Your Healthcare Community Interest Company

1-328569033

Community end of life care

Quality Report

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Date of inspection visit: 15 – 17 November 2016
Date of publication: 09/06/2017

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-727827222	Hollyfield House		KT5 9AL.
1-727899272	Surbiton Health Centre		KT6 6EZ.
1-727827967	Cedars Unit (Tolworth Hospital)		KT6 7QU.

This report describes our judgement of the quality of care provided within this core service by Your Healthcare Community Interest Company . Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Your Healthcare Community Interest Company and these are brought together to inform our overall judgement of Your Healthcare Community Interest Company

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

We have rated this service overall as requires improvement because;

- Some staff were not confident about what process they should follow if patients did not have capacity.
- There were gaps in MUST nutritional assessments, either not available in patient records or not completed thoroughly.
- There were no personalised care plans on nutrition and hydration to ensure that the patient and their family's views and preferences around nutrition and hydration at the end of life were explored and addressed.
- Staff we spoke with were not aware of the vision and values for the end of life care services.
- Systems or processes were not sufficiently established or operated to effectively ensure the provider was able to assess, monitor and improve the quality and safety of end of life care services.
- There was no structured end of life care training plan or register of training to ascertain the skills of staff in different roles and teams.
- There was no care plan and pathway widely in use that was specific to patients who were dying during the inspection.
- Patient's records were not holistic and not all reflected emotional and spiritual needs, and in some records, relevant assessments had not been completed and recorded.

However;

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses; they said they had been fully supported when they did so. Staff monitored and reviewed safety incidents to enable them understood the risk associated with their services.
- The service worked closely with the local hospices to provide a collaborative multi-disciplinary approach to care and treatment.
- Nursing staff received timely appraisals and were supported with professional development and NMC revalidation.
- Patients and their families were very positive about staff and the service they received. The service demonstrated a high level of compassionate care to patients and their families.
- Community nursing staff providing end of life care services told us they were well supported by local team leaders and managers. Staff across the service had opportunities to review the quality of care and the way that teams worked. They told us they felt empowered to develop local solutions based on good practice.

Summary of findings

Background to the service

Your Healthcare Community Interest Company provides end of life care for patients registered with a GP in the Royal Borough of Kingston Upon Thames. This is a nurse led service.

End of life care is provided to patients who have been identified and assessed as having entered the last twelve months of their lives. In common with many areas of the country, cancer patients formed a high proportion of the provider's end of life care patients. We were not provided with the actual figures for cancer and non-cancer patients receiving end of life care from the provider.

End of life care is provided within community adult nursing services by community nurses, physiotherapists and occupational therapists within patient's own homes. Specialist palliative care services were provided by the local hospice, which was registered separately with the CQC.

During this inspection we reviewed 15 sets of patient notes and spoke with seven relatives (We were unable to speak with patients as most of them were not able to communicate with us) and 19 staff including district nurses, community matrons, occupational therapists and community staff nurses. We observed care being provided by the community nurses in people's homes.

Our inspection team

Chair: Professor Iqbal Singh, consultant physician.

Team Leader: Roger James, Care Quality Commission

The team included CQC inspectors and a variety of specialists: Occupational Therapist, Physiotherapist, Speech and Language Therapist, Nurse Specialists, Pharmacist and an expert by experience (carer of people who had used community services).

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting Your Healthcare, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew.

We carried out an announced visit on 15 -17 November 2016. Before and during the visit we held focus groups with a range of staff who worked within the service, such as nurses, specialist nurses, therapists, managers and BME staff. We spoke with people who use services, observed how people were being cared for, and spoke with carers and family members.

Summary of findings

During our inspection, we spoke with fifty-two members of staff of all disciplines and grades. We also observed two staff handovers involving thirteen staff.

We visited staff bases and spoke to managers, team leaders, the matron, community nurses, district nurses, care support workers, physiotherapists, occupational therapists, community matrons, tissue viability nurses, therapy assistants and administrators.

We looked at fifteen paper and electronic care records and spoke with fifteen patients and ten relatives/carers. We accompanied staff on fifteen home visits and saw staff providing care and treatment in patients' homes and looked at the paper based care records in the home environment.

What people who use the provider say

We spoke with patients in clinics, at rehabilitation classes and on home visits. We received positive feedback from everyone we spoke with.

Patients and carers were pleased with the services they received and spoke in glowing terms of the care and kindness that staff gave them.

Patients told us that staff go the extra mile and that they value the services provided. Patients described staff as 'wonderful' and 'amazing'.

Patients and relatives we spoke with were positive about the care they received. We were told that staff were approachable, responsive, caring and compassionate.

The patients we spoke with were complimentary about the staff and told us staff were caring, friendly and sensitive to their needs.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- Ensure end of life care plans provide sufficient information to identify the personal wishes and preferences of patients and their families.
- Ensure that all care pathways reflect and reference evidence based best practice guidance for staff.
- Re-assess staff competence around the Mental Capacity Act and best interest decisions.
- Ensure the availability of personalised care plans on nutrition and hydration so that patients and their family's views and preferences around nutrition and hydration at the end of life were explored and addressed.
- Conduct an in depth assessments and regular reviews of patients' nutrition and hydration needs.
- Ensure staff have appropriate technology to reduce non-effective work time and excess hours for community staff.

