areas we inspected.
- We saw that leaflets and posters giving details on how to complain about community services was available in all of the locations we visited, from GP surgeries and specialist clinics to the community services hubs and hospitals. The leaflets contained contact information for the Customer Care Team and gave advice on how to access help and support.
- We saw how at Gravesham Community Hospital a patient who had complained about not having enough information regarding the daily routines of the ward had been encouraged to join a patient forum. We were shown how the complainant had subsequently developed a patient guide which had been included in the patient admission pack.

Are services well-led?

Good

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 of findings

Instructions

Overall in patient services were well led. However, we identified that the leadership in inpatient therapy services needed strengthening.

Staff told us they felt valued and supported to give high quality care by their managers, supervisors and the Trust Board. We found that staff were motivated and happy at work and felt confident to raise any concerns. We were told that matrons and managers were visible and available and executive team members visited the Community Hospitals.

Staff in the Community Hospitals were aware of the Trust vision and we saw examples of local philosophies of care being developed. However in Children and Young People's Services staff were not always able to identify or relate with them.

The Trust had been through a sustained period of change and reorganisation leaving certain staff groups feeling disaffected. However the majority of staff we spoke with said they felt valued and supported by their managers and were proud of to work for the Trust. Staff from teams affected by the most change told us that the leadership did not listen and 'imposed change' without listening. The Trust was aware of poor leadership in certain areas and communication issues and was working to address this through supporting managers and finding practical solutions where possible.

Our findings

Instructions

Vision and strategy for this service

- The majority of staff we spoke with understood the difficulties the Trust was experiencing, in particular the challenges to the commissioning of services.
- Staff at a senior level told us the Trust's ongoing negotiations with commissioners about the type of services they delivered at present and also of those scheduled to be provided in the future was affecting their day to day work. Staff considered that the lack of appropriately commissioned services impacted on their ability to provide high quality care to children; this was especially noticeable within the Dartford, Gravesham and Swanley community paediatric team who described being "Frustrated" at not being able to fully implement the NICE Autism pathway.
- The Trust covered wide and disparate communities from busy cities and ports to isolated rural settlements and we noted the difficulties in providing parity of services across the county.
- We spoke with senior members of the trust who told us that because of the recent restructuring and the complex relationships with the seven CCGs it was a challenge to deliver consistently good care across the county. They discussed the pressures and barriers and told us that the trust was on a journey with five strategic goals to deliver.
- The End of Life Care Strategy is a plan for the future but was not impacting significantly on service delivery at the time of our visit. Staff could not explain the vision or the strategy. Local teams had a shared purpose and these were often very similar across the Trust but there was no sense of looking to the future. Staff felt they were already providing a very good service.

Guidance, risk management and quality measurement

- There was a robust governance framework and reporting structure. We saw from the monthly quality performance report and risk register that there were clear lines of responsibility and communication.
- Key performance indicators, workforce issues and learning from incidents, complaints and patient experience were discussed at team meetings and reported through to the Board.
- Some auditing of end of life care provision had begun with a training needs analysis of staff working in the community hospitals. We also saw evidence of a pain management audit that was in progress when we visited.
- Staff were able to describe how learning from incidents was implemented. For example, we were told how a system had been implemented across the community hospitals for identifying patients at risk of falls using coloured arm bands.

Are services well-led?

Good

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.

Leadership of this service

- Information from the NHS Staff Survey 2013 indicated that the Trust performed on average, about the same as other community trusts with regards to staff receiving support from their immediate managers.
- "Getting to the top of the Trust's agenda" was how staff described one of the biggest challenges faced by the Children and Young People's Directorate.
- Staff told us that the Trust's Board were now more visible, holding walkabouts in locations across the trust and that several all staff leadership events had been held although it was difficult to find time to release staff for these.
- Individual teams told us that they were well lead by their immediate line manager and felt that there was a strong leadership team above that. They all told us that they got good support from their team members. Other staff told us that the Trust offered excellent clinical leadership and support with learning about patients' conditions.
- In terms of end of life care skills and knowledge, the managers had no more training than the staff they were managing and in some cases, less. There was poor dissemination of learning outside the immediate team. Some staff brought back ideas from their degree modules and shared these with colleagues but there was no effective system for spreading good practice more widely.
- Senior nurses in some of the community hospitals had a limited understanding of what good end of life care, based on current NICE guidance looked like. They were intuitively providing kind and compassionate care but lacked insight into the field of palliation.

