

Torbay and South Devon NHS Foundation Trust

RA9

Community end of life care

Quality Report

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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)
RA954	Brixham Hospital	Brixham Hospital	TQ5 9HN
RA956	Dawlish Hospital	Dawlish Hospital	EX7 9DH
RA957	Newton Abbot Hospital	Newton Abbot Hospital	TQ12 2TS
RA958	Paignton Hospital	Paignton Hospital	TQ3 3AG
RA979	Totnes Hospital	Totnes Hospital	TQ9 5GH







This report describes our judgement of the quality of care provided within this core service by Torbay and South Devon 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 Torbay and South Devon NHS Foundation Trust and these are brought together to inform our overall judgement of Torbay and South Devon NHS Foundation Trust

Summary of findings

Ratings

Overall rating for the service	Requires improvement	
Are services safe?	Requires improvement	
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 we rated the trust as requires improvement for community end of life care services. They required improvement in order to be safe, effective and well-led although were good in relation to being caring and responsive.

- There was poor completion of treatment escalation plans (TEPs), particularly within the community hospitals where more than half of those we reviewed had not been completed in line with trust policy in relation to recording of do not attempt pulmonary resuscitation (DNACPR) decisions.
- Where patients did not have capacity to be involved in decisions about resuscitation we saw inconsistent recording of mental capacity assessments and we did not see best interest discussions with relatives being recorded.
- At Brixham and Totnes community hospitals healthcare assistants were checking controlled drugs and syringe drivers without being trained or competency assessed.
- There was inconsistent end of life care training for registered nursing staff working in the community hospitals with some having received training in the end of life care resources while others had not
- Not every community hospital had end of life care link nurses.

- There was no trust-wide community and acute multi-disciplinary meeting
- There was no end of life care strategy in place that described the priorities for the trust as an integrated organisation, the future structure of services and how they were going to move forward in terms an integrated end of life care service.

However:

- We saw evidence of good local leadership of wards, community nursing teams and the end of life care service.
- There was good use of audit and evidence of learning from incidents being used to improve performance.
- There was a passion and commitment among the trust staff to deliver high quality end of life care. Staff were seen to be caring and compassionate and focused on patient choice and involvement in their care. Relatives and people close to those at the end of life were supported.
- We saw a particular example of outstanding practice in the development of a carers course where people caring for loved ones with life limiting illnesses could access an ongoing support group.

Summary of findings

Background to the service

Torbay and South Devon NHS Foundation Trust community end of life care was provided by nine community nursing teams and in nine community hospitals across Torbay and South Devon. Community specialist palliative care services were provided by the local hospice via a service level agreement. This included specialist palliative care clinical nurse specialist (CNS) input for each of the nine localities and a community consultant in specialist palliative medicine.

The specialist palliative care team (SPCT) provided support and advice for patients with complex needs and symptom management issues at the end of life. Between April 2014 and March 2015 there had been 150 deaths across the community hospital sites. Between January and December 2015 the community nursing teams supported 524 patients at the end of life being cared for at home in Torbay. The trust was unable to provide data for the number of patients at the end of life being supported by community staff at home across Southern Devon.

The trust itself had a palliative and end of life care team for the community that consisted of a whole time equivalent (WTE) strategic lead, a WTE specialist palliative end of life care tutor/assessor, two 0.2 WTE end of life care home facilitators and a 0.72 WTE service co-ordinator/administrator. The role of the trust's palliative and end of life care team for the community was to assist the

delivery of generalist palliative and end of life care to ensure a consistent approach across the trust. A primary focus of this had been on the development of good quality end of life care tools and resources across all parts of the community.