Your Healthcare Community Interest Company

Community end of life care

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good because;

- Staff understood their responsibilities to raise concerns and to report and record safety incidents. There were systems in place to report incidents and learn from them to reduce the chances of them happening again.
- The management and senior staff regularly reviewed incidents and shared the findings with individual staff and at team meetings.
- There was appropriate equipment available in patients' homes and at various health centres and we saw that equipment for patients at the end of life had appropriate safety checks completed.
- Medicines were prescribed in line with national guidance and we saw good practice in prescribing anticipatory drugs for patients at the end of life. Anticipatory drugs were prescribed for patients at the end of life and that these drugs were available in patients' homes.
- We saw that Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) documentation was completed consistently.
- Clinical staff had appropriate safeguarding awareness training and people were protected from avoidable abuse or harm. Adult safeguarding policies and procedures were supported by mandatory staff training.

However,

- Patient's records were not holistic and not all reflected emotional and spiritual needs, and in some records, relevant assessments had not been completed and recorded.

Safety performance

- The service monitored safety information through regular quality dashboard reports on safety indicators such as pressure ulcers, falls and medication errors.
- The service completed information for the Safety Thermometer. The Safety Thermometer allows organisations to establish a baseline against which they can track improvement. The end of life care services reported no SIRI in the past 12 months as at the time of reporting.

Good

Are services safe?

Incident reporting, learning and improvement

- The service used a recognised electronic reporting system. All staff we spoke with told us that they used the system.
- Service managers ensured incidents were correctly classified, including those considered a serious incident (SI) or Never Event. There were no Never Events reported. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Staff we spoke with knew how to recognise and report incidents on the provider's electronic recording system. They reported incidents and were able to discuss them with their line managers. They gave us examples of a range of reportable incidents such as accidents, pressure ulcers, medication errors, slips, trips and falls. However, due to lack of equipment or IT connectivity issues, staff could not always access on-line reporting in the community but had to return to a hub office to do so; this could cause delays in reporting incidents.
- Staff used regular team meetings or newsletters to share learning and trends from incidents; this was confirmed by community nurses in both north and south localities who had attended meetings with other teams where actions from incidents or good practices had been shared. They told us that they felt confident to discuss or raise concerns.
- Incidents were reported through to managers and reviewed at governance or quality and safety meetings including details of the actions plans put in place as a result. Senior staff were required to produce evidence that actions had taken place.
- All the community nurses told us that incident reporting, including near misses, was positively encouraged. One of the nurses gave us an example of a syringe driver incident they had reported. They said their manager supported them through the process and they felt there was a 'no blame' culture.
- Staff told us they discussed incidents, and learning from incidents, during handovers and team meetings. However, staff said that not all teams had regular team meetings so not all senior staff shared this information.

Duty of candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- A duty of candour policy was available which detailed how staff should communicate with patients following a reportable patient safety incident.
- All staff we spoke with about this were aware of duty of candour and could give examples of when this had been or would be used. We saw evidence that the duty of candour was included as part of the RCA process.
- Staff we spoke with were aware of their responsibilities to be open and honest following incidents that had caused moderate or severe harm to a patient. However, some staff told us that it was their understanding that the service usual practice was for informal verbal feedback to the patient.

Safeguarding

- Nursing staff were knowledgeable about safeguarding procedures and knew to whom who they would report any concerns. We saw information about how to report any safeguarding concerns and safeguarding adults information was displayed in the hospital, clinic and community bases we visited.
- Staff we spoke with were aware of their responsibility to keep people safe and, when needed, report any safeguarding concerns. Staff were able to identify safeguarding leads within the organisation for both adults and children. Team leaders told us they discussed learning from safeguarding incidents during team meetings and hand over meetings.
- There were safeguarding policies and procedures available, and a safeguarding lead who could provide guidance and support to staff in all areas of safeguarding concerns during normal working hours.
- Staff received training in adult safeguarding as part of their mandatory training. All community nursing staff received safeguarding adults' level two training. Staff received training updates at a level appropriate to their area of work.

Good

Are services safe?

- Training data for 2015/16 in relation to safeguarding showed that approximately 98% of staff in adult community services had completed level 1 & 2 training in line with the provider's target of 95%.
- Staff gave examples of the types of concerns they would report and were aware of how to refer a safeguarding issue to protect adults and children from suspected abuse. Staff told us they had received feedback from safeguarding concerns and referrals they made. This was cascaded from the providers' safeguarding team to frontline staff through their line managers.

Medicines

- The community nursing teams had a system in place to check that control drugs (CDs) were being administered to patients appropriately. Records of administration of drugs were kept (such as medication administration record) when patients were being given medicines via a syringe driver.
- On our inspection we found that anticipatory medicines were prescribed and obtained in a timely manner. Anticipatory medicines are an important aspect of end of life care; they are prescribed drugs in order to control symptoms such as nausea, breathlessness, anxiety and pain.
- The management and ordering of medicines was given priority by the teams. There was good liaison with both GPs and out of hour's services around prescription of medicines for end of life care.
- Medication administration records we checked were completed clearly and legibly, detailing the times of administration of medicines prescribed 'as required' and checks to ensure the safety and suitability of controlled drugs kept at patients' homes.
- A senior nurse told us that guidance was available for staff to prescribe appropriate end of life medicines to manage patients' pain and other symptoms in line with national guidance and best practice.

