

# The Rotherham NHS Foundation Trust

RFR

# Community end of life care

## Quality Report

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# Summary of findings

## Locations inspected

<b>Location ID</b>	<b>Name of CQC registered location</b>	<b>Name of service (e.g. ward/unit/team)</b>	<b>Postcode of service (ward/unit/team)</b>
RFRX3	BreathingSpace		
RFRPA	Oakwood Community Unit		







This report describes our judgement of the quality of care provided within this core service by The Rotherham 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 The Rotherham NHS Foundation Trust and these are brought together to inform our overall judgement of The Rotherham NHS Foundation 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?	Good	
Are services well-led?	Requires improvement	

# Summary of findings

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# Summary of findings

## Overall summary

### Overall rating for this core service

We carried out this inspection because when we inspected the service in February 2015, we rated the service as requires improvement. We asked the provider to make improvements following that inspection.

At this inspection, we rated services for community end of life as requires improvement, because;

The use of the end of life individualised care plan for adults was not embedded into practice and not used by all the services that provided end of life care. Managers within the community nursing service had recently began to review the use of the document in April 2016 and evidence on inspection showed that the document was not fully completed. Audits for community end of life were not embedded and actions were required to improve the quality of care provided in the community. These included staff completing and discussing advanced care planning to reduce the need for patients to be admitted to hospital unnecessarily.

Staff had completed mental capacity training, however 'do not attempt cardiopulmonary resuscitation (DNACPRs) were not completed appropriately for patients who lacked capacity and mental capacity forms and assessments were not completed. This was identified as a risk within the CQC comprehensive inspection in February 2015. Policies required to be reviewed in line with national guidance and the trust's timescales; these included DNACPR policy and syringe driver policy.

The trust still needed to build on the work they had commenced for the end of life strategy. For example, they needed to improve advanced care planning and implementation and embedding the individualised end of life care plan. These areas were not included as risks on the risk register. Preferred place of care was not always recorded on the patient's record which would identify where they wanted to be cared for within the last few days of life.

Ongoing communication was still required to aid integration of the acute and community services.

The trust had made some improvements from the CQC inspection in February 2015. These included staff reporting incidents and receiving feedback from the trust. Incidents were now shared across various methods. Safety huddles were held to discuss staffing levels and to look at the allocation of staff when required. Procedures were in place for patients whose visits required to be rearranged and patients who wanted visits would be seen. Staff could access patient's electronic records and further software had been added to the laptops to use in areas with connectivity issues. The implementation of the care co-ordination centre allowed patients to access a professional at any time who would contact the appropriate team.

We also saw that anticipatory medication was provided to patients and staff could prescribe medication quickly for patient's whose symptoms could not be controlled. Staff managed patient's pain and nutritional needs and completed the appropriate assessments. Equipment was available for patients and staff would often pre-empt and ensure equipment was at the patient's house incase it was required.

All community areas provided good links with GPs and the palliative care team to manage the patients. Some GP surgeries were on the same patient electronic system and could see the care records provided by the community services.

Staff provided compassionate and supportive care within the home and ward environment. Patients were encouraged to be involved in decision making about their end of life care needs. Staff communicated well and worked together to plan the care and treatment.

Senior staff in all community settings could complete fast track forms; this enabled care to be put in place quickly for patients whose condition was deteriorating and may have requested their preferred place of death at home.

# Summary of findings

## Background to the service

### Information about the service

Community end of life care was provided by community nursing teams to a population of around 260,000 people in and around Rotherham. The Rotherham community services had been restructured into seven localities: Central North, Central 2, Rother Valley South, Rother Valley North, Health Village, Wentworth South and Maltby and Wickersley. Each locality had its own local network of GPs, community care teams and other health and social professionals to provide care close to where the patient lives.

Breathing Space and Oakwood Community Unit also provided end of life care for people requiring 24 hour nursing care. Breathing Space is a 20 bedded unit based in the community of Rotherham which provided care for patients with respiratory conditions. Oakwood Community Unit is based in the grounds of the acute trust and the unit is split into two areas with 19 beds on the Elm unit and five beds on the Willow unit for neuro-rehabilitation patients. At the time of inspection, there were three patients on Oakwood Community Unit receiving end of life care.

The community nursing teams, Breathing Space and Oakwood Community Unit are all managed within the directorate of integrated medicine.

The trust does not provide specialist community end of life care; this was provided by Rotherham Hospice who worked closely with the trust.

We spoke with 24 members of staff including advanced nurse practitioners, senior nurses, locality lead nurses, district nurses, community matrons, associate matrons, community nurses, healthcare assistants, student nurses and administrative staff. During the inspection visit, the team saw six patients and five relatives. We visited several community nursing teams, Oakwood Community Unit, Breathing Space, integrated rapid response team and care co-ordination centre. We visited three patients in their own homes, observed care being delivered and looked at 13 patient electronic and paper records.

Community end of life care had previously been inspected as part of a comprehensive inspection in February 2015 and was rated overall as requires improvement. Well-led was rated as inadequate with safe, effective and responsive rated as requires improvement. Caring was rated as good.

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

## Our inspection team

Our inspection team was led by:

Chair: Carole Panteli, Nurse Director

Head of Hospital Inspection: Amanda Stanford, CQC

Team Leaders: Cathy Winn, Inspection Manager, CQC

The team that inspected community end of life care included CQC inspectors and community nursing specialists.

## Why we carried out this inspection

We inspected this core service as part of our responsive, follow-up inspection.

# Summary of findings

## How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the core service and asked other

organisations to share what they knew. We analysed both trust-wide and service specific information provided by the organisation and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit on 27 to 30 September 2016. During the visit we talked with staff and 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.

## What people who use the provider say

Patients and their relatives and carers spoke very positively about the end of life community services they received and the support available from all staff.

## Areas for improvement

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

The trust must:

- Ensure that all DNACPR forms are completed appropriately and accurately ensuring that mental capacity assessments are completed for patients where it has been assessed they lack capacity.

The trust should:

- Ensure that all areas in the community adopt and embed the individualised end of life care plan and ensure that advanced care planning is discussed to prevent any inappropriate admissions to hospital.
- Review arrangements to monitor the patient's preferred place of care and death.

# The Rotherham 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

We carried out this inspection because when we inspected the service in February 2015, we rated safe as requires improvement. We asked the provider to make improvements following that inspection.

