Care Plus Group (North East Lincolnshire) Limited

Community end of life care

Quality Report

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Summary of findings

Locations inspected

This report describes our judgement of the quality of care provided within this core service by Care Plus Group (North East Lincolnshire) Limited. 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 Care Plus Group (North East Lincolnshire) Limited and these are brought together to inform our overall judgement of Care Plus Group (North East Lincolnshire) Limited.

Summary of findings

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Summary of findings

Overall summary

This service was not rated as we do not currently rate this type of organisation.

At this inspection we found:

- Local risk registers were not in place and risks identified by service leads were not captured fully on the corporate risk register.
- Patient risk assessments were not accessed by all staff delivering end of life care.
- Learning from incidents was not shared regularly with staff.
- The service contributed to a multi-agency strategy; however staff were not clear about their particular service area.
- There was a lack of clear transition procedures for patients moving between services resulting in the possible delay of delivery of services.
- Staff told us they felt a sense of disconnect between some of the teams delivering end of life care.

However:

- All staff understood how to report incidents and could explain the process confidently.
- Staff had the necessary qualifications and skills to carry out their roles effectively and had regular supervision and appraisals.
- All staff worked proactively to ensure patient care was prioritised.
- Feedback from patients was positive; staff were seen to be caring and compassionate.
- Services were planned and delivered to meets patient's needs.

Summary of findings

Background to the service

Care Plus Group are a social enterprise and take the specific form of a Community Benefit Society. The company provide community district nursing and end of life care in the North East Lincolnshire area.

End of life and palliative care is provided by all community district nursing teams; however there were three identified teams within the Care Plus Group which specifically offered end of life and palliative care. These are the Macmillan specialist palliative care team, the Haven team and the cancer survivorship team.

The Macmillan specialist palliative care team provided information and advice regarding pain and symptom control to patients, carers and all professionals within the scope of current palliative care knowledge. Two members of the team were permanently based within a local hospital to provide on-going support and discharge intervention.

The Haven team consists of a team manager, team co-ordinator, senior nurses, senior care workers, care workers and Marie Curie Health Care Assistants. The team provide health and social care to those patients and families in their own homes. The senior nurse provided in-reach services to the local hospital to support those who were identified for discharge home.

The cancer survivorship team which was a small group of four staff, consisting of a complex case manager, two community care nurses and a support worker. There was in addition an end of life consultant who was jointly appointed to work within The Care Plus Group and the local hospice. The service is for those categorised as a cancer survivor, people in remission or not undergoing active treatment or are living with a progressive disease.

We spoke with 42 members of staff including advanced nurse practitioners, senior nurses, locality lead nurses, community district nurses, healthcare assistants, student nurses and administrative staff. We also spoke to an end of life consultant. During the inspection visit, the team spoke with three patients and eight relatives. We visited several community nursing teams. We visited four patients in their own homes, observed care being delivered and looked at 14 patient records.

At this inspection, we focused on all five areas: safe, effective, caring, responsive and well-led.

Our inspection team

Our inspection team was led by:

Chair: Paul Morrin

Team Leader: Lisa Cook, Care Quality Commission

The team included CQC inspectors and specialists including community matrons.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on the 13 and 15 December. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced visit on 22 December 2016.

What people who use the provider say

Comments we received from patients during our inspection were positive. Staff were described as kind and caring.

Good practice

The International Organization for Standardization (ISO) 9001 process provides a set of standards to help organisations to become better managed, more efficient and more customer focused. This was used for community nursing, rapid response, community end of life care and telephone triage, with a view to rolling it out to all areas. This meant a standardised approach was used to working. For example, community nursing administration staff had been based at eight sites with different ways of working at each one. As a result of using the ISO process, they were all brought together to provide consistency.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The provider MUST:

- Ensure the individualised plan of care, that identifies patient's risk assessments and care pathway, is accessed by authorised people involved in delivering care and treatment.

The provider SHOULD:

- Review risk registers to ensure they reflect the needs of the service.
- Improve transitional pathways to enable patients to move swiftly between services.
- Support staff in their understanding of the service strategy, to enable them to deliver the vision and business objectives.
- Review mechanisms for learning from incidents to ensure this is shared.
- Review roles and responsibilities of the community nursing service and the end of life care teams to ensure effective relationships.

Care Plus Group (North East Lincolnshire) Limited

Community end of life care

Detailed findings from this inspection

Are services safe?

By safe, we mean that people are protected from abuse

Summary

At this inspection we found :

- All staff reported incidents and were fully aware of when incidents should be reported.
- Staff we spoke with had completed safeguarding training and we observed staff following safeguarding procedures.
- Anticipatory medication was available to patients. Staff could prescribe medication and introduce quickly for patients whose symptoms required control.
- Staff told us that equipment was readily available for patients. Staff would often anticipate patients' needs and ensure equipment was at the patients house in case it was required.
- Infection Prevention control audits were routinely completed and consistently achieved 100%.
- Staffing levels were adequate to ensure safe care.
- Mandatory training compliance figures were consistently showing high rates of completion.

However:

- There was a potential risk to the patient, as documentation such as care plans and risk assessments, could not be accessed by some staff on the electronic recording database.
- Staff did not always receive feedback following incidents, although there were plans to address this.