Environment and equipment

- Community nursing staff told us they were able to access a syringe driver and other equipment whenever it was needed. The provider had a guidelines and policy on the use of syringe drivers. Some of the homes we visited in the community had a patient on syringe driver; there were sharps containers to allow for the safe disposal of objects such as needles, syringes and glass ampoules. All the sharps containers were correctly labelled and signed.
- Community staff who provided end of life care for patients ordered any care aids or equipment from an external provider. The types of equipment required to help end of life patients at home were hoists, electric profiling beds and commodes as well as special mattresses to help prevent pressure ulcers.
- Most staff in community teams said access to standard pressure relieving cushions and mattresses was not a problem, even though they sometimes had to wait for the equipment to be delivered.
- Environmental cleanliness and prevention of healthcare acquired infection guidance and procedures were available to ensure equipment was regularly maintained and fit for purpose.
- During our inspection, we visited community team bases, clinics and patient homes. The premises we visited had procedures in place for the management, storage and disposal of clinical waste.

Quality of records

- The clinical records kept were a combination of electronic records and paper records. Paper records, which included care plans, were kept at patients' homes. Electronic records were available only to authorised staff; computers and computer systems used by staff in community nursing teams were password protected.
- We observed well-kept notes in some patients home that reflected the care and treatment provided. There were regular care updates noted in the care plans, the notes were clear, signed and dated. For instance, on a home visit to an end of life care patient, the care plans and progress notes were found to be clear up to date, signed and dated.
- However, in some of the records we reviewed for end of life care patients, the care plans were not always fully completed and progress notes did not always match the relevant goal on the care plan. For example emotional and spiritual needs were not recorded. In some cases reviews were marked as 'on-going', which were not informative enough as it showed no evaluation of the

effectiveness of the care plan, for example pain management or nutritional plans, Waterlow assessment and MUST assessment tools were not always completed accurately and appropriately.

- On a visit to an end of life care patient with a community nurse we noted that the visit was documented the visit appropriately on patient's records.
- The service used a generic community nursing adult care plan for end of life care patients rather than a specific palliative care plan.
- Patients who were in the last days of life had a general care plan in place, including well-documented do not attempt cardio pulmonary resuscitation (DNACPR) status. We reviewed three DNACPR forms and found they were completed accurately.

Cleanliness, infection control and hygiene

- Staff were observed following infection control procedures and protocols in patients' own homes. During visits with community staff to patient homes we observed that staff washed their hands before and after patient contact. We also observed the use of personal protective equipment, such as disposable gloves and aprons when administering care to patients.
- Staff had access to guidelines for dealing with blood and bodily fluids when needed. Sanitising hand gel was always available and we saw this being used by the nurses we were with during the onsite inspection and on visits to patients home.
- Patients told us they observed nurses using hand-washing facilities before and after administering care. There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps in clinic and home environments.
- Hand washing facilities and alcohol hand gel were available throughout the clinic areas we visited. Staff we observed followed good infection prevention and control procedures when working in the community.

Mandatory training

- Community staff in the different teams described good access to mandatory training. They told us their mandatory training was up to date and it was reported that the service had a strong focus on training.
- Mandatory training covered a range of topics which included fire safety, health and safety, basic life support, safeguarding, manual handling, hand hygiene, communication, consent, complaints handling and information governance. Most of the staff dealing with end of life care patients were provided with symptom control, syringe driver and pain management training and these were not part of the mandatory training requirements of the provider.
- Community nurses had access to training and development in end of life care skills and knowledge. Staff were provided with additional end of life care training, and covered a range of topics including achieving priorities of care, symptom control, communication and holding difficult conversations, syringe driver awareness, verification of death, and pain management.
- Nursing staff we spoke with confirmed they had undertaken the provider mandatory training. We saw records of attendance at mandatory and statutory training for nurses and health care assistants who had completed their mandatory and statutory training. Across all community services the compliance rate for mandatory training was between 95% and 100%.

Assessing and responding to patient risk

- There was a formal arrangement for specialist input to end of life care services from the local hospice, where community nurses could receive professional support.
- Patient's records incorporated regular assessments of patients' needs to minimise risks and maximise symptom control. We saw that patients had been regularly reviewed.
- There was out of hour's provision for community staff to access support for end of life care patients from the local hospice. The advice was given by specialist palliative care nurses or palliative care consultants based on patients' needs.
- Staff could articulate what to do if a patient deteriorated and were aware of the escalation processes for senior manager support and what they should do in an emergency.
- We also saw that patient home visits were allocated based on staff skill mix and patient need. Where appropriate evidence based care and treatment was

discussed. There were daily discussions of complex patients and their comprehensive risk assessments, any changing risks, any end of life issues including falls risk assessments.

