# Wye Valley NHS Trust

RLQ

# Community end of life care

## Quality Report

Tel: 01432 355444
Website: http://www.wyevalley.nhs.uk

Date of inspection visit: 22, 23 and 24 September 2015
Date of publication: 20/01/2016

# 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) |
|---|---|---|---|
| RLQ03 | Bromyard Community Hospital | | |
| RLQ06 | Leominster Community Hospital | <Placeholder text> | <Placeholder text> |
| RLQ08 | Ross Community Hospital | <Placeholder text> | <Placeholder text> |

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

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

Where applicable, we have reported on each core service provided by Wye Valley NHS Trust and these are brought together to inform our overall judgement of Wye Valley NHS Trust

# Summary of findings

## Ratings

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

# Summary of findings

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# Summary of findings

## Overall summary

**Overall rating for this core service** Requires Improvement l

The community end of life service were rated overall as requires improvement. Improvements were required in relation to the assessment of patients' mental capacity to make decisions before decisions were made about care that was in their best interests. The specialist palliative care team (SPCT) worked as part of a multidisciplinary team approach between hospital and community based services, with specific team members dedicated to providing the community element of specialist care. Their role was to assess, support, deliver, monitor and evaluate end of life and palliative care provided by the service. Services provided safe, coordinated care and we saw that staff were focused on continual learning and service development. Equipment used for patients at the end of life was easily accessible in the community and staff told us they felt they had the resources to deliver quality care.

The organisation did not have the all the processes and information to manage current and future performance. The trust did collect some information on the percentage of patients who died in their preferred location. However, the trust did not collect information on the percentage of patients who achieved discharge to their preferred place within 24 hours. Without this information, we were unable to monitor if the trust was able to honour patients' wishes. Without collecting this information, the trust was unable to assess if they needed to improve on this.

End of life care within the community was influenced by national guidance such as the Gold Standards Framework and we saw that good multidisciplinary working was in operation with the needs of the patient central to all care activities. Patients and relatives we spoke with told us the care they received was delivered with compassion and that they were respected and treated with dignity. The community provided a seven day specialist palliative care advice service and we saw that the needs of the local population were considered when reviewing the service provided. Improvements had been made to the assessment and care planning of patients at the end of life with the development of a multidisciplinary care record for the last days of life. We also saw that the trust had taken action to replace the syringe drivers in line with national recommendations. The SPCT attended mandatory training although there were some areas where compliance was as low as 50%.

We saw evidence of a clear vision developed for end of life care and there was proactive leadership at SPCT and community service levels. Trust board representation for end of life care had been identified although not yet developed or embedded which meant we did not see evidence of proactive board level involvement in terms of the development of the end of life care strategy.

# Summary of findings

## Background to the service

**Information about the service**

Wye Valley NHS Trust provides community end of life care at Leominster, Ross and Bromyard community hospitals. End of life care is also provided in patient's homes by community nurses. There is a specialist palliative care (SPCT) team to support patients who require complex symptom management both in the community hospitals and in their homes. The SPCT team consists of a consultant in specialist palliative medicine and a lead palliative care nurse who covers both acute and community services. At the time of inspection there were 6.9 whole time equivalent (WTE) SPCT clinical nurse specialists (CNS') based in the community, equating to 10 part time posts. The SPCT nurses work in caseload pairings attached to specific GP practices within a geographical area of the region.

The SPCT team provide advice and support for district nurses, patients and their families between the hours of 9am and 5pm, seven days a week. Out of hours specialist advice and support can be obtained from the local hospice and there is a SPCT consultant on-call rota. End of life care is delivered by district and community ward based nurses who work to care for patients with guidance from the SPCT team.

During our inspection we spoke with one patient and three relatives. We also spoke with 19 members of staff which included; the palliative care consultant, specialist palliative care nurses, ward based nursing staff, medical staff, a non-executive director with an interest in end of life care, reception staff, community nurses and a community manager. We observed care and treatment, looked at care records and 11 Do Not Attempt Cardio-Pulmonary Resuscitation (DNA CPR) forms. We received comments from our public listening event and we also reviewed the trust's performance data.

## Our inspection team

Our inspection team was led by:

**Chair:** Dr Peter Turkington, Medical Director, Salford Royal NHS Foundation Trust

**Head of Hospital Inspections:** Helen Richardson, Care Quality Commission

The team included one CQC inspector and clinical nurse specialist in end of life care.

## Why we carried out this inspection

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

## How we carried out this inspection

We visited three community sites and accompanied the SPCT on home visits, to observe patient care and treatment.

We spoke with 19 members of staff, including the palliative care consultant, specialist palliative care nurses, ward based nursing staff, medical staff, a non-executive director with an interest in end of life care, reception staff, community nurses and a community manager.

During our inspection we spoke with one patient and three relatives.

# Summary of findings

We looked at patient notes that included care plans, risks assessments and service specific documents.

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 announced visits on 22, 23 and 24 September 2015. 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 patients who use services. We observed how patients were cared for and talked with carers and/or family members and reviewed care or treatment records of patients. We met with patients who use services and carers, who shared their views and experiences of the core

## What people who use the provider say

Patients and relatives we spoke with were positive about the care they received. We were told that staff were approachable, responsive, caring and compassionate. Relatives told us the care was of a high standard and that staff responded promptly to patient's needs.