Detailed findings

Incident reporting, learning and improvement

- Staff delivering end of life and palliative care understood their responsibilities in regard to reporting incidents. Staff were able to explain how to log an incident on to the electronic incident reporting system used. Staff were able to provide clear examples of the types of incidents that should be reported.
- Governance processes were in place to capture trends and lessons learnt, and clinical incidents were discussed via the clinical forum which senior nurses attended. However, we did not see regular discussion recorded regarding incidents during operational team meetings. The Chief Nurse told us that 'lessons learnt' meetings specific to end of life care, had recently been introduced and rolled out to include front line staff. We saw minutes of the first meeting held in November 2016.
- Staff told us they did not get feedback following incident recording unless it was deemed a serious incident, then they would then be involved in the investigation process.

Are services safe?

- A senior manager told us that meetings were planned to cascade information regarding lessons learnt to staff. We saw that there had been one recent meeting, which was the first of a series of meetings planned.
- Incidents were outlined in the quarterly performance report, which was produced by the Chief Nurse. We were not assured that this report was circulated to all staff.
- We asked the provider to submit data relating to end of life incidents between the periods of May to October 2016. We viewed 55 incidents. Five incidents were attributed to the lack of patient documentation within the home which compromised patient care. The majority of others related to pressure area and tissue viability issues.
- Never Events are serious incidents that are wholly preventable, where 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. There were no never events reported in community end of life care between April 2016 and September 2016.

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.
- Staff we spoke with understood their role in duty of candour and senior managers were aware of the process to follow. Staff told us apologies were offered to patients and their families, where it was felt there had been issues and the provider encouraged openness and transparency.

Safeguarding

- Systems were in place to protect people in vulnerable circumstances from abuse. All staff were required to complete adult safeguarding training as part of the organisation's mandatory training requirements. The training was delivered either by face to face training or e-learning and incorporated information about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs), consent and the use of restraint.
- The end of life care team achieved 97% compliance for mandatory level two adult safeguarding training for the period April to October 2016. We saw that the internal target was 90%.
- Information regarding safeguarding was displayed in the community base offices and the provider had appropriate safeguarding policies in place to support staff in their decision making.
- Staff were aware of their responsibilities in relation to safeguarding and when they would need to raise a safeguarding concern. We were told of an example during a staff focus group which had occurred the previous day. Staff spoke with confidence regarding the protocols they followed and the subsequent action taken by a local authority.
- We saw the provider had appropriate safeguarding policies in place to support staff in their decision making. There was community staff attendance at safeguarding operational group meetings.

Medicines

- Medicines were managed by the community district nursing teams. The nurse within the Haven team told us they may occasionally administer a drug prescribed following the patient's medication administration chart, but this only occurred if the district nurse was not available or delayed.
- Nurses within the Macmillan and Haven team receive syringe driver training. We saw that the team achieved 88% compliance with the training for the period October to December 2016.
- We reviewed four medication administration charts whilst visiting patients in the community. Controlled drugs (medicines controlled under the Misuse of Drugs legislation and subsequent amendments) were stored securely with appropriate records kept.
- Patients in their own homes who were receiving end of life care were prescribed 'anticipatory' medicines. Anticipatory medicines were 'as required' medicines prescribed in advance to ensure prompt management of increases in pain and other symptoms. On inspection at a patients house, anticipatory medication was in place. Staff we spoke with all identified the importance of having anticipatory medications in the house.
- Some community district nurses were community practitioner prescribers. This allowed the staff to prescribe medication including controlled drugs and to be administered to the patient quickly.

Are services safe?

Environment and equipment

- All staff we spoke with told us they had no difficulty obtaining equipment when they required it.
- Syringe drivers in the community were held in local base points by the community district nursing team where they could be accessed easily. The rapid response team also held syringe drivers that could be accessed out of hours. Staff commented they could also access the hospice for any syringe driver needs.
- Mechanical hoists and specialist mattresses were available to all staff although responsibility for the ordering of this equipment lay with the community district nursing team. The nurse within the Haven team told us it was recently agreed they could order equipment such as mattresses. However, more specialist equipment such as moving and handling devices remained the responsibility of the community district nurses.

Quality of records

- We reviewed 14 sets of patient records. We saw documentation used by all teams providing end of life of palliative care to the patients. The community district nurses used a specific red folder within the patients home so their documentation could be easily identified. The Haven team and Macmillan nurse completed separate documentation pertaining to the element of care they were providing, for example assistance with washing and dressing. All documents were legible, signed and dated.
- We were told by all staff we spoke with that the community district nursing team were the responsible keyworkers and it was their responsibility to write the care plan for patients requiring either end of life or palliative care at home.
- We visited four patients at home and reviewed their records. We saw examples of concerns raised by the Haven team within the patients daily written journal log, which was kept in the patient's own home. Concerns were reported to the community district nurses, such as the patient experiencing increased pain. However it was difficult to be assured appropriate action was taken as records were disjointed due to the community district nurses logging action taken onto the electronic recording database. Haven team told us community district nurses verbally confirmed what they had done, if they had time.
- Risk assessments were undertaken by the community district nurses and held on electronic recording database. A paper copy was not available for staff visiting the patients at home and Haven team staff told us they did not read the risk assessments on the electronic recording database. However general risks were shared during staff handover.