Staffing levels and caseload

- End of life care was provided by community nurses who worked in their designated local area. The specialist palliative care was provided from the local hospice by clinical nurse specialist for end of life care.
- Community nurses were also able to refer patients to the hospice and other end of life / palliative care service providers for assistance for end of life care patients whenever it's needed.
- The provider did not use a recognised tool to calculate required staffing levels for end of life care services. Caseload management for end of life care patients was undertaken by the nurse in charge of the service, and was based solely on experience and judgements. There were no dedicated allocation of end of life care caseload for staff.
- Caseloads were discussed during handover meetings; the needs of each patient, details of new patients, expected and unexpected changes to the patients' health or circumstances were discussed which then allowed an appropriate response to be planned from the most suitable member of staff.
- Staff in all areas we visited during the inspection told us they were busy, but they felt they had sufficient time to provide a meaningful and quality experience for their patients.

Managing anticipated risks

- Community adult healthcare services undertook a range of environmental risk assessments to ensure that staff were working in a safe working environment. Where risks had been identified prior to a visit all staff took appropriate measures to ensure they were safe.
- The service had lone working policies and guidelines and staff were provided with lone worker emergency alarms. All of the community nurses we spoke with were aware of these procedures and told us they used them when needed. Staff knew what action they would take if a potential risk to a colleague was identified. Staff told us they would use their mobile phone in an emergency to seek help and assistance.
- The service managed foreseeable risks and planned changes in demand due to seasonal fluctuations, including disruptions to the service because of adverse weather.

Major incident awareness and training

- There was a business continuity plan regarding major incidents. The plan identified key contact details and a process for staff to follow in an emergency.
- At local level community nursing teams told us they had systems to make sure people got visits despite bad weather. For example; Patients who did not need to be seen would be telephoned to check their health and welfare.

Requires improvement

Are services effective?

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

Summary

We rated effective as requires improvement because;

- There was no care plan and pathway widely in use that was specific to patients who were dying, during the inspection.
- Staff at all levels including managers were unclear how much information they needed to record on care notes and the format this should take when making best interest decisions for patients who could not consent during their last days of life.
- Some staff were not confident about what process they should follow if patients did not have capacity.
- There was no structured end of life care training plan or register of training to ascertain the skills of staff in different roles and teams.
- We either did not see MUST assessments in some of the care records we reviewed, or the MUST assessments we saw, were not completed at appropriate intervals and did not contain relevant information.
- There were no personalised care plans on nutrition and hydration to ensure that the patient and their family's views and preferences around nutrition and hydration at the end of life were explored and addressed.

However;

- Staff with appropriate skills and knowledge were used by community teams to provide end of life care for dying patients.
- Staff participated in annual appraisals and had access to further generalist training as required.
- A multi-disciplinary team (MDT) approach to care was evident across the end of life care services provided by the community nursing team and also evidence of collaborative working with the local authority.

Evidence based care and treatment

- People's care and treatment was planned and delivered in line with current evidence-base guidance, standards, best practice and legislation. Staff told us they received monthly bulletins and emails from managers regarding updates to NICE guidance. Community staff referred to NICE guidelines in discussions, and policies and procedures quoted NICE and other professional guidance.
- Staff were aware of the Advanced Care Plan (ACP), but we did not see any evidence of its use. However, following the inspection, the provider told us that ACP discussions were initiated by the local hospice it works in partnership with, and not Your Healthcare, as part of the joint working and partnership arrangements. Advance care planning (ACP) is a nationally recognised means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live and die in the place in the manner of their choosing. ACP is a key part of the Gold Standards Framework Programmes. It should be included consistently and systematically, so that every appropriate person is offered the chance to have an advance care planning discussion with the most suitable person caring for them.
- We asked the provider to tell us their arrangements for end of life care services to achieve the Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying People. They told us that a care plan was in draft and being consulted upon which is built on the five (5) priorities. Timescales for implementation of the care plan were not provided.
- Staff told us the provider met regularly with the local hospice to network with the wider end of life care team. Staff attending these meetings learnt the latest evidenced based practice and news relating to end of life care and shared it with the multidisciplinary team to improve practice.
- The expertise of the specialist palliative care team from the local hospice was used widely and highly valued by community staff; however there were no formal service level agreement with the local hospice for the provision of these specialist services.

Requires improvement

Are services effective?

- Patients who were in the last days of life or in a rapidly deteriorating state were identified in a timely way, and their care was reviewed, they had their needs met in at appropriate intervals, with escalation of their needs by the community nursing team.
- Staff told us that the Liverpool Care Pathway (LCP) had never been used for their end of life patients. The service was piloting its own version of an end of life care plan. The care plan was not widely available to all staff in the community nursing team, and had not yet been audited to determine if it was effective. However, we were told after the inspection, that following the pilot, the care plan had been agreed and will be fully rolled out across all Your Healthcare services from 1 April 2017.
- Staff told us about clinically driven local audits, which aimed to improve practice and patient care. For example staff told us an audit of pressure ulcers showed that the incidence of pressure ulcers had reduced. The community team were also auditing care plans, DNACPR and the use of MUST and Waterlow scores to maintain record keeping standards.