At this inspection, we rated community end of life care as good for safe because:

- Most staff reported incidents and received feedback. We saw evidence of sharing and learning from incidents.
- Staffing levels had improved since our last inspection; however, there were some teams under pressure in community nursing due to vacancies and long term sickness. Safety huddles were held twice weekly to discuss staffing levels across the service and to balance risk.
- Procedures were in place for patients whose visits required to be rearranged.
- Anticipatory medication was provided to patients and staff could prescribe medication quickly for patient's whose symptoms could not be controlled.
- Equipment was available for patients and staff would often pre-empt and ensure equipment was at the patient's house in case it was required.

However:

- The individualised care plan for adults paper record was not always fully completed within the community nursing services and did not contain information relevant to the patients end of life needs.

### Detailed findings

#### Incident reporting, learning and improvement

- Staff were aware of how to complete incident reports and felt they were encouraged to by their managers. Most staff we spoke with said they would complete incident forms, however within the focus group a small number of staff commented that sometimes they were too busy to complete incident forms.
- The trust used an electronic incident form which allowed staff members completing the form to receive a response once it had been reviewed by a manager. Some staff commented that they did receive feedback in response to the incident.
- Incidents were discussed in monthly trust newsletters that were circulated around teams. We observed this during our inspection and staff said that they received and read the newsletters. We observed some of the newsletters on display.
- We asked the trust to submit any incidents relating to end of life care provided in the community between



## Are services safe?

March 2016 and September 2016. Four incidents were submitted; these related to patients developing pressure ulcers in the terminal phase of their condition. We saw that appropriate measures were in place to reduce the risk and provide patient comfort.

- Staff informed us of other incidents that had occurred in relation to end of life care. These included a patient being discharged with a syringe driver in place but not referred to the community nursing team and different dosages labelled on the syringe driver machine. Staff completed incident reports and discussed with colleagues how to prevent reoccurrence.
- We observed during our inspection staff completing incident forms when they felt the need to highlight issues with patient discharges. We spoke with one of the community locality leads in regards to a specific example who was looking into improving patient discharges by working with staff from the acute hospital.
- Never Events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. There were no never events reported in community end of life care between March 2016 and September 2016.

### Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with understood their role in duty of candour and senior managers were aware of the process to follow. We saw that duty of candour was discussed at team meetings.

### Safeguarding

- All staff were required to complete adult and children's safeguarding training as part of the trust's mandatory training requirements. The training was delivered either by face to face training or e-learning and incorporated information around the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs), consent and the use of restraint. Staff we spoke with had completed safeguarding training.

- Mandatory training targets for both safeguarding adults and children were set at 80%. Five community teams exceeded the target for safeguarding adults training with the Maltby and Wickersley team reaching 94%. Central North achieved 79%, and the lowest compliance was at the Health Village with 53%. Staff groups within the community units were varied with 53% for Oakwood Community Unit and 83% at BreathingSpace.
- Staff completed safeguarding children level two training. Nurses and additional clinical staff completed the training. Within the nursing group, four of the community nursing teams exceeded the trust target with Central 2 achieving 100%. The lowest compliance was the Health Village with 42%. Staff groups within the community units were varied with 70% for Oakwood Community Unit and 98% for BreathingSpace.
- Information regarding safeguarding was observed on the community units and within the base points in the community.
- Staff were aware of their responsibilities in relation to safeguarding and when they would need to raise a safeguarding concern. We saw one example where a registered nurse visited a patient and was concerned about the patient's care. They completed the relevant safeguarding forms and attended a best interest meeting. We saw detailed minutes of the meeting and the action plan that was put in place. The nurse felt that they were kept informed during the process and the patient's safety was maintained.
- We saw that the trust had appropriate safeguarding policies in place to support staff in their decision making. There was community staff attendance at safeguarding operation group meetings where matters would be discussed.

### Medicines

- We observed that two syringe driver prescription forms on Oakwood Community Unit were completed accurately and appropriately. Medicines were stored correctly on both of the community units.
- We reviewed two prescription charts on Oakwood Community Unit; these were completed fully and medication was prescribed for analgesia as needed. This allowed the patients to receive further medication to alleviate any symptoms they may have. Controlled drugs (medicines controlled under the Misuse of Drugs legislation and subsequent amendments) were stored securely with appropriate records kept.

## Are services safe?

- Patients in their own homes who were receiving end of life care were prescribed 'anticipatory' medicines. Anticipatory medicines were 'as required' medicines that were prescribed in advance to ensure prompt management of increases in pain and other symptoms. On inspection at a patient's home, anticipatory medication was in place and stored correctly. Staff we spoke with all identified the importance of having anticipatory medications in the house. We observed from patient's notes that these were in the house and staff had administered medication to alleviate patient's symptoms.
- Each community team had several syringe drivers and these were all set up in preparation. In each box was a supply of equipment, patient records and documents that would be required. Each box was set up the same across all the community team for continuity. On one home visit we saw that a syringe driver box was left at the house as the patient's condition was weakening and they may have required alternative medication. This ensured that the medication would be able to be administered quicker and provide symptom management to the patient.
- Algorithms for symptom management were in place in the community teams. Staff were aware of these and it ensured that staff could follow the flowchart to ensure patients received the correct treatment and doses of medication.
- Patients were prescribed fluctuating doses of medication; this allowed staff to increase the dose within the pre-set parameters whilst with the patient. This ensured that patients received effective management in a timely manner to alleviate their symptoms. On reviewing patient's notes we observed that staff increased medication when the patient showed or expressed their symptoms were not controlled.
- We observed in one patient's records that there was not enough medication in the patient's house to increase the dose in a syringe driver. The nurse provided a break through dose to alleviate any pain and ensured that the medication was prescribed quickly and sent to the house.
- Community matrons and some nurse practitioners on the community units were non-medical prescribers. This allowed the staff to prescribe medication including controlled drugs and to be administered to the patient quickly.