Cleanliness, infection control and hygiene

- There were infection control and prevention policies in place to keep patients safe.
- We saw that staff within the end of life team conducted several audits which were part of the essential steps assessments. Essential steps was a recognised assessment tool, which was accepted by The National Clinical Institute for Health and Care Excellence (NICE).
- We reviewed data relating to essential steps assessments which were completed. The team achieved 100% compliance consistently throughout 2016 and 2017.
- We observed staff visiting patients at home and saw staff used appropriate protective equipment such as gloves and aprons. Alcohol gel was readily available and staff carried their own supply.
- We saw staff washing their hands before and after providing care and treatment. Patients we spoke with told us they also observed staff completing hand washing.
- Staff consistently achieved high compliance rates in relation to infection control training. 100% compliance was recorded during the period of April 2016 and October 2016, for staff delivering end of life care.

Mandatory training

- Mandatory training was provided for all staff and was undertaken by all staff providing end of life care. Data showed that 95% of end of life care staff were compliant with training requirements in relation to consent, equality and diversity and conflict resolution. This was above the organisations target of 90%.
- 97% of staff had attended training in fire safety and 100% compliance was achieved for patient handling.
- Staff told us they felt the mandatory training was well managed and were always reminded when a specific session was due. Time was made available for staff to undertake these courses.

Assessing and responding to patient risk

Are services safe?

- Changes to patients conditions were recorded in their daily notes by all staff providing care and treatment. The community district nurses provided advice and support to the Haven team. Advice and support from Macmillan nurses regarding deteriorating patients was provided to all staff in the community.
- Staff told us they would ring the nurse if a patient became unwell or ring for an ambulance. There was some confusion amongst unqualified staff as to which nurse they would ring in this situation. Some staff told us it was the nurse within the Haven team and some told us it would be the community district nurse. There was no policy to assist staff, in the event that the patient deteriorated.
- All staff we spoke with told us that patients reaching their end of life were a priority and visits would be organised to reflect this. In addition to this we observed staff re-arranging their caseload to accommodate those patients who were deemed to be in crisis.

Staffing levels and caseload

- The Macmillan team had recently reorganised and divided into two localities (East and West) to cover Northern Lincolnshire and Goole area teams. This was to accommodate new staff joining the team and to meet growing demand for the service. At the time of inspection the team consisted of one manager, 14 nurses, three social workers and two administrators. The team met each Thursday to plan caseloads and ensure new staff were fully supported. Two staff (band 6 and 7) were permanently based at the local hospital and actively managed referrals for patients experiencing complex issues. There were no vacancies within this team.
- The Haven team consisted of one manager, five senior nurses, 14 senior care workers, seven care workers, one administrator and two co-ordinators. In addition to this, there were two bank nurses and five bank support workers. The team met each morning for handover from the rapid response team and Marie Curie nurses. Marie Curie staff were provided in partnership with the Care Plus Group. A further handover took place in the afternoon to ensure caseloads were managed effectively.
- The cancer survivorship team consisted of a complex case manager, two community care nurses and a support worker. The team was funded by Macmillan and provided support to all North East Lincolnshire G.P's, to support patients living with and beyond cancer. There were no vacancies within this team.
- Staff delivering end of life and palliative care told us that they felt staffing levels were sufficient to ensure patients received safe care and treatment.
- Community district nursing staff were accountable for all clinical responsibilities such as medication administration and pressure area care. We spoke with the nurse from the Haven team who told us they felt as qualified nurses they could undertake more responsibility, which alleviated some of the caseload pressure from the community nurses.
- Staff in the community teams worked extra shifts to cover any low staffing levels. No agency staff were used and only regular bank staff that were known to community teams were used.
- Caseloads were managed internally and in some instances evening calls that could not be completed by the Haven team were passed to the rapid response team. This was an infrequent arrangement.
- The rapid response team responded to any nursing care needs after 8pm. The rapid response team told us their workload was much busier now and felt they were 'generally stretched'.
- All staff within the end of life team held twice weekly team meetings to plan caseloads and discuss patient's dependencies. We observed a daily team handover meeting which supported this.

Managing anticipated risks

- Community teams managed foreseeable risks and planned for changes in demand due to seasonal fluctuations. Local working instructions were in place for staff in relation to what to do in cases of bad or severe weather.
- The provider had a lone worker policy in place which was up to date. Staff told us teams ensured colleagues remained in touch with each other throughout the duration of the day. Patients who were not known to the service or were receiving visits for the first time were seen by two staff initially.
- All staff we spoke with told us they felt safe during working hours.
- Fire procedures and exit routes were displayed in the community base units.

Are services safe?

- Staff in all areas we spoke with were aware of plans for their service, their role in those circumstances and who to escalate the concerns to.
- A senior manager on call was available 24/7 and staff were clear as to who they should contact.