Pain relief

- Patients identified as needing end of life care were prescribed anticipatory medicines. These were 'as and when required medicines' prescribed in advance to properly manage any changes in patients' pain or symptoms.
- Community nurses discussed options for pain relief including use of a patch to enable a patient to have more sustained relief from pain which would control their symptoms and manage their pain. We observed home visits with community staff nurse where options for pain relief were discussed with the patient and their family. We also observed a home visit where a patient's self-management of pain was discussed including use of a patch to enable a patient to have more sustained relief from pain.
- We observed that community nurses assessed patients' pain, and requests for any reviews were promptly made to GPs, to enable prescription changes on the same day, avoiding the patient remaining in pain.
- Community nurses were supported by specialist palliative care team from the local hospice for pain management. We observed that they communicated with GPs on patient's behalf when increase in pain control medication was required to accommodate the rapid change in patient condition.
- Pain management and the use and effectiveness of medicines to control pain were discussed every day at staff handover meetings. We observed two handover meetings during our inspection where it was evident that observation of a patient's pain and the effectiveness of medicines were reported back to the team.

Nutrition and hydration

- We were told by the nursing leadership that screening tools were used to determine how best to support patients in need of nutrition and hydration. A patient in receipt of end of life care, for example, will be assessed using the Malnutrition Universal Screening Tool (MUST). The assessment will then determine the nutrition and hydration intervention needed by the patient. However we did not see this in practice, nor did some of the care records we reviewed contain any of the above mentioned assessments.
- Staff told us they used the MUST scale to help identify patients who may be at risk of malnutrition. However, the MUST charts in patient's records we saw were not completed at appropriate intervals and did not contain relevant information.
- There were no personalised care plans on nutrition and hydration to ensure that the patient and their family's views and preferences around nutrition and hydration at the end of life were explored and addressed.
- Patients' records we reviewed showed that community staff had not conducted in-depth assessments or regular reviews of patients' nutrition and hydration needs. The IMPACT team lead acknowledged that more staff training was required in relation to nutrition and hydration for end of life patients in nursing homes.
- End of life care patients had access to specialist assessment from a speech and language therapist for swallowing difficulties and of dietitian input if required.

Requires improvement

Are services effective?

Technology and telemedicine

- Staff we spoke with told us that more effective mobile working devices for community nurses and therapists would reduce non-effective work time.
- The provider was piloting a new electronic patient record system for use by the community nursing team. This enabled community nursing staff to access patient records and communicates details of patient care with other care partners when out on a visit. However, this was at its infancy and had not been audited to determine its effectiveness.

Patient outcomes

- Community nursing staff told us the specialist palliative care team from the local hospice would measure patient's outcomes.
- Managers told us clinical outcomes on end of life care were not being measured by the provider, however they had plans to implement monitoring of patients outcomes in line with the Priorities of Care set out in One Chance to Get it Right (June 2014).

Competent staff

- We saw records that showed 100% of staff had attended a corporate induction programme. A corporate induction was completed by staff joining the service. Staff told us new staff also received an induction at locality level.
- Staff training and development was supported by the provider. We found the provider encouraged skills development. Staff of different grades confirmed that their training needs were identified as part of appraisal, and staff could request further training that was relevant to their role.
- Staff in the different teams described good access to mandatory training and additional specialist training when required. There was regular supervision and appraisal of staff. Team meetings were used to provide peer group supervision and case study discussions.
- There was no structured end of life care training plan or register of training to ascertain the skills of staff in different roles and teams.
- Community nurses had access to ad hoc end of life care training in some of the following topics; symptom control, communication and holding difficult conversations, syringe driver awareness, verification of death, and pain management. Staff told us they work alongside the palliative care staff from the local hospice when dealing with patients with complex needs.

Multi-disciplinary working and coordinated care pathways

- All staff were positive about the multi-disciplinary team (MDT) meetings which involved many staff involved in providing care and treatment including a GP, nurses, therapists and social workers. Community nursing staff attended meetings at GP surgeries to discuss the ongoing needs of patients.
- Staff that we spoke with at all levels described good MDT working amongst colleagues and said they maintained close relationships with them. Staff felt able to consult with colleagues and there was a good rapport within the different specialists. We found examples of effective multidisciplinary working both within and across teams. For example, senior nurses were available for community nurses to consult, sought advice and support from them. These included specialists in, for example, tissue viability, multiples sclerosis and palliative care.
- Community nursing handovers we observed were well-managed and comprehensive. The conditions of individual patients were discussed and decisions were made on the course of treatment. Staff themselves said that communication within the service was good.
- All the community staff we spoke with told us that they worked effectively with both secondary (the acute hospital services) and primary care (general practice and community staff). They told us that they were able to refer patients into secondary care when needed.

Referral, transfer, discharge and transition

- There were range of services and teams with clear referral criteria, designed to meet the needs of patients along care pathways. There was evidence of teams referring patients appropriately to services that best met their needs.

Requires improvement

Are services effective?

