Care Quality Commission

Dorset Healthcare University NHS Foundation Trust

RDY

Community end of life care

Quality Report

Sentinel House
Nuffield Industrial Estate
Nuffield Road
Poole
BH17 0RB
Tel: 01202 303400
Website: www.dorsethealthcare.nhs.uk

Date of inspection visit: 23 - 26 June 2015
Date of publication: 16/10/2015

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)
RDYNM	Sentinel House		
RDYFD	Wareham Community Hospital		
RDYFF	Swanage Community Hospital		
RBD30	Yeatman Hospital		
RDY22	Alderney Hospital		

This report describes our judgement of the quality of care provided within this core service by Dorset University Healthcare NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Dorset University Healthcare NHS Foundation Trust and these are brought together to inform our overall judgement of Dorset University Healthcare NHS Foundation Trust.

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

We rated end of life care as **requires improvement** because:

We found improvements were required in the responsiveness and strategic leadership of end of life care services. The safety and effectiveness of services were good and staff providing end of life care across the trust were compassionate and caring.

- We found planning and delivery of end of life care was inconsistent across the geography of the trust, based upon historical commissioning arrangements.
- The generalist palliative care service, commissioned in Bournemouth and Poole, was more responsive than the community nursing service in West and North Dorset as they could support both health and social care needs of patients. If personal care services were not available to support a discharge in rural Dorset these patients did not have timely access to end of life care in their preferred place of care.
- The generalist palliative care teams did not use an objective tool to measure its daily capacity to support patients. The team had a waiting list, and so patients were sometimes waiting to access the end of life care to meet their needs.
- The strategy, and strategic objectives, for end of life services was still in development. Service leads articulated a vision and priorities for end of life care services across the trust, but this had not been shared with staff.
- There was no evidence of regular reporting on the quality of end of life services to the board.
- Priorities for improvement focused on achieving the Gold Standard Award standards, but progress had been slow.
- Staff in end of life care services were aware of their responsibilities. They raised concerns and reported incidents and used the systems were in place for reporting and learning. They had received mandatory training to support safe care and were aware of safeguarding and how recognise and respond to concerns.
- Appropriate equipment was available to support the delivery of safe end of life care.

- Facilities for end of life care in community hospitals were a good standard, and where they fell short of this, plans were in place to make improvements. Mortuary viewing rooms were not used by staff, because they were not fit for purpose.
- There were processes in place for the safe management of medicines. All staff were trained in the use of one model of syringe driver. There was a palliative care drug administration chart available, but this was not used across all services.
- Patient records were stored securely on electronic patient records and an end of life assessment proforma was used as part of the Gold Standard Framework. There were some inconsistencies in the records reviewed.
- Staffing in end of life care services was adequate and staff across teams prioritised end of life care. There was limited medical cover for patients admitted to a community hospital out of hours.
- End of life care was planned and delivered in line with best practice guidance. The trust had responded to the withdrawal of the Liverpool Care Pathway by introducing a new communication care plan around end of life care.
- We found that pain assessment took place on a continual basis and staff were responsive to this.
- Staff had access to relevant training and support. All the teams we spoke with valued the expertise of the specialist palliative care team and used this service often as a learning resource and for referrals where patients had complex symptoms that were difficult to manage.
- Our observation of practice, review of records and discussion with staff confirmed there was effective multidisciplinary team (MDT) working practices. Staff worked collaboratively to understand and meet the range and complexity of people's needs
- A combination of electronic patient records and paper forms in patient homes were used. There were some inconsistencies in the information recorded, such as preferred place of death. The trust had audited Do not attempt cardio-pulmonary resuscitation and found

Summary of findings

they were well completed. However, at inspection we found that almost half those reviewed did not include a clear explanation as to why patient or relative was not involved in the decision.

- Staff had a good understanding of Mental Capacity Act (2005). However, some were still awaiting formal training. Recording of decisions needed to be more detailed.
- Staff treated patients with dignity, respect and kindness. Relatives we spoke to told us that staff delivered compassionate care and that staff were very attentive to their needs and that of the dying person.

- Care plans had been developed to be used with patients in vulnerable circumstances, such as people with a learning disability.
- People felt confident to raise complaints and concerns and these were dealt with in a timely way.
- There was an open and supportive culture with staff being very engaged, open to new ideas and interested in sharing best practice in end of life care.

Summary of findings

Background to the service

The end of life care service across the Dorset Healthcare University NHS Trust includes:

- Generalist palliative care teams for patients registered with a GP in the Bournemouth and Poole areas. This is a nurse led service, commissioned to provide care (including personal care) in the last 16 weeks of life.
- Community nursing teams in the remainder of Dorset who provided care for patients at end of life. The personal care element of this was provided by domiciliary care agencies.

- Both services were supported by a specialist consultant led palliative care team which was provided by the acute trust operating out of the hospice at Forest Holme.
- The service runs over seven days a week.
- Community hospitals also provided end of life care services, and sometimes were the patients preferred place of care.

Our inspection team

Our inspection team was led by:

Chair: Neil Carr, South Staffordshire and Shropshire Healthcare NHS Foundation Trust Chief Executive

Team Leader: Karen Bennett-Wilson, Head of Mental Health Inspections, Care Quality Commission

The team inspecting end of life care services included a CQC inspector, a GP with experience in end of life care services, a senior nurse with experience in palliative care and a specialist palliative care nurse. Evidence relating to end of life care services was also collected by teams inspecting community services for adults and community inpatient services.

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection programme of NHS trusts.