## Areas for improvement

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

The provider **MUST** ensure that:

- The trust must ensure that where a person lacks capacity to make an informed decision or given consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

The provider **SHOULD** ensure that:

- The trust should ensure incidents are coded to identify when they have involved a patient at the end of life so that SPCT input can be provided in terms of learning and improvement.
- The trust should ensure they continue to take action to improve and sustain SPCT attendance at mandatory training.
- The trust should ensure incidents are recorded and evaluated where patients have not died in their preferred place of care in order to identify potential learning and improvements.
- The trust should ensure ongoing trust board representation for end of life care is developed and embedded.

Wye Valley NHS Trust

# Community end of life care

**Detailed findings from this inspection**

Good

## Are services safe?

### By safe, we mean that people are protected from abuse

There were effective procedures in place to support safe care for patients at the end of their lives and we saw evidence that incidents were reported, reviewed and that learning was identified. However, there was not a system to identify when reported incidents related to end of life care. This meant that while incidents were reported it was unclear if end of life care related incidents had the input of the SPCT team in relation to learning and ongoing improvements. We saw that anticipatory medicines were generally prescribed for patients at the end of life and that these medicines were available in patient's homes in the community. Staff had access to guidance on anticipatory prescribing via the trust intranet. Controlled drugs were available and stored securely in line with national guidance in community inpatient services.

Appropriate equipment was available in both community inpatient services and in patients' homes and we saw that syringe drivers were monitored using appropriate safety checks. The trust had taken appropriate action to replace all syringe drivers in line with the former National Patient Safety Agency (NPSA) recommendation that all Graseby syringe drivers should be removed by the end of 2015. The SPCT attended regular mandatory training although there were some areas where compliance was 50%. However, we saw that where staff were not up to date with training they had been booked to attend in the coming weeks.

**Incident reporting, learning and improvement**

- Staff delivering end of life and specialist palliative care understood their responsibilities with regard to reporting incidents. Staff we spoke with told us that when an incident occurred it would be recorded on an electronic system for reporting incidents.
- Incidents were not identified or coded to be identified as relating to end of life care or involving a patient who was at the end of life. It was therefore unclear how the SPCT would be involved in a review of incidents relevant to end of life care. Incident reporting and review was not a standing agenda item for the SPCT six weekly team meeting. We did not identify incidents specifically relating to end of life care during our inspection.
- District nurses told us they attend a weekly learning handover where there is an opportunity to reflect on issues that have been raised in the preceding week. They also told us that team meetings included a discussion around reported incidents and we viewed meeting minutes that demonstrated this.

Good

# Are services safe?

- We saw evidence of incidents discussed at ward meetings in the community hospitals, as well as seeing minutes of meetings where staff had received feedback on previously reported incidents.
- Staff were aware of their responsibilities in relation to duty of candour and being open with patients when incidents occur, however staff were unable to give us examples of incidents specifically relating to end of life care.

**Safeguarding**

- Systems were in place to protect patients in vulnerable circumstances from abuse. Staff understood their roles and responsibilities in relation to ensuring vulnerable adults and children were safeguarded.
- Staff were aware of the process of raising a safeguarding concern and gave us examples of when they had appropriately involved the safeguarding team.
- At the time of our inspection, specialist palliative care nursing staff mandatory training completion for safeguarding adult's level one was 67%. Completion of safeguarding children level 2 training was 50%. These did not meet the trust target of 90%. However, where staff required training updates we saw that these had been booked. However, after the inspection the trust told us that there were updated figures available that showed increased levels of training but were unable to provide evidence to support this on our request.

**Medicines**

- Medicines were generally well managed. Inpatients and community patients who were identified as requiring end of life care were prescribed anticipatory medicines. Anticipatory medicines are 'as required' medicines that are prescribed in advance to ensure prompt management of increases in pain and other symptoms. However, we saw that one patient in the community was not prescribed anticipatory medicines for the full range of symptoms that patients can experience at the end of life. The patient was symptom free at the time but this had not been identified by either the district nurses or the SPCT nurses. The issue was addressed at the time of inspection.
- We visited four patients in the community who had anticipatory medicines prescribed and these were available and stored safely in their home for when they were required.
- There were guidelines on the trust intranet (West Midlands Palliative Care Symptom Control Guidelines) as well as the Wye Valley NHS Trust formulary for medical staff to follow when prescribing anticipatory medicines. Medical staff we spoke with were aware of the guidance and how to access the SPCT for advice should they need it.
- The four prescriptions and administration records we looked at in the community were completed clearly; including the times of administration of medicines prescribed 'as required'.
- We saw in practice that patients at the end of life would routinely have their medicines reviewed during each visit in the community. Reviews included a full assessment of patient's condition, including any changes. We also saw that the SPCT nurses worked closely with general community nurses to review patient's symptoms and liaise with medical staff to make changes to medicines as necessary.