### Environment and equipment

- Syringe drivers were used in accordance with National Patient Safety Agency (NPSA) Rapid Response Alert. The same type of syringe driver was used across all services and within the local hospice.
- Syringe drivers on the hospital site were maintained within the equipment library where they could be accessed at any time of the day. At the time of the inspection two patients required syringe drivers on Oakwood Community Unit which had been acquired from the equipment library. The appropriate checks were completed appropriately.
- Syringe drivers in the community were held in local base points where they could be accessed easily. The rapid response team also held syringe drivers that could be accessed out of hours. Staff commented they could also access the hospice for any syringe driver needs. We observed that some patients had syringe drivers in the house as preparation in case the patient's condition deteriorated and the equipment was required suddenly.
- All equipment maintenance records were held centrally within the clinical engineering department on an electronic database. Staff could access the database within the community and we saw evidence of this on our inspection. Administration staff took responsibility for liaising with the department for servicing the syringe drivers and we saw robust plans to ensure they were checked and maintained. We checked 25 syringe drivers which had all been serviced in the last 12 months in line with the trust policy. The service dates on the syringe driver matched the dates documented on the electronic maintenance records.
- Both community units had all individual single rooms which could be used to provide end of life care when required.
- Mechanical hoists and specialist mattresses were available to be used on both community units.
- Staff had access to pressure relieving mattresses within their base points and would deliver these as needed to patients. The integrated rapid response team also had these mattresses available for immediate use to be used out of normal working hours.
- Equipment for patients (such as mattresses) were available from a contracted company. Staff completed a form that was required to be authorised by the tissue viability team prior to the delivery of equipment. Some staff told us that equipment was delivered on certain

## Are services safe?

days and patients receiving end of life care were experiencing delays with this equipment, even though different priorities could be requested. Some equipment could be collected, for example family members would collect commodes at times.

- The trust supplied telephone review questionnaire reports in which patients were contacted to identify if they were happy with the equipment that had been provided. The majority of patients identified they were satisfied with the delivery service and identified that they received their equipment one to four days after being assessed.

### Quality of records

- Patient's records were stored securely at both community units. We reviewed three sets of notes in the Oakwood Community Unit and found assessments were completed and care plans in place.
- Patient information in the community teams was stored securely on an electronic record system, and included paper records for medication which had been administered.
- We reviewed seven sets of notes in the community teams and found risk assessments and care plans in place. These had been reviewed appropriately and reassessed. Every patient had information completed within a nursing assessment on the electronic record; this provided information about the patient such as pain control, ability to mobilise and aids required. We saw in-depth evaluation documented in the electronic patient record that identified the patient's condition and care provided. For example, we saw the rationale of why a patient's pain control needed to be increased.
- We looked at six individualised care plans for adults; none were fully completed. The individualised care plan for adults was a 20 page paper document to be used when a patient was terminally ill and life expectancy was a few days or hours. The individualised care plan identified three key areas that were required to be assessed with the patient such as communication, symptom management and essential care needs. In two of the individualised care plans no documentation had been completed to identify that these had been discussed. In one individualised care plan only the communication element had been documented to identify that it had been discussed. In three care plans no signature was completed that was required to identify who the assessing clinician was.

- In all six of the individualised care plan for adults, staff completed the ongoing care record for evaluating the patient's care. Staff would evaluate on both the electronic record and the paper based individualised care plan for each patient, however the majority of the information was documented on the electronic record and not in the individualised care plan.
- In the individualised care plan for adults, the final page related to care after death identifying date and time of death. None of the six records had this page completed when the patient had died.

### Cleanliness, infection control and hygiene

- We saw staff used appropriate protective equipment such as gloves and aprons. Alcohol gel was available on both the community units and community nurses used their own supply available to them.
- We saw staff washing their hands before and after providing care and treatment. Patients we spoke with told us that they also observed staff completing hand washing.
- Clinic areas we visited were visibly clean and we saw appropriate use of clinical waste and sharps bins.
- Microbial decontamination audits were completed monthly for the community units and submitted for April to July 2016 where 100% was achieved. For community teams the audits were completed every three months and submitted for June 2016, however only four teams out of seven submitted a score. The four teams that submitted a score achieved 100%.
- Hand hygiene audits were completed monthly for the community units. For April to July 2016 these showed staff were adhering to bare below elbow requirements. Staff in BreathingSpace achieved 100% each month, in Oakwood Community Unit nurses achieved 90% in April and May 2016 which increased to 100% for June and July 2016. For community teams the audits were completed every three months and submitted for June 2016, however only five teams out of seven submitted a score. The five teams that submitted a score achieved 100%.

### Mandatory training

- All registered nursing staff in the community were required to complete training split over two sessions for palliative care. The training lasted for two hours and looked at issues that may affect patients at the end of their life. The sessions were repeated over the month

## Are services safe?

and ran from July 2016 to November 2016. Staff who had completed the training commented that they felt the training supported them to provide care to patients with end of life needs. We saw that some staff were scheduled to attend the training and provided us with the dates.

- Information supplied by the trust showed that overall mandatory training figures for Oakwood Community Unit were 79% and BreathingSpace was 87%. Within the community nursing teams compliance varied between teams and subject matter. For example, resuscitation training for the Health Village was at 53% for nurses and 100% at Maltby and Wickersley team.

### Assessing and responding to patient risk

- At the inspection in February 2015 some patients receiving end of life care who required home visits were not visited due to staffing levels. We saw during this inspection, if patients were not visited on the day that had previously been agreed, they received a telephone call requesting if their visit could be postponed and why. This was documented on the patient's electronic record and would not be moved more than once. If patients requested that they still wanted a visit, then the staff accommodated this. We saw evidence of visits altered on the nurses communication board to alert staff not to change the new date.
- The community services planned for weekend cover and participated in the daily conference call. Over the weekend, a band 6 sister was on duty to act as a co-ordinator for the whole of the community service and respond to any difficulties. The amount of staff needed was calculated and patients were identified, including those who may have complex needs, such as syringe driver equipment or specific symptom management. We looked at the information for the weekend of 24 September 2016 and we saw that four patients required syringe driver care. One community matron was assigned to see patients on a weekend who were requiring support with their long term conditions.
- We spoke with staff who felt that patients who required end of life care were a priority and calls would be organised around these visits.

### Staffing levels and caseload

- The community nursing teams had been redesigned and divided into seven locality teams in line with GP

surgeries. These consisted of a locality team leader, community matron, band 6 district nursing sisters, registered nurses and health care assistants. Associate matrons worked across several localities.

- Each community nursing team had a caseload which included patients who required end of life care. Visiting schedules were set to individual need and would generate a visiting day. All staff would visit end of life patients however the registered nurses and district nursing sisters would review the care required. Community matrons would work in conjunction with the team to see complex patients as required.
- Information provided by the trust showed that on Oakwood Community Unit there were five whole time equivalent (WTE) registered nurse vacancies and one WTE vacancy at BreathingSpace.
- At the time of our inspection, staffing levels within each community nursing team varied. Five teams were well staffed however; two teams had a high number of vacancies and were struggling to cope with the demands of the caseload. Staff told us they tried to help each other out within the team when possible. The trust had no specific concerns regarding staffing levels in the community teams, except for the usual operational pressures caused by sickness. The threshold for staffing levels in community teams was 85% and in April to June 2016 the average staffing levels was 96%. Staffing establishments were reviewed on a weekly basis to ensure vacancies and sickness were appropriately managed. A monthly report was compiled to show shifts which were staffed to plan which was 98% at the end of July 2016.
- Staff in the community teams worked extra shifts to cover any low staffing levels. The trust identified that community teams did not use bank or agency staff for this reason. Locality leads in the community teams met twice a week to hold a safety huddle to discuss staffing levels across the service and to balance risk. This occurred every Monday morning to discuss staffing numbers for the week ahead and every Friday morning to plan staffing for the weekend. The weekend plan was shared with the senior on-call weekend manager.
- No planned nurse to patient ratios were used within community nursing teams. Managers told us that there were plans to carry out work to establish the capacity and demand of the community nurses workload, which would take into account patient dependency however; this work had not yet started.