How we carried out this inspection

To get to the heart of the experience of people who use services', 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 Dorset Healthcare University Foundation NHS Trust, 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 23, 24, and 25 June 2015. During the visit we held

focus groups with a range of staff who worked within the service, such as nurses and 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.

For this core service we visited a range of services including generalist palliative care team, community nursing teams, and community hospital. During the visit we spoke with a range of staff who worked within the service, such as nurses, healthcare assistants, therapists

Summary of findings

and managers. We spoke with people who use services as well as carers and family members. We observed how people were being cared for. We reviewed care or treatment records of people who use services.

What people who use the provider say

Patients and their relatives were overwhelmingly positive about the quality of end of life services received across the trust.

Feedback we received from relatives about end of life care received at two hospitals was very positive. One lady told us that staff on the ward were "sensitive and attentive" to both her and her family. She referred to the care and the quality of the care provided as "seamless".

Another family were supported and appreciated being able to stay in a suite on the ward, where they were checked on regularly by the staff. They told us that staff gave them "constant care and attention which was wonderful". They received a bereavement card a few days after the death of their relative. A relative wrote to the trust to express her gratitude for the standard of care they had received.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust MUST ensure:

- Strategic leadership and governance arrangements are strengthened and there is regular reporting to the Board on the quality of end of life services
- A needs assessment and review of end of life services is undertaken and plans developed to improve responsiveness across the geography of the trust.
- An end of life strategy is developed, consulted upon and communicated effectively to staff, patients, relatives and the wider community.

The trust SHOULD ensure:

- The palliative care medicines administration chart is used consistently across all services where end of life care is provided
- All staff are trained in the Mental Capacity Act 2005 and in the documentation of all decision processes in relation to the Act.
- Patient and relative involvement, or reasons why not involved, are recorded on DNACPR forms.
- There is consistent record keeping across services for all aspects of end of life care
- Mortuaries and viewing rooms are fit for purpose, if they continue to be used. End of life care plans reflect the needs and wishes of individuals.

Dorset Healthcare University NHS Foundation Trust
Community end of life care
Detailed findings from this inspection

Good ●

Are services safe?

By safe, we mean that people are protected from abuse

Summary

- Staff in end of life care services were aware of their responsibilities. They raised concerns and reported incidents and used the systems were in place for reporting and learning. They had received mandatory training to support safe care and were aware of safeguarding and how recognise and respond to concerns.
- Appropriate equipment was available to support the delivery of safe end of life care.
- Facilities for end of life care in community hospitals were a good standard, and where they fell short of this plans were in place to make improvements. Mortuary viewing rooms were not used by staff, because they were not fit for purpose.
- There were processes in place for the safe management of medicines. All staff were trained in the use of one model of syringe driver. There was a palliative care drug administration chart available, but this was not used across all services.
- Patient records were stored securely on electronic patient records and an end of life assessment proforma was used as part of the Gold Standard Framework. There were some inconsistencies in the records reviewed.

- Risks were appropriately assessed and escalated as required and staff had access to specialist advice and support.
- Staffing in end of life care services was adequate and staff across teams prioritised end of life care. There was limited medical cover for patients admitted to a community hospital out of hours.

Safety performance

- The end of life core service worked with and across many other community services and as such does not have a high number of incidents. A total of 29 incidents were reported by the generalist palliative care team (Poole and Bournemouth) between December 2014 and June 2015. Of these incidents, pressure ulcers accounted for the highest number of incidents as the risks of developing a pressure ulcer for the end of life patients is high.

Incident reporting, learning and improvement

- The staff we spoke to were aware of the process for reporting incidents using the trust wide electronic system. All incidents, accidents and complaints were recorded using this system.

Are services safe?

- Staff told us that they received feedback from incidents that had been investigated, and made changes where possible to prevent incidents from happening again. The staff felt that this system worked well and they had the information they needed to learn from incidents.
- We looked at an example of an incident relating to the development of a pressure ulcer. The investigation documentation that was considered by a panel was open, concise and identified all of the issues raised by the incident. The result of the investigation was shared with other staff to ensure that there was learning from the incident across the generalist palliative care service. In this case the pressure ulcer was found to be unavoidable due to the patient's rapidly deteriorating condition and imminent death.

Safeguarding

- Staff we spoke to had a good understanding of safeguarding and understood the types of abuse that might be found. Staff knew how to escalate safeguarding concerns to the local authority. Staff also knew where they could get advice about potential safeguarding issues.
- 81% of staff in the generalist palliative care team had received mandatory training in safeguarding adults (level 2).
- Staff had a detailed understanding of how families can inadvertently move into safeguarding territory with the administration of smaller than required amounts of strong pain medicine, due to fear of overdosing the patient. The staff were perceptive in exploring these issues and providing support where needed.

Medicines

- The generalist palliative care team staff did not hold stocks of medicines. However, they had a system for checking controlled drugs (CDs). These are strong pain killers and sedatives used in end of life care that had been obtained for patients and were kept in their home.
- On our inspection we found that anticipatory medicines (just in case medicines) were prescribed and obtained in a timely way. These are medicines that patients may require near the end of their life to relieve symptoms such as pain and restlessness. 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.