During our inspection we met with the palliative and end of life care team for the community and visited five of the nine community inpatient hospitals; Dawlish, Paignton, Newton Abbot, Brixham and Totnes. We also visited three patients in their own homes where we observed care being delivered by district nurses and spoke with patients and their relatives. In addition we met with three of the nine community nursing teams. In total we spoke with eight patients and four relatives. We spoke with the end of life strategic lead, the end of life tutor/assessor, an end of life care home facilitator and two of the specialist palliative care nurses from the local hospice. In addition we spoke with community inpatient staff including matrons, ward managers, GPs, physiotherapists, occupational therapists, ward nurses, health care assistants and ward clerks. In total we spoke with 55 staff, eight patients and four relatives. We looked at the records of eleven patients identified as receiving end of life care and 26 treatment escalation plans (TEPs) that included records of DNACPR (do not attempt cardiopulmonary resuscitation) decisions.

Our inspection team

Our inspection team was led by:

Chair: Tony Berendt, Medical Director, Oxford University Hospitals

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team inspecting the end of life services included a CQC inspectors and two specialist advisors who all had experience of end of life care.

Why we carried out this inspection

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

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?

We undertook an announced inspection of Torbay and South Devon NHS Foundation Trust on 2-5 February 2016.

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. During the visit we held focus groups with a range of staff who worked within the service. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider say

Patients and relatives we spoke with told us they were highly satisfied with the quality of care they received and that staff treated them with respect and maintained their dignity.

Specific feedback included a relative who told us the support they received from the community nursing team during the time that their loved one was dying had helped them to feel like they were being 'carried' and that staff had shown them incredible kindness.

Good practice

We saw a particular example of outstanding practice in the development of a carers course where people caring

for loved ones with life limiting illnesses could access an ongoing support group. Feedback from this was positive and described by carers as helping them to feel valued and better able to cope with their situation.

Areas for improvement

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

Action the provider **MUST** take to improve

- Ensure that treatment escalation plans and do not attempt resuscitation decisions are appropriately completed and recorded in line with trust policy and that audits of these lead to measurable action plans used to improve performance.
- Ensure that healthcare assistants checking controlled drugs and syringe drivers is risk assessed and that training is provided and they are competency assessed.
- Ensure that patients who do not have capacity to be involved in decisions about resuscitation have a

clearly recorded capacity assessment along with clearly documented best interest decisions and a detailed record of all discussions with the patient and family members.

Action the provider **SHOULD** take to improve

- Ensure that all ward nurses are trained in the use of the end of life care resources.
- Ensure that symptom management training is available to nursing staff and that symptom management tools such as pain assessment tools are consistently used to support care.

Summary of findings

- Ensure that staff working in areas where end of life care may be an infrequent occurrence such as community hospital wards are appropriately and proactively supported to develop their skills in end of life care and/or to care for patients at the end of life.
- Ensure that the end of life link nurse/ward champion programme is reviewed with a view to all hospital wards having representative attendance at regular meetings and training events.
- Ensure that data is routinely collected and analysed on the trust's performance against preferred place of care wishes of patients at the end of life.
- Ensure that a strategy for end of life care is developed, to include clear strategic priorities and a structure to support its implementation.
- Consider a trust wide multi-disciplinary meeting so that patients are reviewed across the whole end of life care pathway within the trust on a regular basis.

Torbay and South Devon NHS Foundation Trust

Community end of life care

Detailed findings from this inspection

Requires improvement



Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated end of life community services as requires improvement because:

- There were incidents relating to the poor completion of treatment escalation plans (TEPs) where do not attempt cardiopulmonary resuscitation (DNACPR) decisions were recorded. We saw that action had been taken in relation to this, however, we saw it continued to be problematic for community staff.
- Of the 27 TEPs we viewed 56% did not include a record of clinical information and reasoning.
- The trust policy for the use of TEPs stated that all patients in community hospitals would have a TEP completed on admission however we saw that this was not consistently happening and in one case a patient with a clear record from their own GP stating they did not want to be resuscitated did not have a TEP in place.
- At some of the community hospital sites healthcare assistants were checking controlled drugs including those administered via a syringe driver without being appropriately trained or competency assessed.

However:

- There was good evidence of incident reporting, learning and improvement and staff were consistently aware of reporting procedures.
- We saw that medicines were generally managed safely in relation to end of life care, including the use of just in case anticipatory medicines to support the management of symptoms quickly and effectively in the community.