**Environment and equipment**

- Community services had access to appropriate equipment to keep patients safe and comfortable.
- We saw that the former National Patient Safety Agency (NPSA) recommendation that all Graseby syringe drivers should be removed by the end of 2015 had been added to the trust risk register. In addition we saw that a programme of replacement had been implemented alongside training for staff on how to use the new machines. We viewed two replacement syringe drivers in use, one in a community hospital and one in a patient's home.
- Syringe drivers were subject to regular safety checks and monitoring to ensure administration of medicines via this route was safe. We viewed completed four hourly monitoring forms that were in use for this purpose.
- District nurses we spoke with told us they had no problems accessing equipment for patients at the end of life in the community. Syringe drivers and specialist mattresses were available as required and district nurses could access these as needed.
- Staff told us that equipment was accessible within a few hours for patients at the end of life who were discharged via the fast track route.
- The mortuary body stores Bromyard and Ross community hospitals were well equipped and maintained with daily monitoring in place. Bariatric equipment was not available; however staff told us that

patients could be transferred to Hereford Hospital or more quickly to funeral directors if this was required. The temperature of the mortuary fridges was recorded on a daily basis and the fridges were alarmed should the temperature fall outside of the normal range.

**Quality of records**

- The SPCT used an electronic record system that enabled sharing of patient information within the team and with other health care professionals.
- In community hospitals the seven records we viewed were stored in lockable trolleys. In patient's homes records were kept in folders that were accessible to all community staff involved in the patient's care.
- We reviewed 11 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms in total, four in patient's homes and seven in the community hospitals. Of the 11 forms we viewed, eight were completed correctly and were visible in the front of patient's notes. They were appropriately signed and dated, included clear clinical information and decision making, and the decision was approved by a consultant or the patient's GP. The three that were not correctly completed did not have clear clinical information and decision making recorded on the form.
- We viewed an audit of DNACPR records in the community hospitals, dated January 2015 and saw that 88% of these had been correctly completed at the time of the audit.
- At the community hospitals we visited we saw that charts were used to monitor the general health of patients. These included national early warning scores (NEWS), a method for assessing a patient's condition using a scoring system against their physiological parameters to help identify deteriorations in their condition. In addition we saw the use of fluid balance charts, food charts and risk assessments both in community hospitals and in some patient's homes. We saw that charts were generally consistently completed.

**Cleanliness, infection control and hygiene**

- There were infection control and prevention systems in place to keep patients safe. The in-patient areas we visited appeared to be clean.
- There were sufficient hand wash basins, liquid soap, paper towels, hand gels and protective equipment available.
- Staff undertaking community visits had adequate stocks of hand gel and personal protective equipment (PPE) to take out with them.
- We visited the mortuary body stores at Bromyard and Ross community hospitals and saw that they were clean, regularly checked and that hand washing facilities were available.
- Staff had access to PPE, such as gloves and aprons. Staff were seen to be using PPE, washing hands and using hand sanitising gel.

**Mandatory training**

- Mandatory training was provided for all staff and was undertaken by all staff providing end of life care. There was evidence of some inconsistencies relating to training completion. For example, data produced by the provider stated that 100% of specialist palliative care nursing staff were compliant with training requirements in relation to moving and handling of inanimate loads, but only 57% were compliant with moving and handling people. We were told that this was in part due to new nurses starting in the team and we saw that where staff were out of date in terms of mandatory training, they had been booked onto a course.
- The SPCT manager was aware of areas where mandatory attendance at training needed improvements and was working towards ensuring training targets were reached.
- The SPCT provided education on a formal and informal basis which included staff from external organisations, including those working in local nursing homes.

**Assessing and responding to patient risk**

- Staff assessed and managed patient risk as part of an ongoing holistic assessment process. We observed good use of risk assessments for patients receiving end of life care. This included the assessment of risk in relation to nutrition and hydration, falls and the potential for pressure area damage.
- Changes to patient's condition were recorded in their daily notes by nursing, medical and therapy staff. Advice and support from the SPCT regarding deteriorating patients was available in the community. We observed interactions between community nursing staff and one of the SPCT nurses about managing a patient's seizures and saw that specialist advice was sought appropriately and in a timely way.

Good

# Are services safe?

- We spoke with relatives who were aware of how to access help and support should a patient's condition deteriorate in situations where they were cared for at home. We met a family who had called on the community nurses the night before our visit due to deterioration in the patient's condition. The family told us they had been clear about the process to follow in the circumstances and that staff had responded quickly and compassionately to their needs.

**Staffing levels and caseload**

- Staff told us they felt staffing levels were sufficient to ensure that patients received safe care and treatment. However, we were aware that the community hospitals we visited reported they did not have full staffing establishments (see the community inpatient report for further details). In particular, at Bromyard we were told that during a week long period they had only been able to staff the ward with one registered nurse and that during this time they had not been able to deliver end of life care.
- End of life care was delivered in the community hospitals and in patients own homes. Specialist palliative care support and advice was provided from 8am to 5pm seven days a week. Out of hours, and at the weekend, end of life care was provided by general community and inpatient staff who could access specialist support from a consultant on call rota and the local hospice.
- The community SPCT clinical nurse specialists (CNS) were divided in to five caseload pairings. This meant that two part time CNS' would share a caseload in a specific area of the community. These caseload pairings were attached to specific GP practices that in turn were designated GPs for care and nursing homes.
- The SPCT CNS' we spoke with told us their caseloads were manageable and that they thought the system worked well. They told us that the team was up to full establishment and that this had impacted positively on their ability to deliver appropriate and high quality care.