- The community nursing team accepted referrals from the hospitals, hospices and GPs. Staff were observed in a daily meeting prioritising new referrals. For example, new patients who had complex or considerable needs were seen promptly.
- There was a single point of access available Monday to Friday between 8am and 6pm and 9am until 5pm on weekends. The single point of access received the referrals for all specialist community services teams. Referral to other disciplines such as occupational therapists or physiotherapists to help patients cope with symptoms such as breathlessness was straight forward and effective.
- Discharges from hospitals were managed efficiently and timely to allow the patient to be cared for in their preferred place of care during their last days.
- Community teams had close working relationships with social workers and GPs and liaised with hospice and other end of life care providers when needed, we were given examples of joined up working across these services that had taken place for one patient that meant they had the care they needed when they needed it.

Access to information

- Staff access to IT systems was variable. Staff told us the IT system worked well at base locations, but there was limited access out in the community. The limitations of the IT systems had affected the effectiveness and performance data of all teams' communications.
- Paper care records were kept at patients' home for all people involved in the person's care to document their actions, conversations and the patient's wishes and outcomes. This meant healthcare professionals involved in the patient's care, who visited them at home, had access to up to date information and knew of any changes or developments in the patient's health. However, not all information was transferred to the nursing IT system.
- Information was available on standard operating procedures and contact details for colleagues within and out of the organisation. This meant that staff could access advice and guidance easily.
- Staff at all locations we visited showed us where they could find the providers' policies and procedures on the intranet. We reviewed information on the providers' intranet and saw the information was clear and accessible. This enabled staff to access information about evidence-based patient care and treatment through external internet sites.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We spoke with staff who explained procedures for gaining consent from patients before delivering care and treatment.
- Staff at all levels including managers were unclear how much information they needed to record on care notes and the format this should take when making best interest decisions for patients who could not consent during their last days of life.
- Staff had received mandatory training on Safeguarding Adults, Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff were confident about seeking consent from patients; however some staff were not confident about what process they should follow if patients did not have capacity.
- Patients we spoke with told us staff always gained their consent prior to providing care or treatment. We observed nursing staff explained procedures to patients and gain verbal consent to carry out the procedures.
- Community staff we spoke with understood the DNACPR decision making process and described how they discussed DNACPR decisions with patients and families. They told us they provided clear explanations to ensure that the decision making was understood by all the parties concerned. There was a provider wide guideline for DNACPR within the community nursing team.

Good

Are services caring?

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

Summary

We rated caring as good because;

- Staff were passionate about the care they delivered. This was reflected in the comments made by patients and their relatives. Patients felt supported physically and emotionally.
- Patients were positive about the quality of care they received. We noted staff treated patients with dignity and respect.
- Patients' relatives we visited and spoke with, told us that they were involved in planning their care and were provided with enough information to make informed decisions.
- The majority of the comment cards completed had positive feedback.
- All the feedback received from patients were positive. We observed nurses explaining to the patients what was happening.

Compassionate care

- We observed community nurses delivered respectful and compassionate care with attention to their patient's privacy and dignity.
- We observed a number of staff and patient or carer interactions during our inspection. This included five home visits of which four were with staff providing end of life care to patients at their own homes. We observed consistently caring and compassionate staff.
- During a home visit, we witnessed one patient saying to a member of staff 'I didn't know there were people like you to help'. This patient also told us that the staff were wonderful. Staff spoke with patients in a reassuring, considerate and respectful manner.
- We saw staff providing detailed explanations of procedures, thorough assessment of all needs and reassurance. All patients we spoke with spoke positively about the care and treatment that they had received.
- Staff had developed trusting relationships with patients, their relatives and loved ones. Throughout the inspection, we witnessed patients were treated with compassion, dignity and respect. We observed that staff communicated with patients in a respectful way in all situations. Staff maintained patient confidentiality when attending to their care needs.
- As part of the inspection process, we sent comment card boxes for patients to give us feedback. Out of the 46 comment cards received, majority were positive about the care and support they had received from staff. However, they were all related to community nursing services and not specific to end of life care.

Understanding and involvement of patients and those close to them

- Patients were involved in planning of their treatment and nurses acted on patients wishes. When patients asked questions, these were responded to appropriately and where further information needed to be obtained by a nurse patients were informed when, and how they would be provided with the information.
- All patients we spoke with told us they were very happy with the service. They told us nurses arrived on time, were polite and friendly and always explained everything.
- Patients and those close to them were involved with their care. Relatives told us that they had been consulted about decisions and understood what was happening and why. One family member had been invited to a multidisciplinary meeting with staff to discuss future care needs for their relative.
- Relatives told us that staff communicated to them in sensitive and unhurried manner to ensure they could understand the information being given to them. We observed home visits with patients which were not rushed, giving plenty of time to ensure that patients were able to articulate their needs.

Emotional support

- Throughout the inspection, we witnessed many examples of kindness towards patients and their

Good

Are services caring?

relatives, from well-motivated and committed staff. Patients we spoke with said staff met their emotional needs by listening to them, by providing advice when required, and responding to their concerns.