Safety performance

- A range of safety performance was being monitored over time. For example we saw that safety thermometer information was reported by each inpatient ward every month.
- We viewed quality and safety professional practice reports and saw that the percentage of harm free care in the community hospitals ranged between 86.8% and 90.3% between October 2015 and January 2016. We saw a range of reporting data displayed in each of the community hospitals we visited and this was compiled into safety performance reports for the trust's Community Health and Social Care Divisional Board.
- Safety performance data included information relating to urinary tract infections, falls and pressure ulcer prevention.

Are services safe?

Incident reporting, learning and improvement

- Staff delivering end of life 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.
- The end of life strategic lead told us they were informed of all end of life care related incidents and involved in the analysis and review. Examples of incidents we were informed of included medicine or prescribing errors, incomplete documentation and issues with syringe drivers. For example we reviewed an incident report where an error with a syringe driver in the community had led to medicines being administered at the incorrect infusion rate. As part of the root cause analysis it was identified that syringe driver training for nursing staff was too infrequent with problems with inaccessibility. As a result, the training was brought in-house to be delivered on site at all ward and community locations.
- Incidents were investigated with the involvement of relevant staff and we saw that they were given time to reflect and learn. Staff told us they were involved in discussions about incidents, risks and complaints were discussed and they were encouraged to reflect and learn.

Duty of candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a new regulation which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined threshold
- Staff were aware of their responsibility in relation to duty of candour and being open with patients and their relatives when incidents occur. We saw that the incident reporting forms used included a section on the duty of candour and staff consistently told us that patients/relatives were kept informed when incidents occurred.

Safeguarding

- Systems were in place to protect people in vulnerable circumstances from abuse. Staff were knowledgeable about their roles and responsibilities in relation to ensuring vulnerable adults and children were

safeguarded. Staff understood what constituted a safeguarding concern and we observed staff discussing safeguarding in safety briefings on the community inpatient wards and within the community nursing team meetings.

- 100% of the members of the palliative and end of life care team for the community had attended safeguarding training relevant to their role in relation to both adult and children's safeguarding.

Medicines

- Medicines in the community hospitals were stored safely.
- 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.
- We visited patients in the community who had anticipatory medicines prescribed and these were available and stored safely in their home in 'just in case bags' for when they were required. We viewed audits relating to the use of these bags and saw that their usage was monitored, including the expiry dates of medicines.
- The trust had produced guidelines for medical staff to follow when prescribing anticipatory medicines together with the local hospice and these were incorporated into end of life care documentation. Staff told us that GPs providing medical support in the community and community hospitals all had copies of the guidance.
- Nursing staff in the community told us there had been some challenges in terms of appropriate prescribing of just in case medicines and syringe drivers in the community. They detailed a number of measures taken by senior staff to ensure communication with GPs supported ongoing prescribing in line with the documented guidance. Action taken included staff taking documentation to GPs in order for medicines to be properly prescribed. We saw that medicine incidents of this nature had been reported in line with the trust's incident reporting procedures, however we did not see evidence of audits of the quality of end of life care prescribing.
- Prescriptions and administration records we looked at in the community were generally completed clearly;

Are services safe?

including the times of administration of medicines prescribed 'as required'. However at Newton Abbot hospital we saw that a patient who was having regular oxygen therapy did not have this prescribed.

- Controlled drugs (medicines controlled under the Misuse of Drugs legislation and subsequent amendments) were stored securely with appropriate records kept. However, we were told that in Brixham and Totnes community hospitals sometimes there was only one trained nurse on duty. This meant that at night healthcare assistants could check the administration of controlled drugs. This would sometimes include syringe drivers. There was no evidence of healthcare assistants having undergone competency assessments for checking controlled drugs or syringe drivers.