**Managing anticipated risks**

- Major incident and winter management plans were in place. District nurses told us they had access to 4X4 vehicles during the winter if they were unable to use their own cars and that they received regular weather alerts and support to prepare and plan proactively during these times.
- Emergency equipment was available within the community inpatient unit hospitals.
- There was a clear lone working policy and staff were aware of this and how to mitigate risks of lone working.

Requires improvement

# Are services effective?

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

Community end of life services required improvement to be effective. Assessments of patients' mental capacity to make decisions were not consistently completed or documented before decisions about care that was in the patients best interests were made. The use of mental capacity assessments was an area identified as requiring improvement in the trust's June 2014 Care Quality Commission (CQC) inspection.

We saw a strong evidence base in terms of end of life care guidance, which had influenced the development of the last days of life care document that had been rolled out across the trust. We saw good use of clinical audit, for example that action had been taken against the results of the National Care of the Dying Audit (NCDAH) and that learning had been cascaded across community services as well as acute. We observed good multidisciplinary working across the SPCT and between the specialist and generalist staff. There were training opportunities for generalist staff, such as health care assistants, to develop their end of life care skills including attendance at workshops and specific training opportunities.

SPCT nursing staff were aligned to GP practices and care homes and we saw that specialist nurses supported the use of the Gold Standards Framework within the community. We observed good practice in terms of pain assessment and management and all patients we spoke with told us their pain was well managed.

### Evidence based care and treatment

- The SPCT delivered care in line with evidence based guidance such as the West Midlands Palliative Care Symptom Control Guidelines. The guidance was available on the trust intranet.
- The trust had taken action in response to the 2013 review of the LCP. We saw that the MCR was evidence based, providing individual care plans for patients believed to be dying. This was used to communicate care and treatment. This was in line with the recommendations published June 2014 by the Leadership Alliance for the Care of Dying People (LACDP) (2014).
- We saw evidence that the trusts palliative care strategy incorporated national guidance. This included the National End of Life Strategy (2008), and 'One chance to get it right' Leadership Alliance for the Care of Dying People (2014) guidance.
- We saw evidence that care was based on the National Institute for Health and Care Excellence (NICE) Quality Standard QS13, including the identification, assessment and communication of dying.
- The Gold Standards Framework (GSF) was in use to support the development of good quality end of life care in the community. The framework was used to help staff identify the needs of patients at each stage of their care through detailed assessment. SPCT nurses worked closely with GP practices in using the GSF to support patients at the end of life and regularly attended GSF meetings in the practices they supported.
- Specialist palliative care advice and guidance was also available from the local hospice where the community SPCT nurses were based.

### Pain relief

- There were tools in place to assess and monitor pain, and pain control was a priority for staff involved in end of life care. Staff we spoke with told us they took account of patient's verbal and non-verbal expression of pain.
- Patients we spoke with and their families told us their pain was well managed and that staff were quick to respond to requests for additional medicines when pain occurred.
- We observed district nurses and specialist nurses assessing patients' pain levels in the community and saw that they assessed the type and duration of pain as well as factors that made the pain better or worse.
- We observed the use of pain assessment tools including the Abbey Pain Scale used for the measurement of pain in people with dementia who cannot verbalise their pain. This assessment scale included prompts to assess facial expression, body language, behavioural change and physical change.
- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were

available as needed both during the day and out of hours. Community staff told us they were able to access medicines quickly in the community and that they were planned in advance through the use of anticipatory prescribing to ensure patients had medicines stored in their homes.

**Nutrition and hydration**

- Nutrition and hydration needs at the end of life were assessed and monitored using the last days of life care record. Assessments incorporated patient choice, wishes and comfort and we saw ongoing nursing assessments that consisted of nutrition, hydration and mouth care needs.
- Relatives of patients in the community hospitals told us that staff would regularly consider the patient's nutrition and hydration needs. We were told that patients were offered choice in relation to their meals and that staff would do their best to accommodate special requirements and wishes.
- Specialist palliative care staff told us they would provide advice to generalist staff on a regular basis about nutrition, hydration and regular mouth care to promote comfort at the end of life. We observed community nurses in patient's homes assessing their nutrition and hydration needs and providing advice to family members.
- We observed patients in the community who were assessed for swallowing difficulties and we saw that community nurses were aware of the issues relating to nutrition and hydration at the end of life.
- We saw records for patients in community hospitals who had their nutrition and fluid intake monitored. We also saw that the red tray system was in operation within the community hospitals. The red tray system is a way of alerting health care staff to the fact that a patient requires help with eating.