- There were nurses in generalist palliative care teams who could independently prescribe medicines and adjust prescriptions.
- The trust had a palliative care (end of life) medicines administration chart. This contained the prescription and administration record and also advice and guidance for prescribers. The chart also and included stock recording for controlled medicines such as morphine. The use of the palliative care drug administration chart was limited to certain community hospitals and teams. This could lead to uncertainty around its use if the patient were to move between teams.
- Medicines were stored and managed appropriately in community hospitals visited, including CDs. We saw that trust guidance on the administration as well as the destruction of unused CDs was followed.
- The community nursing teams had a system in place to check that CDs were being administered to patients appropriately. Records of administration of drugs were kept (such as the palliative care drug administration chart) when patients were being given medicines via a syringe driver.
- The trust had consolidated to one model of syringe driver device. These devices are used in end of life care to deliver medicines to control pain and other symptoms continuously over 24 hours. There was a policy and protocol for the use of the device in order to reduce the risk of medicine administration error. Staff had attended training to ensure that they were competent to use this device.

Environment and equipment

- Teams based in the community providing end of life care for patients ordered any aids or equipment from an external provider. Types of equipment required to help end of life patients at home are hoists, electric profiling beds and commodes as well as special mattresses to help prevent pressure ulcers. This was accessed by senior nurses who could assign a priority to deliveries of equipment. The staff were able to arrange for same day/urgent delivery of equipment for patients who were returning home for their end of life care.
- The patient rooms at Wareham Hospital were small and required redecoration, which was planned. There were

Are services safe?

some improvements planned at the hospital, to provide better accommodation for relatives and two rooms with en-suite facilities, which could be utilised for end of life care.

- Dedicated facilities for end of life care patients, and those close to them, were also available at Westminster, Yeatman and Blandford Hospitals. All these hospitals provided 'quiet' rooms for communication with patients and relatives. The hospitals we visited made the appropriate accommodation for end of life care patients a priority, even where dedicated facilities could not be provided.

- We saw mortuary facilities in Blandford, Bridport and Yeatman Hospitals. Refrigeration was provided, but at the Yeatman Hospital this was not fit for purpose as there was inadequate shelving to allow safe handling of deceased patients. The viewing facilities at Yeatman were found to be in a poor state of decoration. Staff told us that mortuary viewing facilities were used infrequently as relatives and carers were happier seeing the deceased on the ward.

Quality of records

- Most records were stored on an electronic patient record system. There were also records in the patients' homes. We were told these included information such as do not attempt cardiopulmonary resuscitation forms, staff contact details and risk assessments for nutrition, pressure ulcers and falls. However, the range of documents kept in the patient's home was found to inconsistent across the trust.

- Patients at end of life had an assessment proforma recorded in the electronic patient record. This recorded a patient's preferred place of care and if there was a 'Do not attempt cardio vascular resuscitation' form completed, where this could be found. The assessment was comprehensive and included details of whether the patient was able to take food and drink or if an intra-venous infusion was indicated. The document also recorded if the patient had an intra cardiac device, such as a pacemaker as there would need to a conversation with the patient and arrangements made to deactivate the device. The assessment also recorded last update from the GP, as well as details of who needed to be contacted out of hours if the patient deteriorated. This proforma formed part of the gold standards framework (GSF) which staff were encouraged to complete to ensure best practice in end of life care.

- The electronic patient record system contained a library of core care plans which could be edited to reflect individual patient's needs and preferences. We looked at 15 sets of records, in five of these there were attempts at personalisation of care plans, such as adding the patient's name. We did not find any other evidence of any editing of standard end of life care plan templates to reflect patient's individual preferences. However, staff were providing care which took patients' needs and preferences into consideration.

- There were some electronic record entries which used inappropriate terminology to refer to patient's condition. This could be misunderstood by another doctor or nurse and cause uncertainty about the care and treatment needed.

- Data was collected on the recording of patient's preferred place of care. However this was recorded on the electronic system in just five of the 15 records reviewed. On two occasions the patients preferred place of death was recorded in diary entries rather than in the correct place that would ensure all staff had ready access to this information.

- Staff told us that issues around using the electronic patient record meant that they frequently had to work beyond their shift finish time to ensure that documentation was entered onto the system.

Cleanliness, infection control and hygiene

- The Yeatman, Blandford, Wareham, Swanage and Bridport community hospitals were visibly clean and hygienic for people receiving end of life care. Many of the old buildings had been refurbished.

- Hand washing facilities and hand sanitising gel was available in all of the areas where care was carried out in the areas we visited.

- Staff were observed following infection control procedures and protocols in the hospitals and patients own homes. Staff we saw were following the trust 'bare below the elbow' policy.

- Equipment that we saw on inspection had been cleaned and labelled as such to indicate it was ready for use.

Mandatory training

- Mandatory training covered a range of topics including fire safety, health and safety, basic life support,

Are services safe?

safeguarding, manual handling, hand hygiene, communication, consent, complaints handling and information governance. Staff were up to date with their mandatory training.

- There were systems in place to ensure that staff had training to enable them to carry out their roles effectively, such as e-mailed reminders to complete training.
- Mandatory training for genalist palliative care team was above the trust's target, 85% up to date, at the time of our inspection, except for adult and children's' safeguarding (level 2) which was at 81%.
- Staff told us that the majority of mandatory training was provided online, they felt that online training did not take account of variations in learning styles. Staff said that they found it difficult to find the time required to undertake training.
- Staff working in end of life care were not required to undertake training in subjects specific to their area of practice, such as management of symptoms, dementia care for end of life patients and communication, but they were encouraged to do so.

Assessing and responding to patient risk

- Community hospital staff, generalist palliative care team nurses and community nurses and other members of the multidisciplinary team (MDT) had regular meetings to discuss their patients, their level of need and any risk that had been identified.
- The generalist palliative care teams provided care for patients up until 9pm at night. Out of hours doctors could be used for urgent medical attention and the specialist palliative care service offered telephone advice across 24 hours.
- Patients identified as requiring end of life care had a holistic assessment after referral to the generalist palliative care team, admission to community hospital or admission to the case load of the community nursing service. However, on admission to a community hospital there could be delays in being seen by a doctor due to short working hours. Therefore there was a reliance on a duty GP or the 111 service. The trust were aware of the medical staffing problem. There were plans in place to increase the amount of medical cover for community hospitals.