## Are services safe?

### Managing anticipated risks

- Community teams managed foreseeable risks and planned for changes in demand due to seasonal fluctuations. Local working instructions were in place for staff in relation to what to do in cases of bad or severe weather.
- Staff within the community teams informed us that during adverse weather conditions when they were unable to access their normal working base they worked around where they lived and accessed their local base to ensure patients were visited and cared for. This ensured that patients who required end of life care were seen and their symptoms managed. A winter weather plan was in place to be used in these circumstances.
- The trust had a lone worker policy in place which was up to date. The policy included risk assessment templates and advised the use of a buddy system for lone working staff. The policy encompassed guidelines for maintaining traceability away from the base which included following procedures to 'check back in' especially at the end of the day. Staff identified they would not always inform their colleagues of their safety and locations at the beginning and end of the day. Locality leads told us during the inspection that this was an area they would now focus on to identify more robust ways of working.
- Fire procedures and exit routes were displayed on Oakwood Community Unit and BreathingSpace and were visible and clear.
- Staff in all areas we spoke with were aware of plans for their service, their role in those circumstances and who to escalate the concerns to.
- The directorate of integrated medicine had business continuity plans in place to manage major incidents or events that would disrupt the delivery of care.

# Are services effective?

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

## Summary

We carried out this inspection because when we inspected the service in February 2015, we rated effective as requires improvement. We asked the provider to make improvements following that inspection.

At this inspection, we rated community end of life care as requires improvement for effective because:

- An individual care plan for end of life care had been commenced but was not embedded into practice.
- DNACPRs were not completed appropriately for patients who lacked capacity and mental capacity forms and assessments were not completed. Staff had completed mental capacity training, however the assessments were not documented.
- Staff were using the syringe driver policy, however it should have been reviewed in March 2016. The DNACPR policy did not include the "2016 decisions relating to cardiopulmonary resuscitation: guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing".
- Audits for community end of life were not embedded and actions remained in improving the quality of care provided in the community. These included staff completing and discussing advanced care planning to reduce the need for patients to be admitted to hospital unnecessarily.

However we also found:

- Staff managed patient's pain and nutritional needs and completed the appropriate assessments.
- Staff could access patient's electronic records and further software had been added to the laptops to use in areas with connectivity issues.
- All community areas provided good links with GPs and the palliative care team to manage the patients.

## Detailed findings

### Evidence based care and treatment

- Following the withdrawal of the Liverpool End of Life Care Pathway in 2014, the trust had developed, alongside other local organisations, an individualised

end of life care plan for adults. We spoke with staff who told us that the guidance was based on the five priorities of care for the dying patient that succeeded the Liverpool Care Pathway (LCP) as the new basis for caring for someone at the end of their life.

- The individualised care plan document was trialed in one of the localities prior to rolling it out to all other community teams. A meeting was held with the community staff after the pilot period and their feedback was used to improve the document.
- The trust held a focus group in April 2016 for the community teams which identified that staff were not aware of the relevant documentation for end of life care. A plan was devised to look at the areas for development. On inspection, two of the community teams identified that they had not completed any individual care plans for adults although they identified that they had provided end of life care for patients. This meant that the individualised care plan for adults was not embedded into practice.
- Both community units did not use the individualised care plan for adults and were not aware of any planned dates to commence this. In minutes sent by the trust, BreathingSpace had identified that they required training to commence using the document.
- Staff used the policy for the use of the ambulatory syringe driver, which was evident in some clinical areas. Most staff were aware of how to access the policy. The review date of the policy was March 2016. On inspection, staff informed us that they were still using this policy and the revised policy was being updated and ratified.
- Following our inspection in 2015 the trust developed an action plan; one of the actions was to review the DNACPR policy to ensure it was in line with best practice. The trust provided a copy of the current DNACPR policy – adult patients, the references in this policy did not include the "2016 Decisions relating to cardiopulmonary resuscitation: guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing". This did not provide evidence that the policy had been reviewed in line with best practice.

# Are services effective?

## Pain relief

- We looked at one prescription chart on Oakwood Community Unit and saw that anticipatory medication was completed for the patient. This ensured that the patient could access medication promptly which would alleviate their symptoms.
- We saw that on one home visit the patient was assessed for pain and this was documented using a pain chart. We also saw that the patient had the appropriate supplies of medication being used and also anticipatory medications to manage their future needs. However on reviewing one set of electronic records we saw that one patient on a syringe driver did not receive the correct dosage as there was not enough medication in the patient's home. The correct actions were taken by the staff in order to manage the patient's symptoms.
- The individualised end of life care plan for adults included anticipatory medication, where the prescriber would titrate the individual dose required. We observed two records where this was completed.

## Nutrition and hydration

- Within the community teams, staff completed nutritional assessments and patient's individual details were added to the nursing assessment on the electronic system. A malnutrition universal screening tool (MUST) was completed on the patient records we observed, along with a nutritional care plan. We checked the review dates of some of the care plans and found them to have appropriate dates for reassessment.
- Within the community units, we saw that patients had nutritional assessments completed. Food and fluid charts were used for patients who had been assessed as a nutritional risk and patients received nutritional supplements as a result.
- Protected meal times were in place on both community units.
- Drinks were provided at meal times and between meals; we observed that drinks were placed within patients' reach.

## Technology and telemedicine

- Telehealth was used to monitor and manage patients with heart failure. Patients recorded their own blood

pressure and weight and input the details into a dedicated machine. The care co-ordination centre received the information and alerted the specialist team of any readings outside of agreed parameters.