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

At this inspection we found:

- Documentation varied across the teams delivering end of life and palliative care. We were provided with a document for care in the last days of life. However, staff we spoke with were not clear about its use.
- Care plans produced by community district nursing teams were not accessed by all teams delivering the care, resulting in a potential risk to patients. The current DNACPR policy was not reflective of current best practise guidelines but was due to be reviewed and developed alongside local hospital guidelines.

However we also found:

- DNACPR documentation was thoroughly completed and was accessible to all staff.
- Most staff received regular supervision and appraisal.
- The provider ensured all new staff completed a robust induction programme.

Detailed findings

Evidence based care and treatment

- Following the withdrawal of the Liverpool End of Life Care Pathway in July 2014, the provider had developed, alongside other local organisations, an individualised end of life care plan for adults.
- Staff followed the five priorities of care for the dying patient that succeeded the Liverpool Care Pathway (LCP) as the new basis for caring for someone at the end of their life. Staff completed documentation specific to the team in which they worked, but there was no single recognised document in place at the time of inspection.
- In addition to the individualised care plan, a booklet was also produced in 2015 called 'My Future Care Plan' which enabled the patient with the support of Care Plus Group staff to take the opportunity to record preferences and choices regarding their care during the end of life journey. This booklet was part of a series of documents which were to be introduced but had not been formally accepted and rolled out.
- There was on-going work to agree a second draft document; however there were no agreed timescales for implementation. Following our inspection the provider told us that this document would be reviewed in April 2017.
- We saw two copies of this booklet during our inspection and both were for reference only. A member of staff told us 'We don't use them but I don't know why. It never got off the ground'.

Pain relief

- The management of medication and pain relief was the responsibility of the community district nurses.
- We looked at four medication administration charts whilst visiting patients in their own homes. Anticipatory medication was completed for the patient, and the families we spoke with told us medication was given in a timely manner which alleviated symptoms.
- We saw during these home visits the patient was assessed for pain and this was documented using a pain chart which was nationally recognised.
- Where appropriate, patients had syringe drivers which delivered measured doses of drugs at pre-set times; all qualified nursing staff were trained in the use of syringe drivers.
- Staff told us there were adequate stocks of appropriate medicines for end of life care and these were available as needed, both during the day and out of hours.
- We saw that a pain audit had been completed in October 2016 in relation to data held on electronic recording database. The results showed 100% compliance.

Nutrition and hydration

- Community district nurses completed nutritional assessments and patient's individual details were added to the nursing assessment on the electronic recording database. A malnutrition universal screening tool (MUST) was completed on the patient records we observed, along with a nutritional care plan. We checked the review dates of some of the care plans and found them to have appropriate dates for reassessment.

Are services effective?

- Care plans regarding nutrition and hydration were not available for other teams to view who also provided end of life care. For example, we visited a patient cared for at home who was receiving nutritional feeds through a percutaneous endoscopic gastrostomy (PEG). Staff from the Haven team, who were unable to access the electronic recording database, did not know the care plan regarding their nutrition, although they provided regular visits to the patient. There was a potential risk the patient may receive inappropriate nutrition or hydration.

Patient outcomes

- The provider completed a local audit which reviewed the end of life care plan in 2015. The strategy stated this was due to be repeated in 2016, but it had not been undertaken. Following inspection the provider told us there were plans to audit the end of life care plan 'Care in the last days of life', once fully implemented.
- A Commissioning for Quality and Innovation target (CQUIN) was in place to ensure patients were provided with an end of life care plan. Both Macmillan and Haven teams achieved 100% compliance in October 2016 and for the previous quarter. There was no data in relation to the content of these care plans; however the figure exceeded national targets.
- Preferred place of deaths data was collated. We reviewed data for October 2016 which showed that 69% of patients died at their preferred place of death within the Macmillan team and 80% for the same period for the Haven team. A senior manager told us that data was collated regularly to monitor improvement.
- A measure was in place under Quality, Innovation, Productivity and Prevention (QIPP) to measure the number of avoidable hospital admissions. We reviewed data which showed the measure was not met. The number of avoidable emergency admissions had increased year on year. For example, in July 2014/15 there were 17 recorded and in the same month in 2016/17, 42 were recorded.

Competent staff

- Community district nurses were required to undertake specific training in the safe use of a syringe driver. The staff member was observed completing the skill and needed to meet certain criteria in order to pass and perform independently. When a staff member did not meet the criteria further training and an action plan was devised in order to become competent. We saw evidence that staff were competent in completing syringe driver care and some staff had copies of their assessment.
- Most registered nursing staff in the community were required to complete training specific to palliative care. Senior managers requested that this training be mandatory, although this was in discussion at the time of inspection. Staff who had completed the training commented they felt this supported them to provide care to patients with end of life needs. We spoke with some staff that had not completed this training yet, but had a date for when they would attend.
- Macmillan staff told us they had received training regarding advanced care planning and we saw examples of these during our visit.
- The provider offered education on a formal and informal basis, which included speakers from external organisations and sharing this learning with staff from the local hospitals. We saw an example of this which was a regional conference for doctors offering a practical update on palliative care.
- All staff undertaking end of life or palliative care were encouraged to undertake specific training to enable them to support patients and families. Training data submitted by the provider for October 2016 showed that 100% of the Cancer Survivorship team completed breaking bad news training, 100% of the Macmillan and Cancer Survivorship team completed advanced communication training, and 100% of the health care assistants with the Haven team completed the palliative care course.
- Qualified nurses from the Haven team had completed verification of death training. We saw within the monthly performance report for October to December 2016 that 100% compliance was achieved for the accurate recording of verification of death.
- Staff we spoke with told us they had the opportunity to attend relevant training and work alongside colleagues to develop their skills and understanding.
- All staff were given the opportunity to discuss any issues during monthly team meetings and individual supervision sessions.
- We saw new staff were supported with a comprehensive induction programme and were shadowed by experienced members of the team.