- We observed community nurses treated their patients with sensitivity and kindness. Patients and carers felt emotionally supported and reassured by the community nursing visits. Patients told us they were very happy with the care they had received.
- We saw a community nurse providing advice and support for a patient's relative who was struggling to cope with the patient's condition. The nurse was patient, empathetic and understanding.
- Nursing staff referred to patients by name and spoke about their care and treatment in a sensitive and caring manner. They provided emotional care and support to patients and their families at the time most needed.
- Staff understood the impact a patient's care and treatment had on their wellbeing and those close to them. They ensured patients; their carers had the support and strength to manage their care at home. This was monitored through regular contact and discussion. Patients and those close to them could change their mind at any time if the intervention became too much for them to cope with.

Good

Are services responsive to people's needs?

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

Summary

We rated responsive as good because;

- End of life care services were planned and delivered to meet people's needs, wishes and choices in a timely manner.
- The provider worked in collaboration with other end of life service providers to provide appropriate package of care for end of life care patients.
- The integration of services and shared working practices between care service providers allowed for more seamless transfers of care and improved the likelihood that patients' needs were responded to in a timely manner.
- There were effective systems in place to ensure patients had received the right care and treatment including medications and equipment.
- There were evidence of staff been responsive to meeting the needs of end of life and palliative care patients.
- There were good examples of staff and teams working responsively to reduce hospital admissions, and promote faster discharge.

However;

- End of life care plans did not provide sufficient information about the personal wishes and preferences of patients and their families.

Planning and delivering services which meet people's needs

- Community nurses had a portfolio of GP practices. This allowed them to build up a relationship with patients while supporting them in their own homes, build a good working relationship with their GP and have a greater understanding about the needs of the local population the practice served.
- Community nurses held monthly meetings with GPs in their locality to discuss patient's needs, their current diagnosis and prognosis and agreed on the care package needed by the patient. These meetings resulted in a comprehensive end of life care package for patients.
- Staff worked closely with their local hospice to ensure end of life care needs of their patients were met. Some of the nursing staff we spoke with told us they had received informal end of life training and advice from the local hospice.
- Equipment was provided to support patients who wished to die at home. This was delivered by an external provider. Staff confirmed that the equipment delivery service was responsive, and that equipment was delivered quickly to patients' homes to facilitate discharge or prevent admission to hospital whenever it was needed.
- District nurses held handover meetings each afternoon to discuss patients care; the nursing staff discussed each patient, their condition, medication and any concerns and agreed actions and follow up.
- End of life care plans did not provide sufficient information about the personal wishes and preferences of patients and their families.

Equality and diversity

- Staff treated patients with respect regardless of their race, religion and sexual orientation. Relatives confirmed that they and their loved ones were shown dignity and compassion throughout their care.
- We saw that staff treated all patients receiving end of life care as individuals. The nursing leadership team told us, equality and diversity training was delivered to all staff during induction and also as part of the mandatory training programme.
- The nursing team had access to translation and interpreting services which were available from a private provider. All the staff we spoke with told us they knew how to access these services if they needed to arrange for translation and interpretation.
- Staff described their experiences in accessing interpreters to help them communicate with patients. They said it helped them to understand the patient's

care needs and helped them gain consent before providing any support. Any identified cultural needs were recorded in the patient record as part of the care and treatment plan.

Meeting the needs of people in vulnerable circumstances

- Community staff we spoke with told us that they were often asked for advice when visiting patient and they always seek to help patients find the information they require.
- Nursing assessments identified patients living with dementia or learning disabilities and care was provided to meet their needs. Staff could give examples of how they had supported patients living with learning difficulties.
- The provider had employed a dementia nurse specialist to support patients living with dementia. However, this is only one person covering the whole geographical area and the population served by the provider.
- We saw that nursing and therapy staff liaised with other agencies, families and carers to maintain routines and support patients in vulnerable circumstances. Staff were flexible with visits and adjusted appointments to accommodate patient needs.

Access to the right care at the right time

- Staff told us they responded to urgent referral requests the same day and could respond within two hours if required. Non-urgent referrals would be followed up the next day. Triage arrangements were in place to ensure referrals were prioritised appropriately. However this is not specific to end of life care.
- The service did not have any quality indicators for monitoring the response times when patients are referred for end of life care services.
- There was a single point of access to the nursing service. Referrals were triaged immediately and the workload allocated accordingly. The community nursing service prioritised patients on a daily basis, particularly those requiring end of life care support. The service received 10,416 referrals through the Single Point of Access (SPA) in 2015/16, which was an 11% increase from the previous year. This is a general figure for community nursing which included end of life care. There was no separate figure for end of life care services.
- The tissue viability nurses provided care in community and hospital inpatient setting. This included supporting district nurses in wound care and management.
- Staff had access to interpreting and translation services and could arrange both face to face and telephone interpreting services as required.
- The provider had produced written information for people accessing the community health service. For example; information was available on healthy eating. Written leaflets could be requested, when required, in a different language or format.

Learning from complaints and concerns

- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively. Managers discussed information about complaints during staff meetings to facilitate learning.
- Community nursing staff described how they had met with a patient following a complaint and taken steps to ensure they improved their communication with patients and their families in a timely manner.
- Senior managers we spoke with were aware of the complaints that had been received relating to their service, their outcome and the learning that had come from them. Staff told us that they got feedback on complaints and any lessons learnt from them. Staff described how they had learned from previous complaints and discussed some examples; the nursing team gave an example of a missed appointment which led to a complaint by the service user and how the complaint was dealt with.
- Patients told us that they knew who to contact if they wanted to make a complaint.