## Patient outcomes

- The End of Life Care Audit – Dying in Hospital 2016, showed the trust scored above or in line with the England average for three out of the five clinical key performance indicators however, they did not achieve five out of the eight organisational quality indicators. These were around the training in communication skills for staff, collection of feedback from bereaved relatives, the presence of an end of life care facilitator and a lay member on the board with a responsibility for end of life care.
- The trust completed a review titled: audit of deaths within 24 hours of admission to Rotherham General Hospital. Notes of 58 deaths were audited between March 2015 and January 2016. The audit identified that 47% of admissions were appropriate and could not have been prevented. The audit also identified that 17% of admissions were appropriate, but may possibly have been prevented. From this it was recognised that five patients were admitted from home where the patient's progressive illness had deteriorated and care planning had not been discussed or agreed; two patients had a DNACPR in place. The audit also showed that a further five patients were admitted to hospital from their own home, the results showed that these admissions could have been prevented. These included patients with advanced disease and within the last few days of life where no care planning had been put in place to identify where the patient would prefer to die.
- An action plan was devised in response to the findings from the audit of deaths with 24 hours of admission. to Rotherham General Hospital. Six recommendations were identified as a result of the audit, however none of these contained timescales to work within and two did not identify the person responsible for identifying if the actions required were adhered to. One of the recommendations highlighted was to attempt care planning for patients who it was felt were approaching end of life, to prevent inappropriate admissions to hospital. The action required identified training for community staff to recognise when it was appropriate to

## Are services effective?

commence the care planning and how to complete it. We saw on inspection that this training had begun however there was no update, timescale or person responsible as part of the action plan.

- Locality leads in the community teams had begun a review five sets of notes in each locality every 12 weeks. This looked at patient's documentation and allowed the reviewer to comment on any information not completed. Areas of concern and actions taken were completed in an action plan. We observed at inspection that staff could not remember which patients had an individualised end of life care plan. It was identified in minutes from April 2016 provided by the trust that the individualised care plans completed in the acute trust could be tracked for audit purposes, however this was not completed for community services. Staff told us they would document on the patient's electronic record when an end of life individualised care plan had commenced.

### Competent staff.

- Part of the registered staff's competency was to complete an observation of a structured competency (OSCE) for the safe use of a syringe driver. The staff member was observed completing the skill and had to meet certain criteria in order to pass and perform independently. When a staff member did not meet the criteria, further training and an action plan was devised in order to become competent. We saw evidence of the OSCE to identify that staff were competent in completing syringe driver care and some staff had copies of their assessment. However copies were not always kept in staff's personal files.
- Syringe driver training was provided by a 'train the trainer' approach and community teams had a trainer in each of the teams. Data showed 50% of the staff had completed syringe driver training on Oakwood Community Unit in August 2016. Five of the community teams had 100% compliance; the other two teams had 61% at Central 2 and 33% at the Health Village. The trust identified they had put in place a training plan to complete further training.
- The nurse practitioner on Oakwood Community Unit was a nurse prescriber. This allowed patients to receive medication quicker. Other senior nurses were due to undertake the training to allow them to be able to prescribe.

- The nurse practitioners and advanced nurse practitioners on the community units provided cover for each other which allowed patients to be seen as needed by the appropriate individual.
- Within each community nursing team, there were staff that had identified that they wanted to become link nurses for palliative care. These nurses linked in with the wider palliative care team and supported staff in their area with any palliative issues.
- We saw that newly qualified staff in the trust completed a preceptorship and a period of supernumerary status which allowed them to complete training within this time.
- We spoke with staff in the community and on the community units who identified that they had completed an appraisal. Staff felt they were effective and a development plan completed. The PDR appraisal target for the trust was 90%; information provided by the trust showed that 84% of community nursing staff and 74% of staff in the community units had completed an appraisal.

### Multi-disciplinary working and coordinated care pathways

- Staff informed us they attended the GP Gold Standard meetings. This is where patients with end of life care needs were discussed. The Gold Standard Framework allowed patient's care to be discussed to ensure their needs were met.
- The individualised care plan for adults was a multi-disciplinary document which was to be used for terminal patients. The document highlighted that different professionals needed to be involved when commencing the plan. We observed six individualised care plans, however only one was completed with different disciplines completing the paperwork. With the remaining five care plans, only registered nurses had completed the paperwork.
- Both the community units and community teams linked with the local hospice and palliative care team. Staff found this very helpful and could contact them at any time.
- Physiotherapist and occupational therapists were involved with patients on the community units and supported patients with equipment needs, if they were to be discharged home.



## Are services effective?

- The community teams shared buildings with mental health professionals and social services colleagues and staff provided advice and discussed patients who required their input.
- The community matrons held monthly meetings where they met with the community physician to discuss patient care and prescribing matters.
- The Health Village locality team were the pilot site to test a new model of care which included GPs, community physician, community matrons, district nursing, mental health professionals, therapists, social care workers and the voluntary sector. The services were co-located in the same building in order to promote integrated working.

### Referral, transfer, discharge and transition

- All patients were referred through the care coordination centre as a single point of access. The referrals were triaged by registered nurses and sent to the appropriate community nursing team. Patients accessed the same phone number which was based at the care coordination centre.
- Some community teams identified a triage nurse who managed incoming calls and referrals from the care co-ordination team (CCC). This allowed other staff to concentrate on visiting the patients. Staff within the triage role would often take less patient visits to complete the role, however this was not sometimes possible. Community nursing teams informed the CCC of patients that required end of life care who may contact the service out of hours.
- Patients that were admitted to Oakwood Community Unit from the acute trust received a discharge letter to allow staff to be up to date with the care provided.
- Oakwood Community Unit received referrals from various services such as GP, specialist nurses and community nurses.
- Both community units had an admission criteria that identified which patients were suitable. At BreathingSpace, it identified that palliative care was provided for respiratory patients. On the Oakwood Community Unit criteria, it did not identify that patients could be admitted for end of life care needs, however we observed during inspection they could be admitted.

- All community teams and units worked closely with the palliative care team and local hospice to facilitate seamless discharge for patients. Staff we spoke with felt they could refer to the specialist palliative care team at any time.