**Patient outcomes**

- The trust had taken part in the 2013/14 National Care of the Dying Audit (NCDAH) where they had not achieved four out of seven organisational key performance indicators. The trust had performed worse than the England average in four out of ten clinical key performance indicators, including a review of patients' nutritional and hydration requirements, assessment of spiritual needs and care after death.
- While the NCDAH was specific to patients in hospitals we saw that action taken to address the areas identified for improvement had included the care of patients in the community through the development of the Last Days of Life document. We viewed sections of the document that included assessment of nutritional and hydration requirements, patients spiritual beliefs and preferences, and care after death.
- We viewed an audit of the Last Days of Life document that had been undertaken between October 2014 and August 2015. The audit focused on identifying where conversations had been documented. We saw that discussions with patients and family about patients being in the last days of life were recorded in 80% of audited documents. 71% included recorded discussions around nutrition and fluids and that 70% recorded the patient and family preferences. Action to address shortfalls included continued development of training and support for staff around the use of the Last Days of Life document.
- The trust was signed up for repeating the National Care of the Dying Audit later in 2015.
- The trust had submitted data to the FAMCARE 2 Project: a post bereavement survey of relatives about the care and support they and their relative received. Data was submitted for deaths known to the palliative care team and the trust were awaiting results at the time of our inspection.
- The SPCT audited the multi-disciplinary care records to assess patients preferred place of death between October 2014 and August 2015. Of 84 patients across the trust, including the community hospitals, 24% of patients achieved their preferred place of death. 57% were unknown due to this not being recorded, 19% did not achieve their preferred place of death, including two patients in community hospitals.

**Competent staff**

- End of life and palliative care was provided by well trained and competent staff.
- SPCT nurses we spoke with told us they had the opportunity to attend relevant training and conferences and take part in projects that developed their roles.
- Nurses within the community SPCT told us they had received an annual appraisal and that training and development plans were aligned to this process.

Requires improvement

# Are services effective?

- Members of the SPCT across the trust attended monthly group supervision sessions where there were opportunities to reflect on their practice.
- District nurses had access to opportunities to develop their end of life care skills and knowledge. We saw examples of district nurses having attended additional end of life care training and modules.
- The trust SPCT worked closely with the local hospice and the community SPCT nurses were based at the hospice. Training was often provided collaboratively with hospice staff and there were opportunities for general nurses to attend.
- Healthcare assistants could attend specific training courses on end of life care at the local hospice and we saw minutes of community hospital staff meetings that demonstrated the trust encouraged staff to attend.
- All members of the SPCT were trained in enhanced communication skills.
- General nursing staff we spoke with confirmed they had received training in the use of syringe drivers.

**Multi-disciplinary working and coordinated care pathways**

- Members of the SPCT participated in multidisciplinary team (MDT) meetings, working with other specialists and district nurses to support good quality end of life care across the community.
- The community SPCT met with hospital, care home and hospice colleagues on a weekly basis, including allied health professionals such as psychology and spiritual support services.
- The SPCT participated in site specific MDTs including haematology and lung.
- District nurses we spoke with told us that the community SPCT nurses were accessible via phone to support coordinated patient care at the end of life and we observed this working in action.
- The SPCT worked closely with local hospice services where community SPCT nurses were based and we saw evidence of agreed local pathways, with patients moving between services effectively.

**Referral, transfer, discharge and transition**

- Patients were referred and transferred appropriately. The planning of discharge or transition to an alternative place of care was a MDT process which included the input of hospital and community staff, as well as support agencies who were involved in providing end of life care to patients at home.
- Staff we spoke with in the community hospitals and in the community told us that it was possible to discharge patients to the preferred place of care within a few hours at the end of life. They told us that access to equipment and appropriate medicines was straightforward but that there could be problems with accessing appropriate care packages for patients who needed them, particularly those living in rural locations.
- Community nurses told us that when a patient was at home at the end of life they worked closely with the GP, specialist staff and the family to ensure patients had what they needed to stay at home. Community staff were proud of their ability to support this.
- Specialist staff told us that when a patient had not died in their preferred place of care, the team would review the action taken and identify areas for improvement. However, the trust did not keep records of incidents relating to patients who did not die in their preferred place of care.

**Access to information**

- We saw that information needed to plan and deliver care and treatment, including risk assessments and care plans, were shared appropriately and made available to relevant staff.
- Care plans were kept in patient's homes and accessible to all staff involved in their care.
- The Last Days of Life document would be used for patients identified as being in the last days of life. We saw this in use in the community and in community hospitals. Examples we viewed were appropriately completed and included a full range of assessment information, including details of patient and family choices, wishes and preferences.
- We viewed records that included detailed information about the management of symptoms, discussions and interventions. We also saw that when patients were seen by the SPCT information and advice was clearly recorded so that staff could easily access the guidance given.