Requires improvement

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We rated well-led as requires improvement because;

- Staff we spoke with were not aware of the vision and values for the end of life care services.
- Systems or processes were not sufficiently established or operated to effectively ensure the provider was able to assess, monitor and improve the quality and safety of end of life care services.
- Staff relied on the general community nursing handover to pick information about end of life care. Some staff said, these meetings were not useful for end of life care services.

However;

- All staff understood their roles and responsibilities and took account of their actions.
- There was an open and supportive culture with staff being engaged, open to new ideas and interested in sharing best practice in end of life care.

Service vision and strategy

- Your Healthcare provided an integrated approach to end of life care, in partnership with local statutory and non-statutory organisations. Following the inspection, the provider sent us the local CCG strategy for end of life care, which they stated they followed.
- Staff we spoke with were not aware of a separate vision for end of life services, however they were aware of the general vision of the community adult services, that was to provide safe and good quality support to every person dying at home every time.
- The aims of the provider were to deliver care that was safe, joined up, simple and easy to access, and based on the best available evidence.
- There were clear priorities available to help deliver the vision of the community adult nursing services, of which the end of life care formed part of.
- As a service, we found that teams were looking for opportunities to improve the quality of the services delivered and teams were encouraged to develop ideas to make improvements.

Governance, risk management and quality measurement

- Each team across the service had weekly and monthly meetings to review incidents, performance issues and planning, amongst other topics. End of life care was part of the community nursing team.
- We saw evidence that incidents such as pressure ulcers fed through the board reporting structures by the quality committee. We saw evidence of sharing feedback from incidents across localities to drive an improvement in the quality of service.
- There were no end of life care governance meetings which enabled the escalation of information upwards and the cascading of information from the management team to front-line staff. We spoke with a wide range of staff and none of them were aware of any end of life care governance systems within the organisation.
- Staff relied on the general community nursing handover to pick information about end of life care. Some staff said, these meetings were not useful for end of life care services.
- There was no dedicated end of life care team handover, staff did not have the opportunity to meet and discuss end of life care issues nor provided with valuable feedback about end of life services.

Leadership of this service

- Following the inspection, the provider told us the Your Healthcare board lead for Foundation was on the membership of the Kingston CCG End of Life Care Steering Group, which acts as a forum for the commissioner to ensure collaborative working between their providers.
- Senior staff told us their management team were approachable and visible. Local team leadership was effective and staff said their direct line managers were supportive.

Requires improvement

Are services well-led?

- There was only one nurse team leader responsible for end of life care. The nurse took responsibility for the clinical leadership of the end of life care. However, there was no senior manager or board lead responsible for end of life care. This nurse had to relate to a community services manager and had limited support further up the organisation. This limited the nurses' capacity to lead the service whilst developing and influencing how end of life care is provided and managed within multi-disciplinary teams across the organisation.

Culture within this service

- We visited various locations during our inspection including community nursing bases, several clinics and the head office. We found that staff were consistently positive, friendly, helpful and approachable at all sites.
- There was a culture of teamwork and a focus on key outcomes such as reducing hospital admissions or pressure ulcer incidence. In one team, a new staff member said it was the best team they had worked in, and that the team appreciated the different skills they could bring to the group.
- All the therapy staff we spoke with were positive about integrated services and felt positive about their role and contribution in the service. They said they were proud to work for their team and enjoyed their role.
- Managers told us morale with the community nursing and therapies teams was good. However many staff we spoke with in different roles, although committed to their patients felt disconnected and undervalued by the organisation. Some told us they felt isolated in their role.

Public engagement

- Senior staff in the community nursing teams told us that felt that patient engagement within the teams had been good, and were still looking for opportunities to make it even better to improve their profile.
- Another example of public engagement was noted at Surbiton Health Centre, where Your Healthcare teamed up with Friends of Surbiton & Tolworth Health Community and launched a photographic competition to brighten its walls. Local residents were invited to take part in the competition with the chance of winning John Lewis vouchers. The themes for the images were health, local activities and Kingston.

Staff engagement

- Senior managers told us that communication with general community staff was seen as a priority and that they were using social and print media for this.
- The Quality Matters Newsletter had helped to keep staff informed of what was happening across the organisation.
- The provider had achieved 74% response rate to their staff survey in 2015/16. Within the frontline staff, 83% of them agreed that Your Healthcare provided equal opportunities for career progression or promotion.

Innovation, improvement and sustainability

- We found several examples of innovative practice which aimed to improve the quality of care for patients, but again, this was more tailored to the adult community nursing than the end of life care.
- Staff told us the provider was an inclusive organisation and it encouraged staff to innovate in line with its core business values.
- Schwartz Rounds were embedded. This is a forum in which staff can openly and honestly discuss social and emotional issues that arise in caring for patients. The provider had supported staff to participate in the "Rounds".