Culture within this service

- Kent Community Healthcare NHS Trust came into effect in 2011 and was created following the merger of East and West Kent Community Health Services. Whilst some staff had embraced the merger, it was apparent that there remained a sense of loyalty towards individual staff member's predecessor organisations. For example, we were constantly told by staff that they were either "East Kent" or "West Kent".
- The Trust told us that they were aware of poor leadership in certain areas and communication issues and was working to address this through supporting managers and finding practical solutions where possible. We heard about the various methods the trust was using to change the culture of the organisation which included the leadership and management development programme, staff audits and action plans to address staff health and wellbeing. In particular the trust was investing in the middle management tier to enable them to lead and develop their teams more effectively.
- Staff sickness rates at the community hospitals as 6.78% (range 2.59 – 10.03%). Short-term sickness rates were 2.14% (1.28 – 3.11%). This is below the trust average of about 4.25% The stress related sickness absence rate was 1.84% (0.01 – 2.77%).

Public and staff engagement

- Staff recognised the importance of the views of people who used the service about the services provided. Staff were involved in actively seeking feedback from people.
- The Trust engaged with the public through patient surveys which were collected using hand held devices and feedback through the trust website and comments made via the Patients Advice and Liaison Service (PALS). We saw that the devices offered real time patient feedback across all services although the uptake could be improved, we noted high levels of patient satisfaction for those services surveyed.
- Patients and carers were encouraged to contact the customer care team to share their experience of the services they had received. We were told that the trust received a low volume of complaints and this was confirmed by the patients we spoke with and the complaints information available.
- The Trust introduced the Families and Friends test in April 2013, ahead of the requirement to introduce it in community trusts nationwide. The overall score for the Trust was +77 (the parameters being -100 to +100). This compared with a benchmark score of +75 for aspirant community trusts. The scores for the community hospitals were variable, ranging from +55 in Sheppey and +56 in Tonbridge Hospital to a high +92 for Hawkhurst and +83 for Deal.
- Staff told us about the Schwartz Rounds which were a forum for staff to meet once a month and explore the impact that their job had on their feelings and emotions. These were part of the clinical governance multi-disciplinary meetings to which all staff were invited to attend.

Are services well-led?

Good

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.

- We saw that the Trust maintained action plans following the CQC annual staff survey. The survey for 2011/2012 indicated areas where the trust scored below the national average; for example, staff working extra hours or pressured to attend work when unwell. Action plans were in place to address the worst scoring areas.

Innovation, improvement and sustainability

- The paediatric audiology service was reviewed as part of the New-born Hearing Screening Programme Risk Assessment and Quality Assurance initiative on 17 January 2013. The service attained ratings of an "Acceptable standard" in the four assessment criterions. The service was commended by the quality assurance team for the marked improvement in the performance against Key Performance Indicators (KPI'S) with regards to carrying out screens within 4 weeks, when compared to the services previous quality assurance report of 2011.
- The Trust was financially stable with systems in place to enable growth and development of services depending on the needs of the commissioning groups. We saw examples of the Trust developing services for long term care such as the integrated discharge team and the rapid response pilot.
- A cycle of continuous improvement was not embedded in end of life care services and the limited auditing and analysis of the services had not resulted in any significant changes to practice except the standardisation of the syringe drivers used across the Trust.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	**You are failing to comply with Regulation 20 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which states:** Records 20 (1) The registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of— 1. an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user. **Why you are failing to comply with this regulation:** • Staff understanding of the correct completion of do not attempt cardiopulmonary resuscitation (DNACPR) forms was limited and most staff had not completed training in the use of the DNACPR process. • A DNACPR form cancelled over a month previously was still in force and Staff were unclear why this person still had a DNACPR showing against their name on the printed handover sheet. • In Deal Community two DNACPR were incorrectly completed. There was no record of the decision having been discussed with the people or their families and no record of any involvement of the wider MDT. The people whom the forms related to both had capacity. • No audits of DNACPR records had taken place across either the community hospitals or the community nursing teams therefore the provider could not be fully assured that DNACPR forms were being appropriately used across the trust