- Patients in a rapidly deteriorating condition would require transfer to the acute hospital, unless advanced care planning had been carried out. This arrangement was in place for patients who were admitted to the community hospitals for end of life care.
- The end of life care plan contained specific interventions for managing symptoms such as pain. We found no pain assessment tool in use in the trust. However, patients' relatives told us that the assessment and management of pain and symptom control were good across the end of life teams.
- Staff in the generalist palliative team were encouraged to telephone the base if they were delayed in a patient's home due to crisis or rapid deterioration. This allowed other visits they had scheduled to be reallocated to other staff to allow them the time to spend with that individual.

Staffing levels and caseload

- The trust used a recognised tool to calculate required staffing levels for all inpatient units providing end of life care services. There was not a similar tool available for community settings, although the trust had plans to roll out a programme using e roster. Caseload management in the generalist palliative care teams was undertaken by the nurse in charge of the service and was based solely on experience and judgements.
- Staff told us that they worked beyond their capacity on occasions. However the service did have a waiting list of between two and 10 patients.
- The rates of sickness in the generalist palliative care team was at 5.1%, slightly above the trust's overall reported sickness rate of 4.7%.
- Community nursing teams took on the role of provision of end of life care in areas of Dorset which were not covered by the generalist palliative care team. In some areas staffing was stretched. The level of staffing capacity fluctuated with the acuity of patients. This had a particular impact on end of life care services if patients require two nurses to visit up to three times per day. Staff told us end of life care was always prioritised.
- At Blandford Community Hospital we were told the staffing at night was increased proactively due to concerns over safety rather than in response to an incident.
- Medical staffing at community hospitals was insufficient to ensure that patients were seen by a doctor when they were admitted. Patients admitted in the afternoon

Are services safe?

would have to wait for a duty GP to see them or there was increased reliance of the 111 service. The doctor we spoke to was unable to complete his work in the time he was scheduled.

Managing anticipated risks

- Staff in the generalist palliative care services provided care up until 9pm, and along with community nursing teams were involved in lone working and travelling at night. There were systems in place, with staff checking in with each other and being provided with a personal attack alarm.

- We spoke to staff about how they would continue to provide a service in the event of adverse weather. Community hospitals had a rota of staff that lived locally; this would be used to provide a core staff. Community nurses told us they would prioritise the work that could not be delayed and staff would check in to a central point to co-ordinate what resource was available.

- Staff providing end of life care in the community knew their caseload and would be able to respond to manage risks such as adverse weather conditions.

Are services effective?

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

Summary

- End of Life care was planned and delivered in line with best practice guidance. The trust had responded to the withdrawal of the Liverpool Care Pathway by introducing a new communication care plan around end of life care. Teams were working towards Gold Standards Award accreditation standards.
- We found that pain assessment took place on a continual basis and staff were responsive to this.
- Information was collected on the effectiveness of treatment and reflective practice contributed to improvements.
- Staff had access to relevant training and support. All the teams we spoke with valued the expertise of the specialist palliative care team and used this service often as a learning resource and for referrals where patients had complex symptoms that were difficult to manage.
- Our observation of practice, review of records and discussion with staff confirmed there was effective multidisciplinary team (MDT) working practices. Staff worked collaboratively to understand and meet the range and complexity of people's needs
- Despite some limitations in accessing patients' records across the trust, the generalist palliative care team had access to records in the acute trust as well as community hospitals and teams.
- Staff had a good understanding of Mental Capacity Act (2005) although some were still awaiting formal training, and recording of decisions needed to be more detailed.

Evidence based care and treatment

- Community hospitals and community teams were preparing for accreditation against the gold standards framework (GSF). The GSF is a range of tools, measures and quality assurance to ensure that there is an evidence based approach to end of life care.
- Staff told us that they were using the personalised care and communication care plan for the last days of life based around the five priorities of care explained in the

'One Chance to Get it right' document. This was implemented following the discontinuation of the Liverpool Care Pathway nationally in 2014. This document was part of the electronic patient record.
- Care plans were in place for individuals to reflect their choices and wishes. However, of the 15 electronic records we reviewed, only five had been personalised. Care plans and journal entries in the patients' electronic record reflected that appropriate care and treatment was given.
- Generalist palliative care teams and community nursing teams referred to the palliative care handbook produced by Christchurch Macmillan unit to advise them on medication prescription and symptom control.
- The expertise of the specialist palliative care team in Poole was used widely and highly valued by staff in end of life care within the trust.
- An end of life care facilitator (senior nurse) had recently been appointed to provide leadership in evidence based practice and promote partnership working with other organisations support patients at end of life.

Pain relief

- Pain symptoms 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 was reported back to the team.
- All teams were pro-active at communicating with medical staff if a patient did not get adequate pain relief.
- An objective pain scoring system was not always used when assessing a patient's pain.
- Advice about pain relief was available by telephone 24 hours a day from the specialist palliative care team.

Nutrition and hydration

- Food and drink were always available for patients and relatives in community hospital settings. Patients' with care needs around food and drink were assessed. Symptoms such as nausea were managed and this was recorded in the records we reviewed.

Are services effective?

- There was access to specialist assessment from a speech and language therapist (for swallowing difficulties) and dietitian if required.
- Staff we spoke to were aware of the General Medical Council (GMC) guidance for doctors in the support of nutrition and hydration for patients at end of life.