### Access to information

- Community staff used laptops during their patient visits to record information onto the patient's electronic record. In most areas staff could access the record, however in areas where connectivity was poor staff could access another application on their laptops to upload the information. This allowed up to date information to be recorded. The specialist palliative care team could review information documented by the community nursing teams, if a patient was admitted to hospital. However some other wards and areas would not have access to this information, such as accident and emergency.
- The trust were in the process of completing an electronic clinical information portal. This allowed community staff to access the system to identify if a patient had been admitted to hospital and which ward they were currently on. We saw community nurses access the system and plan the care required for discharge home.
- Both the community units could access the same patient electronic record which allowed patient's information to be accessed when they transferred between services.
- Most GP surgeries used the same patient electronic record which allowed both the community nursing teams and GP to see the progression or deterioration of a patient. We saw patient electronic records where the GP had reviewed information documented by the nurses and acted in response to provide further medication to provide symptom management.
- The patient's electronic record included the Electronic Palliative Care Co-ordination system (EPaCCS) which allowed the recording and sharing of people's care preferences and key details about their care at end of life. We looked at ten patient records and six records did not contain any information in the EPaCCS document.
- On one patient's electronic record it identified that the individual care plan for adults was commenced but the document was not scanned onto the system following the patient's death. This meant that information on the document was missing from the patient's record.

## Are services effective?

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

- We reviewed 19 do not attempt cardiopulmonary resuscitation (DNACPR) forms within the community, BreathingSpace and Oakwood Community Unit. Five of the DNACPR forms were completed at BreathingSpace by the nurse consultant in line with the trust's policy and two were observed in the community. All seven patients had the capacity to understand the decision made and the DNACPR forms reflected this and all seven forms were completed appropriately.
- We reviewed 12 DNACPR forms at Oakwood Community Unit during the announced and unannounced inspection. In all 12 patients it was identified that they did not have capacity to understand the decision made for DNACPR. In 11 of the forms and medical records there was evidence that discussion had taken place with family members regarding the DNACPR decision, although one had documented they had discussed the decision partially. In ten of the records no assessment for mental capacity had been completed and there was confusion on the unit where these would be kept. One staff member felt they would be at the front of the medical notes and another thought they would be on the patient's electronic record. In one of the records the mental capacity assessment had been incorrectly completed identifying that they did not complete the forms. At the best interest meeting the error was identified and rectified.
- During the unannounced visit we reviewed one of the DNACPR forms for a patient that did not have capacity. The DNACPR and medical notes documented that discussion with the family had occurred on a specific date, however the DNACPR form was not signed until six days later. This meant DNACPR forms were not completed accurately and timely.
- We observed that all the DNACPR forms were at the front of the patient's medical or nursing notes and clearly visible.
- Staff were aware of which patients in the community units had a DNACPR in place. Within the community, there was a place to record and scan the DNACPR information on the patient's electronic record. However this was not always completed.
- Community matrons have completed comprehensive training in order to complete DNACPR forms. Staff identified that they referred to medical colleagues if the patient lacked capacity to be able to make an informed decision. One matron told us what information they provided to the patient and family when completing the form. Two DNACPR forms had been completed by the matrons.
- Some community staff felt that the medical staff would make the decision when a patient required a DNACPR. We visited two patients whose medical condition required them to be on the GP's Gold Standards Register and discussed at multidisciplinary meetings.
- The trust's DNACPR policy stated resuscitation officers would audit DNACPR documentation annually in January. At the time of inspection, the trust were unable to provide the most recent DNACPR audit and action plan.
- We observed staff carrying cards that identified the five mental capacity act principles and most staff said they used the card to identify if a patient had capacity. However they did not complete the mental capacity forms, if it was identified that they did not have capacity. Within the community teams staff used the electronic record to document the patient's cognitive impairment. Some staff were confused about the forms and felt that the mental capacity forms and safeguarding forms were the same.
- We observed that staff obtained consent before performing any observations or providing patient care.

# Are services caring?

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

## Summary

When we inspected the service in February 2015, we rated caring as good.

At this inspection, we also rated caring as good because:

- We observed staff providing compassionate and supportive care within the home and ward environment.
- We observed staff maintaining privacy and dignity of patients when providing care.
- Patients were encouraged to be involved in decision making about their end of life care needs. Staff communicated well and worked together to plan the care and treatment.

## Detailed findings

### Compassionate care

- We observed staff providing care and saw that they were respectful and caring to patients. Privacy and dignity of the patient was maintained during the interactions.
- Staff were sensitive and compassionate in the way they discussed aspects of care with the patient and family. Staff engaged with patients to introduce themselves and listened compassionately to patient concerns.
- We looked at the friends and family test results for both community units and community nursing teams for the period February 2016 to August 2016. We found that over 100% of patients recommended the service provided in the community units. Within the community nursing teams this ranged between 97% and 100%.
- We spoke with five patients receiving end of life care and relatives. All spoke positively of the care they received. Patients described staff as being very helpful and supportive of their needs. One carer commented that they felt their family member was well cared for in their absence.

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

- We spoke with six patients who all said that they were involved and participated with their care.
- We observed staff involving patients in their care in a way they could understand.
- Patients commented that they felt involved in their care and described being included in the decision making about treatments they received.

### Emotional support

- Staff were supportive to patients and showed empathy and compassion during their procedures.
- We observed people's emotional needs were assessed as routine as part of the end of life care.
- We observed staff interacting with patients and relatives in a supportive and reassuring manner.
- We heard good examples of staff providing additional emotional support to patients. For example, a memorial service was held each year on BreathingSpace for patients who had died. Relatives and carers of patients who had died were invited to this. We saw an order of service booklet for the service and staff explained that all relatives were given a bookmark and a 'forget me not' tag which they could attach to a memory tree which was located in the main atrium of the unit.
- Community teams provided bereavement support for relatives. Staff told us that they felt that it was important to help the family too when patients required end of life care.
- Oakwood Community Unit liaised with local undertakers that patients had chosen themselves.

# Are services responsive to people's needs?

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

## Summary

We carried out this inspection because when we inspected the service in February 2015, we rated responsive as requires improvement. We asked the provider to make improvements following that inspection.

At this inspection, we rated community end of life care as good for responsive because:

- The implementation of the care co-ordination centre allowed patients to access a professional at any time.
- Community nursing teams ensured they saw patients with end of life care needs and prioritised deteriorating patients.
- Senior staff in all community settings completed fast track forms; this enabled care to be put in place quickly for patients whose condition was deteriorating and may have requested their preferred place of death at home.
- Patients could be admitted onto the community unit 24 hours a day.
- Services were planned in a way to meet the individual's needs and the local population.

However, we also found that:

- Preferred place of care was not consistently recorded or monitored.

## Detailed findings

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

- Visiting hours on the community units were flexible to meet the needs of the patients and their condition.
- Community staff referred patients to specialist nurses and to the local hospice where a community palliative care team were based. We were told at inspection that there were no delays in sending or receiving referrals.
- The trust worked in partnership with the local hospice who provided ongoing support, advice and accessibility over a 24 hour period. The trust had forged a strong working relationship with the doctors in the local hospice and worked together to develop the individualised care plan for adults.