**Consent, Mental Capacity act and Deprivation of Liberty Safeguards**

Requires improvement

# Are services effective?

- We viewed eleven DNACPR forms, four in the community and seven in community hospitals.
- We viewed two forms at Bromyard Community Hospital where it was stated on the forms that the patients did not have capacity. Yet we did not see a mental capacity assessment recorded for either patient. We raised this with the ward manager.
- At Ross Community Hospital we saw a record for one patient where the form stated that they did not have capacity. However, the patient had not received a mental capacity assessment and the form made reference to the reason for the decision made was that the patient's family had requested it. A second patient at Ross Community Hospital had a DNACPR form dated 2012 that had not been reviewed. The form stated the patient did not have capacity but we were unable to identify if this conclusion had been reached following a mental capacity assessment as the patient's historical notes were not available at the time of inspection. The patient's capacity had not been assessed during their current admission, however, ward staff told us they felt the patient did have capacity to be involved in a discussion about DNACPR at the present time. There was a risk that the patient's wishes were not considered and that they were unaware of the DNACPR being in place.
- We viewed prompts on the Last Days of Life document for staff to consider the best interests of patients when making decisions about their treatment and care. It specifically made reference to patients with dementia; however, the document did not include prompts for staff to carry out mental capacity assessments.
- The Last Days of Life document did include prompts for staff to check for an advanced decision to refuse treatment (ADRT), an advance statement (AS) or a lasting power of attorney (LPA).
- We did not see examples of advance care planning having been carried out for patients we saw, however staff told us they did use them and community nursing staff told us they had attended training on advance care planning at the local hospice.

Good

# Are services caring?

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

We rated caring as good.

Patients and their relatives spoke positively about the care they received in the community. We observed interactions between staff and patients and saw that staff were kind, caring and compassionate. Relatives we spoke with told us staff would spend time supporting them alongside the patient and that they demonstrated a good deal of care and compassion.

Staff were seen to treat patients and relatives with dignity and respect in all interactions. We saw that staff would find ways of making the experience of care as easy as possible for patients. We saw evidence of patients and those close to them being involved in care planning and decisions about care and we saw that the SPCT had looked at this as part of an audit of patient's care records in the community hospitals.

### Compassionate care

- Patients were treated with dignity, kindness and compassion. Patients and relatives we spoke with told us that staff were professional, supportive and kind. We observed care provided and saw that patients were treated with compassion, dignity and respect.
- We observed staff caring for patients in a way that respected their individual choices and beliefs and we saw that records included sections to record patient choices and beliefs so that these were widely communicated between the teams.
- Patients and relatives we spoke with told us they were happy with the quality of care they received and that staff took the time to treat them with respect and maintain their dignity.
- Staff we spoke with were passionate about delivering quality care for patients and their relatives at the end of life.
- Mortuary facilities at the community hospitals included viewing rooms that were designed in such a way as to ensure patients were treated with dignity and respect.

### Understanding and involvement of patients and those close to them

- Patients and family members we spoke with told us they felt involved in the care delivered.
- We saw that end of life care documentation included prompts for staff to discuss care issues with patients and relatives and that this was completed in the records we viewed. An audit of end of life care records in August 2015 showed that 70% of records included a documented discussion with patients and relatives about their preferences and wishes. The SPCT continued to run awareness sessions for staff around the new care documentation.
- The GSF was widely used in the community for patients in the last year of life. The GSF was designed to help involve patients in the planning of their care.
- We did not see completed documentation specific to advance care planning although community nurses told us they had attended advance care planning training at the local hospice. We saw that patients were asked about their advance wishes when commencing on the last days of life care document and that these were recorded and accessible to all staff involved in their care.
- The trust participated with a post bereavement survey of relatives about the care and support they and their relatives received. The survey was sent to relatives two months after death. The survey asked relatives about issues at the end of life such as comfort, explanations from staff, emotional support and the way in which the family was included in treatment and care decisions. The trust had submitted data to the project in August 2015 and the results were not yet available at the time of our inspection.

### Emotional support

- Staff working in the community told us they felt they had the time to spend with patients and provide the emotional support to meet their needs. Staff working at the community hospitals told us they prioritised care and support for patients at the end of life and their relatives.
- We observed community nurses taking time to identify patient's emotional needs as a matter of routine when visiting them at home. This included both patients and

Good

# Are services caring?

relatives. Staff interacted positively with patients and relatives and were flexible in the time they spent assessing and responding to patient's emotional support needs.

- Specialist palliative care nurses were trained in advanced communication skills, which meant they were trained to provide emotional support.
- Support was available from chaplaincy and psychology staff and staff we spoke with told us this was readily available to patients and their relatives at the end of life, including home visits for patients in the community.
- Relatives were provided with bereavement support information by nursing staff in the community hospitals with follow up from the SPCT. Patients in the community could also access bereavement services from the local hospice.

Requires improvement

# Are services responsive to people's needs?

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

The organisation did not have the all the processes and information to manage current and future performance. The trust told us that they did collect some information on the percentage of patients who died in their preferred location. However, the trust were unable to provide evidence to support the collection of 2014/15 data on our request. The trust did not collect information on the percentage of patients who achieved discharge to their preferred place within 24 hours. Without this information, we were unable to monitor if the trust was able to honour patients' wishes. Without collecting this information, the trust was unable to assess if they needed to improve on this.

Services were planned and delivered to meet patient's needs, including those patients in vulnerable circumstances. The trust had identified the need to develop services to better meet the needs of patients with non-malignant disease at the end of life and we saw that action had been taken to progress these services collaboratively with other providers.

Community SPCT was available seven days a week and out of hours advice was available from the local hospice and a palliative care consultant on call rota. We saw that 92% of patients were contacted within three days of a referral to the service. Staff and patients alike reported that the SPCT were quick to respond to patient need and that referrals were prioritised based on need.