Patient outcomes

- The work towards accreditation against the gold standards framework included completion of 'after death analysis', to find out how relatives found the experience of end of life care for their relative. The results of the analysis were fed back to teams and ward staff to enable them to improve.
- The generalist palliative care team questionnaire report (April-September 2014) identified that symptom control was rated 'definitely effective' 73% of respondents, and 'to some extent' by a further 18%.
- The trust audit of patients dying in their preferred place of care between April 2014-15 was 89.5% this is higher than the average for England.
- The trust met their target of 85% of patients having an end of life care plan in place. However, the records we reviewed were standard end of life care plans that lacked personalisation and a record of an individual's wishes and preferences.
- The generalist palliative care team questionnaire report (2014) indicates that overall the team was rated excellent or very good by 82% or respondents.
- Advanced care planning training was in the process of being rolled out across the trust, so advanced care plans were not fully implemented or seen on this inspection

Competent staff

- The generalist palliative care team had recently gained practice development accreditation to provide training in end of life care.
- All new support workers recruited to the generalist palliative care team were encouraged to complete a course in palliative care within the first year of employment. Staff grade nurses (band 5) were also encouraged to continue their professional development in end of life care with courses accessed through the appraisal process. Training in end of life care was provided through the local hospices.
- Staff told us that they were able to access the education and training they needed.

- The trust recognised that training in end of life required further support and the newly appointed end of life care facilitator would lead this. A practice educator with experience in end of life care had also been appointed to the trust's learning and development team.
- We spoke to a number of staff who had undergone verification of death training; this reduces delays for families in having deceased patients collected by funeral directors.
- Staff received formal supervision within both the community nursing and generalist palliative care teams.
- 100% of staff in the generalist palliative care teams had completed an appraisal. The appraisal system was reported by staff as being a positive and useful process; all of the staff we spoke with had been appraised in the last year.

Multi-disciplinary working and coordinated care pathways

- During the inspection we attended handover meetings at community hospitals and community teams. These included detailed discussions about patients' physical health and also their psychological wellbeing and the impact of their condition on relatives and carers. We observed examples of excellent interdisciplinary working in an MDT meeting. Staff working in the generalist palliative care team and community teams worked closely in liaison with community matrons looking after patients with long term conditions.
- We observed an MDT meeting to discuss patients at Wareham Hospital (including an end of life patient). The meeting was attended by the hospital doctor, nurse, therapists and social worker. The complex discharge planning and safeguarding requirements of a lady with an lasting power of attorney was discussed. The MDT also discussed delays to discharge due to a lack of home care, as well as transfers between community hospitals to move patients who were not yet ready for discharge closer to home.
- The community rehabilitation teams provided therapy support for patients at home. The input of these therapists was seen by the community nursing teams as providing essential elements of end of life care. We saw examples of effective communication between nursing and therapy staff.

Are services effective?

- The generalist palliative care teams and GPs had effective relationships with the coroner's office, this ensured that families were informed when the patient died of a notifiable disease (such as one caused by the persons' occupation).
- Other specialist services provided within the community also assisted in the early identification of patients who were approaching end of life. The heart failure team, were able to assist GPs with the decision that a patient's condition was no longer treatable and offer their opinion as to whether the patient was reaching the end of life.
- We observed examples of multi-disciplinary working to support end of life care patients, especially to facilitate rapid discharge from hospital.

Referral, transfer, discharge and transition

- There was good liaison between the community matrons looking after patients with long term conditions and end of life care services. These services worked together to ensure that patients were referred to end of life care services in a timely way.
- There was a clear pathway to refer patients to the generalist palliative care team from the community or acute hospitals for patients identified as requiring end of life care. This service in consultation with the patient's GP referred to the specialist palliative team if advice or a consultation were required.
- The heart failure team referred patients who had exhausted all specialist treatment options for assistance in the management of symptoms. They referred patients to the generalist palliative care teams or community nurses for end of life care.
- The specialist palliative care team accepted referrals from the generalist palliative care teams, community nursing teams and GPs.
- Referral to other disciplines was straightforward and effective, such as occupational therapists or physiotherapists to help patients cope with symptoms such as breathlessness.
- Discharges from hospitals were managed efficiently, and mostly were timely to allow the patient to be cared for in their preferred place of care. Sometimes there were delays in being able to discharge patients quickly due to the availability of carers or suitable care home placements.

Access to information

- There was an electronic patient record system used in community teams, generalist palliative care teams and community hospitals. The system had been in use for two years in community nursing teams.
- Not all services were using the electronic system to its full potential. This could lead to inaccuracies in the data that can be pulled from this system such as preferred place of care.
- Staff also used paper records which were left in patients' homes. Do not attempt cardio-pulmonary resuscitation or 'allow a natural death' forms were only scanned into the electronic record on two of the 15 records seen.
- The electronic patient record could provide information about where the DNACPR or 'allow a natural death' form was stored to ensure this could be accessed by emergency services for example. However, this was not always completed.
- The use of the electronic records system meant that in theory patient information was accessible to be shared across services; however this was not always possible with some restrictions to access. Access to GP records was restricted to those which use the same system as the trust; approximately one third of GPs could not access this system.
- The generalist palliative care team had access to acute hospital records via a separate information system which helped them respond to urgent discharge requests. Community hospitals used the same patient record system as the palliative care teams so that records could be easily shared.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards was being implemented but not all staff had been trained as yet.
- The staff we spoke with had a good understanding of the assessment of mental capacity. However this was not reflected in documentation. It was not clear from the documentation that patients who did not wish to follow advice had mental capacity to make this decision on an individual basis. An example of this was where a patient did not wish to be visited by the generalist palliative care team as frequently as they considered his condition to need. They assumed that he had capacity to make this decision but did not record this in his

Are services effective?

record. The patient was aware they could request support at any time if they changed their mind. The team also telephoned him regularly to check there was no change.