- The care coordination centre was developed to allow patients and health professionals to enable a single point of access and to be triaged to the correct service.
- Bariatric beds were available for patients following an assessment and referral to other areas of the trust.

### Equality and diversity

- The translation services available were provided as a full 'one stop shop' service for all interpretation and British Sign Language requirements. Both telephone and face to face translation services were available for staff to utilise.
- Staff told us during the inspection that they had used translation services effectively. Staff were aware of how to book the service and commented that they had been able to book the service within 24 hours. Staff informed us that leaflets could be printed in various languages as needed.
- Patients in their own home accessed their own spiritual advisor of their own faith. Part of the individualised care plan for adults, allowed staff to document what the patient identified as important to them. This included specific spiritual, religious or cultural needs.
- We looked at six individualised care plan for adults records, four had been partially completed however only one had been fully completed and signed by the assessing clinician. Two records contained no information regarding religious preferences or choice.

### Meeting the needs of people in vulnerable circumstances

- On Oakwood Community Unit there was a board dedicated to dementia awareness. Staff in both units used the 'forget me not' scheme for patients living with dementia and we saw evidence that the scheme was in place.
- The trust had a dementia strategy in place. This included training to increase the awareness of dementia and increasing the number of dementia champions. One staff member had completed training up to level 2 in line with the strategy and staff on Oakwood Community

## Are services responsive to people's needs?

Unit told us they attended dementia awareness training. Information provided by the trust showed that both community units and community nursing teams had exceeded the trusts target of 66% for dementia training.

- We observed the 'this is me' document in one patient's record in Oakwood Community Unit. The document was completed prior to admission by family members and identified the patient's likes, dislikes and preferences.
- During the inspection we saw staff respond to a bereaved patient with learning disabilities. They were visited the same day of the bereavement to provide support and review the new care needs that were required.

### Access to the right care at the right time

- Information provided by the trust identified that 115 visits were rescheduled between March to August 2016. The lowest month was August 2016 where 13 visits were rescheduled and the highest month was May 2016 where 31 visits were rescheduled over the whole of the community teams. Staff contacted more stable patients to ask if an alternative day could be arranged. We were assured that the visits that were rearranged were support visits which were weekly or less frequent and not patients whose condition was deteriorating. We saw that staff documented why the change was required and completed in their electronic record.
- Staff in the community and on the community units completed fast track forms; this enabled care to be put in place quickly for patients whose condition was deteriorating and may have requested their preferred place of death at home. However, preferred place of care was not consistently recorded or monitored.
- Preferred place of death was not completed in three out of six of the individualised care plan records, although

the locality lead felt that this would be picked up within the records audit completed every 12 weeks. Within the records audit completed in October 2016 it highlighted that in 16 patient records end of life requests had been discussed. In four patient records this had not been discussed.

- Staff on BreathingSpace explained that they were able to arrange for patients to visit the local hospice, or for the hospice staff to visit them on the unit if they were approaching the end of their life and their preferred place of care was the hospice.
- The nurse practitioner and medical staff could admit patients to Oakwood Community Unit at any time of the day.
- Oakwood Community Unit had a waiting list for patients to be admitted to the ward at times, however they prioritised patients who required end of life care. The palliative care team and community teams also contacted the unit for a direct admission.

### Learning from complaints and concerns

- Patients we spoke with were aware of how to raise a complaint, but did not need to complain about the service. Staff in both the community units and community nursing teams felt that they had a low number of complaints. We looked at community nursing minutes which discussed any complaints.
- We saw complaints discussed in end of life meeting groups, these specific complaints did not relate to patients receiving end of life care in the community however showed that complaints were shared between and acute and community services.
- Information was displayed on the community units about how to raise concerns.

# Are services well-led?

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

## Summary

We carried out this inspection because when we inspected the service in February 2015, we rated well-led as inadequate. We asked the provider to make improvements following that inspection.

At this inspection, we rated community end of life care as requires improvement for well-led because:

- The trust were not meeting their five year strategy and still required to build on the work they had commenced. Areas where they needed to improve were advanced care planning and implementation and embedding the individualised end of life care plan.
- Not all risks were included on the risk register such as advanced care planning and the limited use of the individualised end of life care plan for adults.
- There had been insufficient action taken since the previous inspection to ensure that DNACPRs were completed appropriately for patients who lacked capacity and mental capacity forms and assessments were not completed.
- Although there was an improvement in staff morale, staff still said they did not feel valued or that their skills were being recognised in community services.
- Communication between managers in the acute and staff in community services had improved, but further improvement was needed with community staff who still felt disconnected. Community nursing staff we spoke with said they felt the link between them and the senior management team had deteriorated since the deputy head of nursing had left.

However:

- Community staff would attend the end of life operational group meetings and this would be cascaded down to other staff.
- A dedicated week was arranged to look at end of life care provided in the community and an action plan created. Staff were involved in the creation of packages and training to support staff.
- Staff felt supported by their immediate line managers.

## Detailed findings

## Leadership of this service

- Community nursing teams and both community units were part of the integrated medicine division directorate. Senior managers informed us that this ensured there was integration between acute and community services. End of life care was provided as part of the care provided by the community teams. Staff based within the acute hospital provided support for staff within the community.
- The head of nursing managed both the acute and community services. However many staff were unfamiliar with this role or other senior roles within the integrated medicine directorate. Staff were more aware of the deputy head of nursing whose role was primarily in the community. The deputy head of nursing for community had left the position recently and most staff we spoke to identified that this was a key link to keep the trust up to date with community matters. The trust had been unsuccessful at appointing to the vacant post and an interim of two community matrons fulfilled the post on a temporary basis which would start in October 2016. Part of their role was to recommence and attend meetings that had previously been attended by the deputy head of nursing and build the link again between the acute and community services. Staff felt optimistic that this would happen. We saw that the head of nursing thanked the locality leads in the community teams for the work they created for end of life care.
- Each locality area was led by a locality lead and clinical matron. Their role was to provide leadership and manage an area of community nurses. Staff in the community felt the introduction of locality lead posts in the areas had made a difference. Staff commented that they felt more cohesive and joined together.
- We spoke with district nurse sisters who understood the importance of staff attending training for end of life care. However, at times, training had been cancelled due to the amount of patients that needed to be visited.
- In April 2016 a review of end of life care took place within the community teams. It was identified that staff were not confident with what training they should have

## Are services well-led?

completed or with how to use the individualised care plan for adults. As a result of the findings an intensive support week took place with the senior managers in the community to look at actions and agreed priorities.