### Planning and delivering services which meet people's needs

- Services were planned and delivered to meet patient's and relative's needs. Patients with end of life care needs in the community were referred to the SPCT by hospital and community staff, GPs and in some circumstances referrals were accepted by patients and family members.
- SPCT community nurses were available seven days a week from 9am to 5pm.
- Wye Valley NHS Trust SPCT services were closely aligned with St Michael's Hospice in Hereford and the SPCT nurses were based at the hospice. The SPCT worked closely with hospice staff to ensure patients and general hospital staff had access to specialist services when they needed them.
- The SPCT had developed a strategy for working closely alongside the local hospice to improve end of life care for patients with non-malignant conditions. This included a joint renal-palliative care clinic based at the hospice and we were told of business plans that were in development to provide a structured palliative care service for patients with end stage respiratory conditions.
- Plans to develop the SPCT service drew attention to the challenges of providing care to patients living in rural locations in the region and we saw this, together with increasing numbers of patients with non-malignant diseases had been incorporated into developing the strategy.
- The SPCT had identified the need for end of life care support to care homes within the region and this was incorporated into current working practices in the community with SPCT nurses being aligned with GP practices responsible for specific care homes. We also saw increased specialist support to care homes as part of the future plans for the service.
- The trust told us that they did collect some information on the percentage of patients who died in their preferred location. However, the trust were unable to provide evidence to support the collection of 2014/15 data on our request. The trust did not collect information on the percentage of patients who achieved discharge to their preferred place within 24 hours.

### Equality and diversity

- Patient's 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 to the trust. 67% of specialist palliative care nursing staff had attended equality, diversity and human rights training. This did not meet the trust target of 90%. However, after the inspection the

Requires improvement

# Are services responsive to people's needs?

trust told us that there were updated figures available that showed increased levels of training but were unable to provide evidence to support this on our request.

- The chaplaincy service provided support and pastoral care for patients of all faiths. We were told that chaplaincy staff were able to access leaders of a variety of faiths in order to meet the spiritual and faith needs of patients and their relatives.
- Staff at Bromyard Community Hospital gave us examples of when they had responded to the multi-cultural needs of patients and their relatives, citing examples of when families from different backgrounds had been appropriately supported, respected and accommodated leading up to and after death.

**Meeting the needs of people in vulnerable circumstances**

- The SPCT had recognised the needs of patients in vulnerable circumstances on relation to the future development of the service. In particular we saw evidence of plans in place to better support patients with dementia at the end of life. 87% of SPCT nursing staff had attended training in dementia awareness. This did not meet the trust target of 90%. However, after the inspection the trust told us that there were updated figures available that showed increased levels of training but were unable to provide evidence to support this on our request.
- There were translation services available.
- The trust recognised the support needs of local care homes in delivering end of life care and ensuring that patients were able to be better cared for at the end of life in the community rather than being admitted to hospital. We saw plans in place to support the development of the GSF in local care homes.

**Access to the right care at the right time**

- 80% of referrals to the SPCT were for patients with a cancer diagnosis, 20% were for those with non-malignant disease.
- The SPCT aimed to respond to all routine referrals in the community within three working days and within 24 hours if the referral was urgent. All referrals to the team went through an administrator who would immediately pass them onto SPCT nursing staff if the referral was marked as urgent or if the patient's needs were complex.
- Data collected by the trust showed that 92% of referrals were responded to within three working days. 40% of these were responded to within 24 hours. There were no reported incidents of patients not being responded to appropriately.
- SPCT nursing staff would contact the patient or their relative by phone when the referral was received to assess how quickly the patient needed to be visited.
- Data on how quick rapid discharge was achieved from community inpatient hospitals was not collected. Therefore, the trust was unable to demonstrate if rapid discharge plans in place were effective and met patient needs.
- We saw examples of SPCT nurses communicating with general community nurses to identify the needs of patients and work collaboratively in meeting those needs.
- General staff, patients and relatives told us that SPCT staff were responsive to their needs and would be flexible in their approach in order to better meet the needs of individuals and ensure they had access to specialist care and support at the right time.

**Learning from complaints and concerns**

- There had been no complaints relating to end of life care in the 12 months preceding our inspection. However, the SPCT recognised that complaints were not specifically coded for end of life care and had therefore requested that the Patient Advice and Liaison Service (PALS) inform the SPCT consultant if any complaints had been made that included an element of end of life care.
- Relatives we spoke with had not needed to complain but had an understanding of the process in which they could complain if they needed to.

Good

# 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.

We observed strong leadership from the SPCT and senior staff in the community. Trust board representation for end of life care had been identified although not yet developed or embedded which meant we did not see evidence of proactive board level involvement in terms of the development of the end of life care strategy. There was a commitment and culture for providing high quality end of life care that was patient focused.

A clear vision had been developed for end of life care and staff told us they felt this was a priority area within the trust. Action had been taken to improve end of life care services across the trust, including the development of an end of life care multidisciplinary care framework and the use of clinical audit as a tool to evaluate and develop the service.