Environment and equipment

- Inpatient and community services had access to appropriate equipment to keep people safe and comfortable.
- District nurses we spoke with told us they were able to access equipment for patients at the end of life in the community. This included syringe drivers as well as other types of equipment to enable them to care for people safely in their homes. Generally staff we spoke with told us that equipment would be delivered within a few hours when requested for patients at the end of life.
- In the community hospitals syringe drivers were obtained from a trust wide equipment library and these were accessible to community staff out of hours. Community nurses based in Torquay could access syringe drivers via the trust contract with an external provider where the drivers would be delivered along with a supply of consumable equipment. Community nurses based in South Devon had to a source their syringe drivers from the community hospitals and collect it themselves.
- Staff told us that equipment was accessible within a few hours for patients at the end of life who were being discharged via the fast track route.
- There was no mortuary or body store at any of the community hospitals and staff told us the procedure for the transfer of the deceased was to use community funeral directors. Staff told us this system worked efficiently and they had not experienced delays in collecting bodies.

Quality of records

- Community nurses in Torbay used an electronic record system that enabled sharing of patient information within the team and with other health care professionals.
- We looked at the care records of 11 patients and saw that comprehensive care plans were in place for patients in their own homes and those in community hospitals.
- We reviewed 25 treatment escalation plans (TEPs) across community inpatient units that included a record of do not attempt cardiopulmonary resuscitation (DNACPR) decisions. We saw some inconsistencies in the quality of records relating to TEPs and DNACPR decisions. Of the 25 we viewed all were kept in the front of the patient notes and had been signed. However, three had illegible signatures and were not supported with clear information about the name and designation of the clinician signing. All 25 forms had a clear record of the decision not to resuscitate, however 14 of these did not include clinical information and reasoning.
- There were inconsistent records of DNACPR discussions with patients, for example 11 of the 25 completed forms did not include a record of if the patient was involved in the discussion. Of those 11 there was a record of relatives being involved in the discussion in two cases. Discussions or decisions not to discuss were not recorded with sufficient detail in the patient's notes.
- In the community, TEP forms including DNACPR decisions were kept in a file in the patients home. We viewed three completed TEP forms for patients in the community where DNACPR decisions were recorded. These had been completed appropriately, however one had not been reviewed where the patient's condition had changed and another did not include a record of the discussion or decision not to discuss with the patient.
- The trust policy for the use of TEP forms in community hospitals stated that all patients would have a completed TEP, detailing whether they were for resuscitation or whether a DNACPR decision had been made. At Brixham hospital we saw four patient records where TEP forms had not been completed. This included a patient where there was a clear record in their notes that stated the patient did not wish to be resuscitated.
- Staff we spoke with in the community hospitals and district nurses consistently told us there had been some

Are services safe?

difficulties getting GPs to complete TEPs as part of routine patient clerking procedures. Senior staff were aware of this and had taken action to raise awareness of the need for completion. For example there was a lead GP for end of life care in the community who had a remit for educating other GPs about end of life care issues and this included the use of TEPs. In addition the end of life care strategic lead told us they would also go and speak with GPs to reinforce the need for TEPs to be completed.

- We saw that an audit of TEP form completion was included in the monthly safety thermometer information collated in the community hospitals. However, this information focused on whether a form had been completed and whether the patient had been involved in the discussion rather than a detailed audit of the quality of the completed document.
- We viewed an audit of TEP forms used in patient's homes carried out in December 2015. This was a retrospective audit from the community nursing teams across all nine localities. Of the 27 records included in the audit there were 16 where TEPs had not been completed. Of those 16, seven were identified as patients where a TEP would have been appropriate and three were identified as patients who had a TEP but it was not in the patient's notes. An action plan as a result of the audit stated the results would be fed back to individual teams via the leads and that advance care planning training that included the use of TEPs would be encouraged. We did not see specific actions with completion dates recorded.

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 PPE (personal protective equipment) to take out with them.
- Staff working in community hospitals had access to personal protective equipment (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 the type and level of training was identified as part of individual job roles. Members of the end of life care team had undertaken training in areas such as infection control, resuscitation, conflict resolution and information governance. All members of the team were up to date with their mandatory training.
- Syringe driver training was identified as mandatory for all community nurses and registered nurses working in the community hospitals following a training needs analysis from May 2015. We viewed records that showed 72 nursing staff working in the community had attended syringe driver training in the last year and all nurses we spoke with confirmed they had attended training.