Are services effective?

- We spoke with staff in the community and on the community units who told us they had received an appraisal. Staff felt the staff appraisals were effective and supportive.
- We reviewed the performance plan for the end of life team for October to December 2016. The team overall showed 80% compliance for both personal development reviews and one to one supervision support. This met with the provider's internal target of 80%.

Multi-disciplinary working and coordinated care pathways

- The provider contributed to the multi- agency end of life strategy group and the mortality review meeting. Issues discussed included training, referral numbers, complaints, IT issues and the DNACPR and bereavement group directives.
- Members of the end of life team participated in multidisciplinary team (MDT) meetings, working with other specialists and hospital nurses to support good quality end of life care across the community.
- Although the Macmillan specialist palliative care team, the Haven team and the cancer survivorship team each had a specific function, there was clear communication between them to ensure patients care and treatment plans were shared.
- We observed a case review meeting in which there was in-depth discussion regarding patient care. We saw collaborative working and active learning, with the attendance of several medical students.
- Two nurses within the Macmillan team were based at the local hospital. This enabled hospital staff to utilise the skills of the nurses and proactively plan the discharge of patients into the community.
- All staff working within the end of life team held strong links with the local hospice and training sessions were offered from this base.
- A Macmillan nurse representative attended multi-disciplinary meetings each month at the GP practice in which the patient was registered. This was to ensure the team remained involved in patient care decisions.

Referral, transfer, discharge and transition

- Patients could access end of life community services through referral by all health and social care professionals, patients, relatives, carers and self-referral.
- At the time of inspection, we saw that the three teams managed their referrals independently. However, we were told there were plans to create a shared referral form and this was currently being developed. An agreed draft form was to be developed in the next three months.
- The referrals for the Haven team were accepted by the registered nurse within the team, if the appropriate criteria were met.
- Referrals to the Cancer survivorship team and Macmillan team were managed by the team administrator who then transferred it across to the duty Macmillan nurse to triage.
- We reviewed the number of referrals which were received by the end of life team. We saw that there was an increase of 15% in the number of referrals received in the last year. This correlated to the same increase in the number of patients choosing to die at home.
- Macmillan nurses saw the greatest increase in referrals with a 40% increase in the last year.
- The Haven team told us referrals often came to their team when the patient was reaching the last weeks of life. All decisions to transfer or agree a place of care was agreed at multi – disciplinary meetings.
- Patients requesting to be cared for at home were supported by the fast track process. The qualified nurse linked to the Haven team provided in reach support to the local hospital to enable patients to be discharged to their preferred place of care.
- There was a small waiting list for Macmillan nurse support. Patients displaying an acute symptom issue were prioritised.
- At the time of inspection there were five patients on the waiting list with the longest wait being eight days.
- All staff within the end of life team worked closely with the local hospice to facilitate seamless discharge for patients. Staff we spoke to felt they could refer to the hospice at any time.

Access to information

- Staff did not have an agreed individualised plan of care that was accepted as the consistent document for all staff to follow. Community district nurses told us they completed an individual plan on electronic recording database. We reviewed four patients records on the electronic recording database. Staff were asked but were unable to find the details of the patients own

wishes and requests regarding end of life care within this system. A generic care plan template for end of life was available; however, it was not fully completed on any of the records that we looked at.