**Service vision and strategy**

- We saw evidence of a documented vision for the service in relation to future and business planning within the SPCT. Future plans included the development of non-malignant palliative care services, for example, for patients with cardiac or respiratory conditions and dementia.
- The SPCT had an annual general meeting where they discussed and agreed their operational policy and work plans and priorities for the following year. We saw a copy of the meeting held in December 2014.
- We were also given a copy of the annual report produced by the team for the year end 2014
- We saw a copy of the team's work plan for end of life care and priorities for 2015. The main priorities were listed as service development, education and audits/ surveys/guidelines.

**Governance, risk management and quality measurement**

- The SPCT held six weekly minuted team meetings in which performance issues, concerns, complaints and general communications were discussed.
- An operational policy was in place that set out the aims and objectives of the team. We saw this was updated annually.
- Within the SPCT, multidisciplinary team meetings took place weekly where individual patient issues were discussed. In addition a six weekly SPCT meeting was held to discuss areas of service delivery and development. Minutes we viewed included discussions around caseloads, education, rota management and representation at other meetings.
- We saw evidence of regular supervision, appraisals and professional development within the SPCT. Group supervision was provided, supported by clinical psychologists approximately six weekly.
- Risks were identified and managed in relation to service planning. We viewed an example of a service model template that included identified risks relating to service capacity, effective community care and the ongoing development of proactive end of life care across the trust.

**Leadership of this service**

- The SPCT was led by a consultant in palliative medicine and a senior nurse.
- We observed clear leadership for end of life care within both specialist and generalist community services. 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.
- We saw evidence of the SPCT providing end of life care leadership across all services within the trust, extending to external services including GPs and care homes.
- All of the ward staff we spoke with knew who the leads were for end of life care.
- Staff spoke highly of the team and felt they were supportive and visible in the ward areas.
- We saw that the trust had an established a replacement for the Liverpool Care Pathway, a multidisciplinary care record for adults for the last days of life which we saw used across the hospital.
- The trust had identified a non-executive lead for end of life care although they had been identified in the weeks preceding our visit and the role had yet to be properly defined and embedded.

Good

# Are services well-led?

**Culture within this service**

- Staff we spoke with demonstrated a commitment to the delivery of good quality end of life care.
- Staff told us they felt proud of the care they were able to give and there was positive feedback from general nursing staff as to the level of support they received from the SPCT.
- The SPCT had a proactive approach to meeting the learning needs of ward and community based staff in order that they could meet the changing needs of the patients. Examples of this included the delivery of face to face impromptu training sessions on the wards at the same time as reviewing their patients. Nurses working in the community told us that the SPCT staff were available at the end of the phone to provide timely advice and were approachable and flexible to meet the needs of patients and the support needs of community based staff. We observed this working in action and saw that there was a culture of prompt, timely and collaborative working to meet the needs of patients.
- Across the wards we visited we saw that the team worked well together with nursing and medical staff and there was good communication between not only the specialities but across disciplines.
- There was evidence that the culture of end of life care was centred on the needs and experience of patients and their relatives. Staff told us they felt able to prioritise the needs of patients at the end of life in terms of the delivery of care.
- We observed good collaborative team working across the community SPCT and district nursing teams. Staff told us there were opportunities to learn and that the delivery of high quality end of life care services within the community was a priority.

**Public engagement**

- The SPCT were involved in raising public awareness around end of life care. Examples included the use of a stand in the hospital reception area during Dying Matters week in May 2014.
- The SPCT collated feedback from relatives and friends of patients who had died in the form of a feedback survey. The survey included questions around their satisfaction of the care their loved one received.

**Staff engagement**

- Staff told us they were encouraged to attend regular meetings and events and to share their experiences and feedback with managers on a regular basis.
- District nursing staff we spoke with told us they worked closely with the SPCT and were actively encouraged to feedback about the services, their roles and the challenges they faced. We saw that this feedback informed aspects of the SPCT working, including the development of training for district nursing staff.

**Innovation, improvement and sustainability**

- The SPCT were focused on continually improving the quality of care and we also observed a commitment to this within the district nursing teams we spoke with.
- The SPCT community nurses worked in pairs to manage a caseload. This supported continuity of care and enabled nursing staff to work closely together as a team within a team to support patients as seamlessly as possible.
- All community SPCT nurses were aligned with GPs and district nursing teams and were allocated to specific care and nursing homes to provide specialist support.
- End of life care training was developed and delivered to meet the needs of generalist staff in hospital and community settings and we saw that the SPCT had a flexible approach to meeting the learning needs of staff as they arose.

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 11 HSCA (RA) Regulations 2014 Need for consent<br>Regulation 11 (1) (2) (3) HSCA 2008 (Regulated Activities) Regulations 2014<br>**Need for consent**<br>1. Care and treatment of service users must only be provided with the consent of the relevant person.<br>2. Paragraph (1) is subject to paragraphs (3) and (4).<br>3. If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act*.<br>* Mental Capacity Act 2005<br>The regulation was not being met because staff in community settings completing DNA CPR forms did not comply with the Mental Capacity Act 2005 and the Code of Practice; and that systems were not in place to assess, monitor and mitigate the risks relating to non-compliance with the Mental Capacity Act 2005. Four out of eleven DNACPR forms we reviewed stated that the patients did not have mental capacity. However there was no evidence of mental capacity assessments being completed. |

This section is primarily information for the provider

# Enforcement actions

## 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.