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 general 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.
- Specialist palliative care was provided from 8am to 5pm five days a week via a service level agreement with the local hospice. 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 the hospice including consultant input.
- We observed safety briefings both in the community hospitals and within the community nursing teams and saw that risks to patients were discussed as part of a routine review of their care and ongoing evaluation. Safety briefings included issues relating to DNACPR decisions and end of life decisions.
- 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 being cared for at home. One patient in the community told us they had needed to access support out of hours when their syringe driver had alarmed and they said nursing staff had been with them very quickly, in less than half an hour.

Staffing levels and caseload

Are services safe?

- Staffing levels were sufficient to ensure that patients generally received safe care and treatment. End of life care was provided in the community and on the nine inpatient units across Torbay and South Devon.
- Specialist palliative care nursing input was provided via a service level agreement with the local hospice. There was a clinical nurse specialist allocated to each locality, including community nursing teams and community hospitals.
- Medical cover in the community hospitals was provided by GPs. There were different contractual arrangements in place depending on the size of the community hospital. GPs in the locality attended annual palliative care/end of life care updates and there were end of life care lead GPs in the community who had a role in sharing best practice and training other GPs. GPs could access advice from palliative care consultants based at the local hospice or at Torbay hospital.
- The community SPCT was divided into nine teams supporting each of the nine community nursing teams and community hospitals and they provided cross cover for leave.
- Staff we spoke with told us their caseloads were manageable and ward staff told us they had sufficient staff to deliver good quality end of life care. However, at Totnes and Brixham hospitals we saw that there was sometimes only one registered nurse on shift overnight which meant that healthcare assistants were required to check controlled drugs and syringe drivers without having been trained or competency assessed.

Managing anticipated risks

- Staff told us that major incident and winter management plans were in place.
- Emergency equipment was available on the community inpatient units at all of the community hospitals we visited.

Are services effective?

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

Summary

We rated community end of life care as requires improvement in order to be effective because:

- There were some inconsistencies in terms of symptom management, for example in a patient with breathlessness where trust guidance had not been followed and the use of morphine had not been considered.
- In the community hospitals there was an emphasis on the identification of patients considered to be in the last few days of life. However the tools in use were limited in terms of identification of patients in the last few weeks or months of life where there may be an opportunity work more proactively to support patients sooner.
- There was guidance in place to manage patient's symptoms at the end of life and we saw evidence of the use of audit tools in relation to the use of the end of life care plan. However, this did not include an audit of effective symptom management or prescribing.
- Where patients did not have capacity to be involved in decisions about resuscitation we saw inconsistent recording of mental capacity assessments and we did not see best interest discussions with relatives being recorded.

However:

- We saw that evidence based care and treatment was seen as a priority in terms of community end of life care.
- The trust had implemented a care planning tool based on the five priorities of care and had undertaken an initial audit and implemented training to address areas of identified improvement.
- Training for nurses in end of life care issues was available and we saw evidence of this being carried out in many areas. However there were some inconsistencies with this, for example where one community hospital had no staff having attended update training in the use of the end of life care resources.

- Patients we spoke to told us their pain was well managed and we saw that pain assessment tools were in use in the community and some of the community hospitals.

Evidence based care and treatment

- End of life care was delivered in the community using the trust's One Chance to Get it Right policy. The policy incorporated guidance from a number of national sources including the National Palliative & End of Life Care Partnership (2015), the Leadership Alliance for the Care of Dying People (2014), and the National End of Life Care Strategy fourth edition (2012).
- The end of life care team had developed, and was using, an end of life care plan for patients at the end of life. This had been implemented in response to the national withdrawal of the Liverpool Care Pathway (LCP) in July 2014.
- The end of life care plan was based on national guidance including the Five Priorities of Care (Leadership Alliance) and NICE QS13 Quality Standards for End of Life Care for Adults (2011). An action plan was incorporated into the document where eight care planning prompts were used including those relating to communication, meeting spiritual needs, providing family support, managing symptoms and maintaining a high standard of basic care. Care was being planned and delivered in line with this guidance for patients identified in the last few days of life across the community and in community hospitals. However, we saw some inconsistencies in how the plan was being used. For example we saw that a number of prompts used as part of the plan were sometimes used incorrectly in the evaluation of care and that the care was not always recorded in a way that reflected individualised care delivery.
- The Gold Standards Framework (GSF) was in use to support the development of good quality end of life care in the community across community nursing teams in each locality where nurses would attend regular GSF meetings with GPs and Hospice based community CNS'. The framework was used to help staff identify the needs