- The Macmillan team told us a document to record specific patient wishes and choices in relation to their end of life journey was produced last year, but was not in use. We viewed the booklet 'My future care plan' which was a document produced in conjunction with the local NHS, commissioning and hospice groups. The booklet which was designed for the patients included aspects of care and treatment enabling the patient to make individual choices about all elements of their care. Staff told us the booklet was well received by everyone, but had not been agreed by all parties.
- No single recognised care plan was in place due to this. Macmillan nurses logged patient information onto the electronic recording database. We were told that a second draft document for consideration was in progress, but there were no clear timescales for implementation and there was no communication shared with staff in relation to this.
- The Haven team told us they have produced their own care plan as they were not 'comfortable' using the electronic recording database. We saw this was a single list of daily activities / tasks they may be asked to provide for the patient. This did not include patients specific wishes and choices. Staff within the Haven team were aware of the community district nurses red folder, which contained medication administration records, tissue viability records, falls assessments and moving and handling assessments. However the Haven team followed their own records specific to them. This meant there was inconsistency in the detail of the documentation that we viewed.
- Risk assessments were not accessed by all staff providing end of life care. Community district nurses told us these were completed on the electronic recording database and we saw evidence of this. Staff in the Haven team were not aware of these risk assessments.
- Spiritual needs were not captured on any documentation we reviewed within the patient's home. It was captured within the electronic recording database. We reviewed four patients on the system and although a box was ticked for spiritual need it gave no further details.
- The rapid access team were occasionally called to support patients receiving end of life care. This occurred when the patient was experiencing difficulty such as increased pain. However, they told us there were occasions when they did not have access to the electronic recording database, prior to visiting to the patient and as such would not have any information regarding the patient including risks.
- Some community district nurses carried laptops. These were in pilot stage at the time of inspection and were only available to a small number of staff. Staff we spoke with using these devices did not report any connectivity problems. Following inspection the provider told us that mobile working was not available to staff delivering end of life care, as further investment was needed.
- Community district nurses used a red folder to share information, which was easily recognised and was left at the patient's home.
- Staff we spoke with at a focus group told us there had been a recent incident involving access to information in a patient's home. A senior manager told us the group were currently reviewing the number of occasions in which essential patient information may not be available when required.
- Most GP surgeries used the same patient electronic record which allowed both the community nursing teams and GP to see the progression or deterioration of a patient. A small number of surgeries used a different electronic system. Staff told us there were regular meetings to ensure staff were informed of changes to the patients care.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We reviewed four do not attempt cardiopulmonary resuscitation (DNACPR) forms during visits to patients receiving care at home. All were fully completed thoroughly and completed by the local GP. In one case, we saw the patients capacity to be involved in discussions had been considered. All had been signed by a G.P.
- Staff were aware of which patients in the community units had a DNACPR in place. There was a place to record and scan the DNACPR information on the patients electronic record. However, this was not always completed and staff verbally exchanged this information.

Are services effective?

- We saw staff delivering end of life care team had achieved 98% compliance in relation to mental capacity and deprivation of liberty training for the period April to October 2016. The provider's internal target was 90%.
- We observed all the DNACPR forms were at the front of the patients medical or nursing notes and clearly visible.
- The provider followed the North and North East Lincolnshire DNACPR policy which was issued in November 2014. It did not include the "2016 Decisions relating to cardiopulmonary resuscitation: guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing". A senior manager told us there were plans to review the current DNACPR to develop a joint policy with local hospitals to ensure consistent practice. We saw reference to this within provider governance meeting minutes and following inspection the provider told us the policy was currently being reviewed and will be completed by March 2017.
- Staff were aware of the principles of best interest's decision making, although staff were not trained to conduct best interests meetings.
- Some staff were not clear when a best interest decision should be carried out. We saw three examples of patients care that had been withdrawn or altered. A formal decision making process was not followed, although best interest decisions were evident. For example a decision was made to reduce the number of assisted positional changes. We saw evidence of these discussions with the patient's family and the reason why the decision was made.
- We observed staff obtaining patients consent before performing any observations or providing patient care.

Are services caring?

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

Summary

At this inspection we found:

- All patients and their relatives we spoke with were positive about the care they received in the community.
- We observed interactions between staff and patients and saw these were kind and compassionate.
- Relatives told us staff ensured privacy and dignity of patients was maintained when providing care and patients who were supported were not rushed.
- Patients and their families were encouraged to be involved in decision making about their end of life care needs.
- Staff communicated well and worked together to plan the care and treatment.

Detailed findings

Compassionate care

- Patients and relatives we spoke with told us staff were professional, supportive and kind. We observed care being provided and saw patients were treated with compassion, dignity and respect.
- Patients and relatives we spoke with told us they were happy with the quality of care they received and staff treated them with respect and maintained their dignity. A relative told us 'they give us all the time we need'.
- We observed staff providing support to a family following the death of a patient. Staff were caring and understanding and provided information to the family with a bereavement support leaflet.
- The provider actively sought feedback from relatives and families. Service user satisfaction surveys were sent out every three months, in addition to the N.H.S friends and family survey. Satisfaction rates were consistently high. Between April 2015 and December 2015, the Macmillan team achieved 100% in relation to the question asked if relatives who were likely to recommend the service.
- We spoke with three patients and eight relatives. All spoke positively of the care they received. Patients described staff as being 'wonderful' and 'always listened'.

Understanding and involvement of patients and those close to them

- All patients and relatives we spoke with told us they were involved in their care and treatment.
- We saw staff discussing care issues with patients and relatives and these were clearly documented in patients Macmillan and Haven team notes.
- We observed staff involving patients in their care in a way they could understand.

Emotional support

- Staff were supportive to patients and showed empathy and compassion during their procedures.
- We observed staff interacting with patients and relatives in a supportive and reassuring manner. We saw evidence of staff signposting patients to other services such as bereavement counselling.
- Some staff within the end of life team had received breaking bad news training.
- Community teams provided bereavement support for relatives. A relative told us a nurse from the Macmillan team continued to visit following her husband's death, to ensure the family received all of the support they needed. One family member told us 'Sometimes I just wanted to cry but they listened and gave me the time I needed'.

Are services responsive to people's needs?