- We saw a good example of a Deprivation of Liberty Safeguard application for a patient at end of life.
- The results of trusts own audit of DNACPR forms between January- March 2014 found 100% compliance against patient communication completed (or the reasons why not) on a DNACPR form. This audit also found 88% of patients' relatives had been communicated with about the DNACPR.

- Our own audit of these metrics during inspection did not reflect such a high level of compliance against standards.
- We reviewed 31 'do not attempt cardio-pulmonary resuscitation' (DNACPR) or 'allow a natural death' forms. 18 of the 31 forms were filled out correctly and indicated that patient and/or their relatives had been involved in decision making. In the 13 other forms there was not a clear explanation as to why patient or relative was not involved.

Good 🟢

Are services caring?

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

Summary

- Staff across all the teams we visited described with passion how they were committed to providing caring person centred end of life care and saw it as a vital service to patients.
- Staff treated patients with dignity, respect and kindness. We saw examples of where staff had provided patients with care which was above expectation.
- Relatives we spoke to told us that staff delivered compassionate care and that staff were very attentive to their needs and that of the dying person.
- Patients and their relatives were informed and involved in planning their care, but care plans did not reflect those individual needs and wishes.

Compassionate care

- We found examples of compassionate care working across the generalist palliative care team, community hospitals and community nursing.
- Staff involved in caring for patients at end of life, were sensitive to the needs of patients and those close to them. We were given examples of where beds were moved to allow a couple to sleep side by side and hold hands in a community hospital.
- The 'purple bow' scheme was in place at the Yeatman Hospital. This was a package of measures that provided a discrete way of letting staff know that a patient was nearing end of life. For these patients, visiting was permitted at any time of day, and family or carers were allowed to bring the patient's pet into hospital if this was practical.
- We spoke with four relatives of patients cared for by the end of life care service, some bereaved in the last month. They reported that the care they and their relative had received was excellent and stated that staff were very sensitive and attentive to their needs.
- Community hospital staff told us of arranging the wedding for a patient who was receiving end of life care, as this was an unfulfilled wish.

Understanding and involvement of patients and those close to them

- We found that patients at end of life were identified effectively and there were early discussions about their preferences for care. We did not observe advanced care planning or decision in the documentation.
- End of life care plans we saw were not all individualised to reflect the choices and preferences of patients however. These care plans did not evidence the person centred care that patients received.
- Relatives of patients provided feedback in the generalist palliative care questionnaire report (2014). 90% of the 77 respondents stated they were involved in decisions as much as they wanted to be.
- From the same survey, 85% of respondents said that they received information in a way they could understand.
- Our discussions with staff, patients and relatives provided evidence that patients and their families were involved and understood their care and treatment.
- We found a good attention to detail and respect and care for the wishes of the patient and those close to them.
- Relatives we spoke with told us that they felt well supported and their wishes were always considered. They told us that the standard of care was good.
- There was early discussion with families if it was necessary to have the involvement of the coroner, such as when a patient is dying of an occupational related disease (for example mesothelioma).
- Staff in all the teams we visited had a caring approach in risk management, for example a patient wanting to stay in their own bed, rather than using the profiling bed provided. Staff told us that this could reduce what they were able to do for the patient, but they would not refuse to give care.

Emotional support

- Staff offered excellent emotional support for patients and their families. Families were asked for feedback on the service when patients die, a sympathy card was sent out a week after the bereavement. There was access to the spiritual support team for bereaved families.

Are services caring?

- Bereavement support was available for families and was provided in partnership with a voluntary organisation.

- We found that the support of families, partners or next of kin were always considered. Assessment of carer stress was also reported on regularly and support was offered.

Are services responsive to people's needs?

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

Summary

- We found planning and delivery of end of life care was inconsistent across the geography of the trust, based upon historical commissioning arrangements.
- The generalist palliative care service, commissioned in Bournemouth and Poole areas, was more responsive than community nursing service in West and North Dorset because they could support both the health and social care needs of patient. If personal care services care were not available to support a discharge in rural Dorset these patients did not have timely access to end of life care in their preferred place of care. Despite these limitations the staff worked hard to respond positively to the needs patients at end of life.
- Most, but not all, community hospitals provided end of life care. These were based in the West and North Dorset
- The generalist palliative care teams did not use an objective tool to measure its daily capacity to support patients. The team had a waiting list, and so patients were sometimes waiting to access the end of life care to meet their needs.
- Community nursing teams were proactive in identifying patients who would require end of life care.
- Care plans had been developed to be used with patients in vulnerable circumstances, such as people with a learning disability.
- People felt confident to raise complaints and concerns and these were dealt with in a timely way.

Planning and delivering services which meet people's needs

- Results from the end of life care quality assessment were being used in setting the future direction of the service, but planning and implementation was at the early stages.
- The purpose of community hospitals varied across the trust due to historical commissioning arrangements. Not all of them provided end of life care for patients. This was part of a Dorset wide review of services that would refocus the use of wards in community hospitals. Due to pressure on discharges from acute hospitals, the trust found it difficult to protect beds in community hospitals for exclusive use by end of life care patients.