Are services effective?

of patients at each stage of their care through detailed assessment. We observed the Gold Standards Framework (GSF) in use throughout the community and saw that this was used as a tool to assess and identify where patients were in relation to the last year or the last days of life. The Gold Standards Framework is a model that enables good practice in the care of patients at the end of life.

- We did not see evidence of the GSF being used in the community hospitals. There was an emphasis on the identification of patients in the last days of life with a limited recognition of patients who were likely to be in the last weeks or months of life.

Pain relief

- There were tools available to assess and monitor pain. However we saw that these were not consistently applied across the community hospitals. For example, we saw them in use at Totnes and Dawlish hospitals but not at Brixham.
- Patients we spoke with told us their pain was well managed and that staff were quick to respond to requests for additional medicines when pain occurred.
- We observed community 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.
- Where appropriate patients had syringe drivers which delivered measured doses of medicines at pre-set times. All qualified nursing staff were trained in the use of syringe drivers.
- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were available as needed both during the day and out of hours.
- Just in Case Bags/boxes were available in community hospitals and in patients homes where it had been identified they may require medicines to manage their symptoms quickly in the near future. Community hospital nursing staff told us there had been no problems getting these prescribed by GPs. However, we were told by nursing staff that sometimes getting syringe drivers prescribed in the community could be difficult, particularly if the GP was unfamiliar with the patient.
- In the community hospitals we saw that anticipatory medicines were generally prescribed for patients who

may need them. However, we also saw an example of a patient who had symptoms of breathlessness where medical staff had not considered the use of morphine to manage the symptom in line with trust guidance.

Nutrition and hydration

- Nutrition and hydration needs at the end of life were identified as part of the trust's palliative care plan. Assessments incorporated patient choice and comfort and we saw that guidance was based on an individual's ability to tolerate food and drink.
- Patients and family told us they had access to food and drink in community hospitals as and when they wanted it. Staff were able to speak with catering staff and request food that patient's at the end of life wanted.
- We observed community nurses asking patients about their food and drink intake as part of their daily assessment when attending to renew a patient's syringe driver. This included asking the patient about their appetite, any symptoms likely to affect their nutritional intake and whether they had access to food they wanted to eat.

Patient outcomes

- The trust collected feedback from the family of patients cared for at the end of life using a bereavement survey format. This had been in place for a few months and we were told that responses were limited, however there was a plan in place to summarise and report on the responses annually.
- The community end of life services had not taken part in the care of the dying audit.
- The end of life care team had audited the 'one chance to get it right' documentation in August 2015. This incorporated a review of the five priorities of care and how they were being implemented/recorded. The audit was carried out as a baseline across community nursing teams and community hospitals. Results showed that community hospitals were scoring higher in terms of recording communication whereas community nursing teams were recording higher in terms of the completion of individualised care plans. The team had planned enhanced training in the areas identified and told us they would re-audit in six months.

Are services effective?

- The use of just in case bags in the community had been audited where these had been issued to GP surgeries. Of the forms returned 63% of bags had been used and 100% of patients had remained in their chosen place of care.