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

Summary

At this inspection we found:

- Services were planned and delivered to meets patient's needs.
- The provider had strong links with the local hospital and hospice and there were regular meetings with community service providers.
- Staff were clear on their aim to support patients to die in their preferred place of care
- Seven day services were provided by the end of life team.
- The provider was developing a joint bereavement service with the local hospice and Cruse to extend and improve services for families of the deceased.
- Staff proactively worked together to ensure patient care was prioritised.
- Although inconsistent, staff proactively recorded patient's wishes and choices through the daily communication process.

However :

- Staff told us it was difficult to plan consistent night care.
- There was a lack of clear transition procedures for patients moving between services resulting in the possible delay of delivery of services.
- Spiritual wishes of the patient were not captured in any of the documentation that we reviewed.

Detailed findings

Planning and delivering services which meet people's needs

- Services were planned and delivered to meet patients and relative's needs. Staff were very clear their priority was ensuring patients were cared for in their preferred place of death, wherever possible. A Commissioning for Quality and innovation target (CQUIN) was in place to support the development of this.
- The provider contributed to the multi-agency end of life strategy group, which was also represented by local GP's, hospice staff, Health watch and commissioners. A key focus area for this group was to improve integrated care for people receiving end of life and palliative care and clearly identify those requiring these services.
- The Chief Nurse also attended the End of Life partnership group meetings, which was designed to develop integrated services between the hospice and Care Plus Group. There was non-executive and executive representation which then links to the organisational board for each provider.
- The provider worked in partnership with the local hospice to provide ongoing support, advice and accessibility over a 24-hour period. We saw on-going discussions as part of the multi-disciplinary strategy group meetings to ensure a consistent service was maintained.
- Consideration had been made to the needs analysis of the local population. Additional Macmillan nurses had recently been employed and the number of teams had increased to two.
- The end of life team provided seven day services. The Macmillan team were available 8.30am to 5.00p.m seven days a week. The Haven team 8am to 10pm for day care and Marie Curie nurses provided night care 10pm to 8am, seven days a week.
- There was confusion, regarding the pathways of care amongst staff. For example, it was not clear when patients would transfer from one team to another. However, staff proactively worked together to ensure the priorities of the patient were maintained, despite not having a clear pathway.
- We spoke with a relative of a patient receiving end of life care who told us 'knowing who to contact is confusing' and 'lots of people coming in'.

Equality and diversity

- Patients receiving end of life and palliative care were treated as individuals.
- Equality and diversity training was delivered to all staff as part of their induction with the organisation.
- The end of life team showed 98% compliance in relation to equality and diversity training.
- The translation services available were provided through a service contract, as a full 'one stop shop' service for all interpretation and British Sign Language requirements. Both telephone and face to face translation services were available for staff to utilise.

Are services responsive to people's needs?

- Staff told us during the inspection they were fully aware as to how to access translation services effectively. However, we were not able to find any examples where translation services had been used.
- Staff told us information leaflets could be obtained in different languages and formats through the quality and performance team.
- Patients in their own home accessed their own spiritual advisor of their own faith. There was no recognised individualised care plan used within the home to identify the religious and spiritual needs of patients. Community district nurses told us this information was held on the electronic recording database, but we saw only a tick box to indicate a religious preference with no detail to support it.

Meeting the needs of people in vulnerable circumstances

- We saw examples of person centred care. Notes were recorded on the daily communication sheet by all members of the end of life team and patient and family wishes were recorded. For example, in one document we saw that the Haven team held a discussion with the family to ensure personal preferences were followed.
- Details relating to the patient's wishes were seen within the daily journal which staff maintained.
- Macmillan nurses were trained to complete advance care plans.
- Staff could access the specialist dementia care and learning disabilities link nurses within the local hospital should they require specific support.

Access to the right care at the right time

- The community end of life team responded to referrals from consultants, GPs, community staff and acute hospital staff. The team aimed to respond to all referrals within 24 – 48 hours, however there was no data to monitor this.
- Teams proactively prioritised care to patients receiving end of life during busy periods, but it was challenging. During our inspection, we observed one community team trying to arrange a visit the same day to a patient with end of life care needs. The patients' needs were complex and specialist advice was required. On this occasion, the nurse was not able to visit the patient at home due to caseload demands, however was able to give the advice and support over the telephone and visited the patient the following day.
- Staff told us we 'work together' to ensure we see as many patients as we can'. Staff felt patients generally received care in a timely manner.
- Staff told us it was difficult to plan for consistent night care. The night care provision was the responsibility of the Marie Curie team and bank staff delivered the care. Staff told us during busy period's staff and patients were reorganised on a night by night basis. There was no guidance for staff to determine priority. Staff told us 'we know the patients well, so we know who would require the service most'.
- Staff in the community could complete fast track forms; this enabled care to be put in place quickly for patients whose condition was deteriorating and had requested their preferred place of death at home.
- Patients and families we spoke with told us staff were responsive to their needs. One relative told us 'they have been great. They always call when they say they do'.

Learning from complaints and concerns

- Patients we spoke with were aware of how to raise a complaint. Staff in both the community units and community nursing teams felt they had a low number of complaints.
- Between the periods of April 2015 to March 2016 end of life services received three complaints. All three complaints related to the length of time it took to access support from the end of life team. We reviewed the investigation process for all three complaints which were detailed and thorough. We saw that referral processes were changed as a result of these issues and staff numbers increased to improve access times.
- Information was displayed on the community base unit about how to raise concerns.