- Staff we spoke with were aware of the senior executive team and commented that they had seen the Chief Nurse at community bases.

### Service vision and strategy

- The trust had a five year strategy for end of life care that was launched in October 2014. This was based on the five priorities of care in the final days or hours of life recommended by the Leadership Alliance for the care of Dying People. The document was based on national key guidance and incorporated the trust's aims and objective in how to achieve the strategy. Within the strategy, it prioritised care in the final days or hours to be recognised, decisions to be made and an individual plan of care to be agreed and delivered. Further work needed to be completed in regards to achieving the strategy in terms of advanced care planning and embedding the individualised end of life care plan for adults.
- An end of life care strategy group was in place which was attended by the staff from the hospice, clinical commissioning group and trust colleagues.
- We saw the trust's vision and values displayed in both the community units we visited; in addition to this, we saw unit philosophies and mission statements for both Oakwood Community Unit and BreathingSpace.
- The trust had a community services vision to change community based healthcare for Rotherham. It was based around local teams from health and social care working together to provide care closer to, or at home. This included community end of life care and looked at providing the care within the patient's home in conjunction with other services.

### Governance, risk management and quality measurement

- There had been insufficient action taken since the previous inspection to ensure that DNACPRs were completed appropriately for patients who lacked capacity and mental capacity forms and assessments were not completed.
- There was an end of life adult operational group that met every month. The information from the group was reported to the patient experience group. The

operational group was composed of staff members from both the acute and community services. We looked at four set of minutes and community representation was at three of the meetings. The group discussed community end of life items and ongoing issues.

- Monthly quality standards and governance meetings took place with the lead matron for community, governance co-ordinator and locality leads. Within the meeting the group identified if any new risks were required to be added to the risk register and patient safety issues were discussed.
- Meetings were held with the locality lead and district nursing leaders every two months where local issues and discussions took place. We saw evidence that end of life care was discussed at these meetings.
- Business and governance meetings were in place on the community units. These meetings were planned to take place each month, however we saw that several of these meetings had been cancelled and there had only been one meeting for BreathingSpace and two for Oakwood Community Unit between April and August 2016.
- The trust provided us with a current end of life risk register; three risks were identified with the latest one added in April 2016 which all related to acute palliative care services. These included staffing in the palliative care team, no designated cancer unknown primary (CUP) nurse and patients may not have received counselling due to no CUP nurse in place. The limited use of the individualised care plan was not documented on the register or the results from the audit of deaths within 24 hours where recommendations were required such as advance care planning.

### Culture within this service

- The trust had adopted a 'star card' scheme. This allowed any staff member to electronically send a card that they could write their own personal message on. Staff showed us copies of the star cards they had received. This helped them to feel supported and felt that they mattered as a staff member. Also all staff could write to the Chief Executive who would respond.
- Oakwood Community Unit felt that it was integrated with both the acute and community services and community matrons visited the ward with any aspect which included end of life care.
- Staff felt that they had been involved locally with changes made to the services. A hot topic board was

## Are services well-led?

created in each community nursing team. This provided information about end of life care which staff could utilise to enhance patient care. The topic would remain in place for a period of six months.

- Staff felt supported by their immediate managers, within the focus group community staff still felt the focus was on acute services and not on community. However some people in the focus group did feel the trust was working towards becoming more integrated. We observed in minutes of meetings that information was provided regarding end of life care; however staff noted that it did not mention community care.
- Staff felt supported to undertake further training for development, for example registered nurses who wanted to progress to become a district nurse sister / charge nurse were encouraged to take on a new role for one year. Staff commented that this role was very effective and helped them advance their skills and competencies in relation to providing patients with effective end of life care; however funding was no longer available to finance the programme any further.
- We spoke with two student nurses on placement within the community nursing teams who identified that they were supported by staff with their learning and had found the experience supportive.

### Public engagement

- Quality assurance walkabouts were conducted in the acute and community settings to obtain feedback from patients and carers. A new process had been implemented for community services in that two out of the six monthly reviews focused entirely on community. The results of the walkabouts were fed back to staff and discussed at the patient experience group.
- Community nursing services and both community units participated in the Friends and Family Test but not any bespoke surveys.
- In minutes provided by the trust it was noted that figures for patient experience feedback was lower than the required amount of 50 patients per month in community nursing.

### Staff engagement

- One locality area piloted the individualised end of life care plan for adults, we were told by the trust that feedback was gained from the community staff and used to improve the document. The information was fed back into the End of Life Care Operational Group.

- Staff within the community nursing teams were involved in workshops that focused on end of life care. Within these sessions an end of life package was created and a standardised approach to the documentation was agreed for use when caring for a patient at end of life in their own home. The locality lead took responsibility for any changes to the package and identified that this would be looked at every three months.
- A 'day to celebrate' was held three times a year and provided an opportunity for teams to present information regarding any innovations and developments that they were proud of. At the last 'day to celebrate' the community teams presented the developments and improvements in relation to end of life care. Any staff member could attend and the trust identified that the celebration was well attended.
- BreathingSpace is recognised locally and nationally as a training centre for respiratory nurses, with Education for Health and University of Sheffield commissioned courses supported by a strong working relationship with the Rotherham Respiratory Group.
- The trust had completed 'listening into action' sessions to listen to the staff and to adopt plans of action.

### Innovation, improvement and sustainability

- The community matrons and advanced nurse practitioners completed DNACPR forms which allowed staff who saw the patient most often to begin difficult and open discussions.
- The trust was piloting a new model of care within the Health Village locality which the trust felt would transform the way care was delivered. It adopted a multiagency approach and the locality had integrated more closely with various care partners. The pilot commenced in July 2016 and it was envisaged that the method would be rolled out to the other six localities by the end of 2017.
- BreathingSpace remained the only entirely nurse-led model of care for respiratory in and outpatients in Europe.
- BreathingSpace had received lung improvement project approval from the Department of Health to look at the eligibility of COPD for the Gold Standards Framework. The initial tranche of this work was presented at the



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European Respiratory Society in 2010 and the follow up work at the Association of Respiratory Nurse Specialists in 2014, where it won the prize for best poster presentation.

- BreathingSpace had promoted the service through publications, presentations and posters. The service

had been collaborating with partners in London regarding research and had applied for recognition of the pre and post-surgical pulmonary rehabilitation programme.

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

Treatment of disease, disorder or injury

#### Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

**Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

How the regulation was not being met:

DNACPRs were not completed appropriately for patients who lacked capacity and mental capacity forms and assessments were not completed.