- There were developments and improvements planned to provide facilities that could be used to enhance end of life care. There were no beds in community hospitals specifically funded for end of life care. However, it was considered important to be able to offer good facilities if patients chose to die in a community hospital.
- The purple bow scheme was a discreet way to identifying patients who were at end of life. A small ribbon was attached to the head of the bed to highlight to staff that the patient is end of life. This scheme was used in one community hospital we visited.
- There were inconsistencies in service delivery models commissioned for end of life care across Dorset. The generalist palliative care teams worked across Poole and Bournemouth and were able to support with personal care. This meant that services could be more responsive to patients requiring nursing and personal care, and were less reliant on social care services. The team in Bournemouth and Poole worked together flexibly across geographical boundaries to support as many end of life patients as possible. In other areas in Dorset this service was not available and end of life was delivered solely by community nursing teams.
- There were business plans in early stages of development for the recruitment of palliative care support workers to support these community nursing teams in the delivery of personal care for patients at end of life.
- Verification of expected death training for staff was also being rolled out across the trust to support timely verification and certification of death.
- The generalist palliative care teams ensured that patients and relatives had open access for telephone advice and to call in to request assistance from the teams. The team was very well connected with other services including community nursing and Macmillan Cancer Care. The telephone communications with patients we heard during our inspection were responsive to need and patient centred.

Are services responsive to people's needs?

Equality and diversity

- We did not see any evidence of publications for end of life patients being available in languages except for English. Information (including end of life care services) accessed via the trust website could be displayed as translated text into Polish and Chinese.
- The services of an interpreter could be provided if required. Staff were aware of how to access this service.
- The trust told us that requests for written information to be provided for patients in other languages would be dealt with on an individual basis.
- Cultural, religious and spiritual needs of end of life care patients were sought, assessed and planned for.

Meeting the needs of people in vulnerable circumstances

- Staff understood that patients at end of life were increasingly vulnerable. Staff had good relationships with other agencies such as social services and continuing health care when additional support was required.
- There was an end of life care plan which has been specifically designed to support patients with a learning disability in planning for their end of life care.
- Staff we spoke to had participated in a study day about the care of the patient with dementia at the end of life. A small number of patients managed by the generalist palliative care team also had a diagnosis of dementia. The needs of patients with dementia were assessed individually with appropriate involvement of family and carers.

Access to the right care at the right time

- The trust provided data for the number of patients who died in their preferred place of care. They exceeded their target of 85% with an actual of 92% up to February 2015.
- Patients who were admitted to a community hospital were not always accommodated near to where they live due to the unavailability of beds. Patients were sometimes moved when a community hospital bed becomes available closer to home. Although good practice, this sometimes meant that patients had several transfers across sites.
- Services were responsive in getting end of life care patients' home from hospital quickly. However the availability of social services home care led to some

people not being able to return to their preferred place of care. We encountered two community hospital patients that were unable to be discharged to die at home due to delays in arranging a care package.
- The generalist palliative care service provided care for cancer and non-cancer patients. Those patients identified as rapidly deteriorating or changing condition were prioritised.
- The service had a capacity rating which was communicated to the community nursing teams and acute hospitals. The capacity of the teams was discussed daily to take into consideration the numbers of patients requiring two staff to visit. However, there was no objective measure of the dependency of patients used to back this up. The generalist palliative care team told us that they routinely had a waiting list of between two and 10 patients.
- The community nursing services were often aware of patients with the diagnosis of a terminal illness before the need for any care as they had effective communication and good relationships with GPs. This meant they could make contact with the patient before they required any input from the nursing team. The community teams we spoke to said that early contact was very effective for patients, who were empowered to refer themselves back to the team when they felt ready to accept support. GPs were also very involved in the decision for patients to seek help from the community nurses. GP support in end of life care was excellent. We saw that end of life care for patients was given priority in all the services we visited.
- Equipment to facilitate care in patients' homes such as profiling beds, hoists and specialist mattresses were supplied by an external provider. Staff told us that this service was very responsive in preventing delays to patients coming home for end of life care.

Learning from complaints and concerns

- The service had a complaints procedure that was understood by staff. Relatives of patients we spoke to would feel confident to raise issues with the staff. Staff dealt with issues and concerns raised by patients and relatives very quickly, which they said led to the small number of complaints about end of life care services.
- The trust's own data found that there were two complaints related to end of life care services for the previous year.

Requires improvement ●

Are services responsive to people's needs?

- Feedback on the experience of relatives after a death was routinely collected with the after death analysis. The comments we saw from relatives about end of life care were all positive.

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

- The strategy and strategic objectives and for end of life services was still in development. Service leads articulated a vision and priorities for end of life care services across the trust, but this had not been shared with staff. Staff were unsure of a trust wide ambition and direction that would be necessary to drive improvements.
- There was not a formally appointed board level lead for end of life care. The role was shared by a locality director and director of nursing. There was no evidence of regular reporting on the quality of end of life services to the board. Quality metrics were in early stages of development and not widely used by teams.
- Priorities for improvement focused on achieving the gold standard framework standards, but progress had been slow.
- The development of end of life services across the trust had been strengthened with the appointment of an end of life care facilitator and a recently formed end of life care operational group.
- Individual teams had good clinical leadership arrangements in place. There was an open and supportive culture with staff being very engaged, open to new ideas and interested in sharing best practice in end of life care.

Service vision and strategy

- The service lead's vision was that end of life care was 'everybody's business' and all staff had a role within it. There was recognition that there was variation in quality between the care provided by the community teams and the generalist palliative care teams. The ambition was described as ensuring that all teams had the capability and the capacity to support end of life care.
- The "End of Life Care Services Across Dorset Healthcare Position Report" was published in June 2015. The document contained the agreed trust priorities and developments in end of life care. It was based on nine of

the standards from the end of life care quality assessment. The report showed positive progress towards six of the standards, and some progress towards others.