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

At this inspection we found :

- Risks and quality outcomes were discussed at governance meetings, but were not consistently shared with staff.
- The risk register was not reflective of end of life care service issues.
- Staff experienced a sense of disconnect amongst some of the team due to some frustrations around clinical responsibilities.
- Staff told us they were confused about which documentation they should use to record patients individual wishes.

However

- The provider contributed to the development of a multi-agency strategy.
- All staff we spoke with told us that managers were visible and approachable and worked positively to support staff.
- Staff felt proud about the care that they provided and considered patient focus a priority.

Detailed findings

Leadership of this service

- The service was led by the Chief Nurse who was also the end of life strategy and Care Plus Group safeguard lead.
- Management teams were clearly visible to the operational teams.
- All staff we spoke with in leadership roles had a good understanding of the importance of high quality end of life care and we consistently heard from staff that end of life care was prioritised based on patient need.

Service vision and strategy

- The provider had contributed to a multi-agency strategy. Two documents were produced. A local hospital strategy and North East Lincolnshire (NEL) strategy. The provider had implemented the strategy 'Promoting High Quality Care for All at the End of Life', that was launched in May 2016 and was developed in conjunction with local commissioning groups, hospitals, and hospice services. This was based on the five priorities of care in the final days or hours of life recommended by the Leadership Alliance for the care of Dying People. The strategy provided key focus areas for the end of life team and how the strategy was implemented.
- The second document which was a further strategy 'North East Lincolnshire Palliative and End of Life Care Strategy 2012-2016. This outlined the strategy and vision for end of life services over the next five years. The NEL strategy had been approved by local commissioners and was followed by the Care Plus Group.
- The provider had produced the document 'stronger together' which outlined the vision and five year plan between Care Plus Group and the local hospice.
- Staff were unclear regarding the content of the strategy, however staff were committed to ensuring that those approaching the end of their lives were cared for in their preferred place of care and that care provided would be high quality, timely and appropriate to patient needs. This was consistent with the vision and strategy.

Governance, risk management and quality measurement

- Risk and quality issues were shared at the integrated governance committee and fed back through the Chief Nurse to the Care Plus clinical forum group.
- Specific risks and incidents were further discussed at the clinical quality forum meetings which were held monthly. Trends and themes were identified at board level.
- The Chief Nurse chaired a separate community locality meeting which identified community end of life and palliative care issues.
- A monthly review took place of all outstanding incidents, complaints, actions and risks by the Chief Executive and the Quality and Performance team.
- We reviewed the current provider risk register; which was not specific to end of life care. There were no risks shown which were reflective of the service, such as lack of consistent documentation.

Are services well-led?

- The provider did not have a robust process to ensure improvements were made to patient care as a result of audit activity.

Culture within this service

- Staff spoke with pride regarding the delivery of the care that they provided. Staff were committed to ensuring patients received excellent support and care.
- Staff in the community felt they were generally listened to. Most staff felt they were given clear direction on a local level, but felt that managers did not always share information. It was generally recognised that the Chief Nurse was extremely busy and did not always have the opportunity to share all information.
- Managers told us they operated an open door policy and encouraged staff to discuss any concerns that they might have.
- Some staff, however, told us that they felt operationally there was a disconnect between the end of life team and the community district nurses. Staff had worked hard to develop an understanding of the roles and responsibilities of each team, but felt that some clinical tasks, such as medication administration, could be re-aligned to ease the pressure from community district nursing teams.
- A freedom to speak up guardian had recently been introduced and was in post at the time of our inspection.

Public engagement

- The provider had over 200 volunteers. One of these were specific to end of life care, although several supported the local hospice.
- We were told by staff that a representative from the health care user group had attended the local strategy development group.
- The families of patients receiving end of life care participated in the friends and family audits.
- The Macmillan nurses regularly ran support groups for families of those bereaved. We saw posters encouraging families to attend.
- There was no patient representation at board meetings; however the council of governors saw service users in attendance and were represented by two local authority councillors
- Patient feedback was captured and shared within monthly performance reports.

Staff engagement

- Staff told us that members of the end of life team regularly attended provider training and events.
- Staff were able to attend board meetings if they wanted to.
- Staff took part in the staff survey each year. We reviewed the results of quarter two within 2016/ 2017 and saw that 83% of staff would be extremely likely or likely to recommend Care Plus Group as a place to work.
- We saw evidence of regular staff meetings and communication with managers.

Innovation, improvement and sustainability

- The provider was working towards developing a joint referral forms which professional and individuals could use to access all of the end of life services.
- Mobile devices were used by all community district nurses following a successful pilot.
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- A partnership between the local hospice, Cruse and the Care Plus Group was developed to strengthen the current bereavement service.
- The organisation had set up an innovation fund which provided staff with money to implement new ideas that would benefit patients. We saw several examples of funding provided following ideas submitted by staff, such as small scale equipment to assist community nurses prevent pressure sores and promote independence.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The individualised plan of care, that identified patient's risk assessments and care pathway, was not always accessed by authorised people involved in delivering care and treatment.