- There was no end of life care strategy in place at the time of inspection, despite this being referred to in the "End of Life Care Services Across Dorset Healthcare Position Report" and requested by the inspection team. The lack of clear strategy made it difficult for staff to be able to articulate the strategic vision for development and improvement of end of life care services.
- The service was developing in several areas under the leadership of a newly appointed end of life care facilitator/GSF lead nurse. This post was supported by a board level locality director.
- The service leads told us their priorities for end of life care were gaining accreditation against the GSF, as well as meeting the nine standards against the end of life quality assessment they had agreed to focus on in 2015/16. There was further business planning occurring to enable the recruitment of palliative care support workers who would be attached to community nursing teams. This would address the inequity between the generalist teams and community nursing teams around the provision of personal care.

Governance, risk management and quality measurement

- We did not see any evidence of reports to the board, or board sub committees, on the quality of end of life care.
- Governance arrangements were in place for risk events and staff told us that they received feedback after incidents had been investigated. Staff also felt confident that incidents led to learning and changes being made, although we were not given any specific examples of where this had happened.
- Risks to end of life care services identified by the leadership team included inconsistencies in quality between different delivery models such as the palliative care team and the community teams. Patients requiring support being discharged from local acute hospitals

Are services well-led?

meant that community hospital beds were not available for end of life patients. Delays in getting appropriate care packages for patients to ensure timely discharge from community hospitals.

- There were team meetings across individual teams to look at patient feedback, audit results and incidents.
- The trust was starting to identify areas of concern and agree metrics to measure performance against standards. However there was little evidence that key performance indicators or data were used to inform clinical leaders at team level how well they were performing. The data was collected and local team leaders could not demonstrate an understanding of the application of this information in service development. This data was seen as something that only senior managers would have an interest in.
- End of life audits and after death analysis were completed as part of the gold standards framework (GSF) that was in the process of being implemented across the trust.

Leadership of this service

- There was no identified clinical leader for end of life care within the trust. However, a GSF/end of life care facilitator was recently appointed to work across services. It was too early to see the impact of this appointment in community hospitals or community teams.
- There was not a formally appointed board level lead for end of life care. Strategic leadership for end of life care was provided at board level by a locality director and the director of nursing and quality. The locality director also had a significant portfolio of other services and staff told us they were not visible to staff at service delivery level.
- There was a newly formed end of life care operational group which had been set up to coordinate end of life care across the trust, bringing together representation from community nursing, palliative care teams as well as mental health, learning disabilities and community hospitals. The group also provided liaison with other providers and the CCG.
- Two operational matrons with expertise in end of life care provided leadership of the two generalist palliative care teams. The teams told us they received good support from these staff and they worked effectively to ensure that the workload between the two teams was shared to optimise capacity.

Culture within this service

- We found an open and supportive culture in end of life care services with staff being very engaged, open to new ideas and interested in sharing best practice in end of life care.
- The community nurses we spoke with told us that end of life care was always considered a high priority for them. They also stated that end of life care was an intrinsic part of their work for patients.
- Teams were supportive of each other and aware of the emotional stress of working in end of life care. The handover meeting was seen as a time for checking on team wellbeing.
- There were systems in place to ensure that staff affected by the experience of caring for patient at end of life were supported. There were opportunities for formal debriefings as well as informal support.
- In addition the teams told us they arranged social events and had 'away days' during work time.

Public engagement

- Staff had undertaken events aimed at raising awareness of the importance of advanced care planning in end of life care. This engagement activity was designed to help members of the public to understand end of life care after the adverse publicity associated with the Liverpool Care Pathway.

Staff engagement

- Staff were engaged around how a 'good' death could be facilitated, there have been working groups recently established to debate this. Feedback from these groups will be used to inform analysis of gaps in services, to ensure a consistent quality of service across the trust.
- Several staff told us that they felt vulnerable at night when working alone. This was also reflected in incidents which have been reported. The trust had responded by developing a plan to use interactive name badges to allow staff to have easy access to help when they felt vulnerable when working alone in the community.

Innovation, improvement and sustainability

- There was a palliative care skills development post based at The Joseph Weld Hospice, in West Dorset. This was a secondment for a trained nurse whose learning was supervised by three advanced nurse practitioners in order to develop specialist skills and knowledge.

Are services well-led?

- Students on placement in the community felt confident to question practice and feel supported in doing so. Students reported to us that the community setting was highly team oriented and communication was good, they found this a worthwhile placement.
- The community hospitals were currently working towards gold standards framework accreditation. This is a framework for ensuring that a person's needs at end of life are met, and those close to them involved and supported. The trust were at the forefront of the pilot for community hospitals GSF accreditation, two hospitals had made their submissions at the time of inspection.

- The priorities for end of life care in 2015/16 were to ensure targets are met on the three remaining standards such as; patients being offered to opportunity to discuss and record their choices or decisions; increased staff training on verification of expected death and assessments of need for families and carers.
- There were also business plans to allow for the recruitment of care assistants to support palliative care in the community nursing teams. If successful this will address the inequity of care provision between the community teams and the generalist palliative care team.

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
	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met: Systems were not in place to** • Assess, monitor and improve the quality and safety of the services provided. Regulation 17 (2)(a) • Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (2)(b) • Seek and act on feedback from relevant persons for the purposes of continually evaluating and improving the service. Regulation (2)(e)