Competent staff

- Community nurses and nurses working on the wards in the community hospitals were able to access training in end of life care issues at the local hospice and there were core training areas that were being provided by the end of life care team within the trust.
- A training needs analysis had been carried out in 2015 to identify the training needs of nursing staff working in the community. Core end of life care training included syringe driver training for registered nurses, advance care planning and the use of treatment escalation plans, verification of expected death and training around the five priorities of care for the dying patient.
- The end of life care team had successfully developed and were delivering a level 3 City and Guilds course on end of life care for healthcare assistants working across the trust and in care homes within the community. During our inspection we spoke with two staff working in the community hospitals who were participating in the training and told us it was benefiting them and increasing their knowledge about end of life care issues.
- Members of the end of life care team told us they were hoping to develop a level 5 end of life care training course for registered nurses in the future and we saw this as an aspiration as part of the community training needs analysis.
- We saw that all nurses within the community end of life care team had received an annual appraisal and we were told that training and development plans were aligned to this process.
- A number of community nurses and those working in the community hospitals we spoke with told us they had attended training around the core areas identified as part of the training needs analysis. However, there were some local variations in this. For example nurses at Brixham hospital told us they had not attended training and we saw this evidenced when we viewed training records. In addition a number of staff in the community and community hospitals told us they felt they would benefit from training around symptom management.
- Some wards in the community hospitals had end of life care ward champions identified. Ward champions are

nurses or healthcare assistants who attend regular meetings and training updates and cascade these to other staff. Not all wards had champions and we spoke to one nurse who told us they were an end of life care champion but had not attended training and they were unfamiliar with the end of life care documentation.

- The end of life care strategic lead told us that previously end of life care ward champions had attended training and updates at the local hospice but that this was no longer the case and the trust were intending to bring it back in house.

Multi-disciplinary working and coordinated care pathways

- We observed multidisciplinary team (MDT) meetings within the community hospitals and the community nursing teams. Staff told us they would work closely with specialists and other teams to support good quality end of life care across the community. For example, staff told us that MDT meetings included allied health professionals such as physiotherapists and occupational therapists and other specialist staff such as tissue viability or diabetic nurse specialists.
- The specialist palliative care nurse in each locality met regularly with community nursing teams to discuss patient care as part of GSF meetings as well as outside of these meetings when required to provide specialist support. However, there were no MDT meetings within the community hospitals that were routinely attended by the specialist palliative care nurses and there was not a trust wide specialist palliative care MDT across the integrated acute and community service.
- The end of life care team and community nursing staff worked closely with local hospice services and we saw evidence of agreed local pathways and shared protocols, with patients moving between services effectively.
- Staff told us that the community based palliative care consultant attended the weekly urology cancer multi-disciplinary team meetings at Torbay hospital.

Referral, transfer, discharge and transition

- Patients were referred and transferred appropriately for end of life care and to their preferred place of death.
- The trust had a rapid discharge pathway in place for patients wishing to go home in the last days of life, the

Are services effective?

aim of the pathway was to ensure a timely and efficient discharge of patients wishing to spend their last few days at home. The trust did not collect data relating to this at the time of our inspection.

- End of life care specialist staff told us there was a clear pathway for referral to specialist palliative care services and community nursing teams told us they felt they had clear processes in place to ensure patients were referred appropriately for specialist support. For example, community nurses met regularly with the specialist palliative care nurse attached to their team with the exception of Brixham at the time of our inspection. However, staff in the community hospitals were less clear about the pathway. For example, while all staff were aware of the end of life care team within the trust and the availability of support from the local hospice not all of the nursing staff we spoke with knew who the specialist nurse was who was attached to their hospital. Therefore, while we saw that a referral pathway was in place for all services this appeared to be operating in a more proactive way with the community nursing teams than with the community hospitals.

Access to information

- We saw that risk assessments and care plans were in place for patients at the end of life. Patients were cared for using relevant plans of care to meet their individual needs.
- Once a patient had been identified as being in the last days of life staff would use the palliative care plan document. This guidance incorporated prompts for staff to assess patient symptoms, identify advance decisions, discuss spiritual needs and agree options regarding hydration and feeding.

- In the community paper records were kept in patient's homes and these were kept up to date during the visits we observed.
- An Electronic Palliative Care Coordination System (EPaCCS) was in use so that information about patient's care preferences and key details about their care at the end of life was available to community nursing staff, hospital staff and GPs. However, staff told us there had been an issue with GPs in the community not accessing the system.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff we spoke with demonstrated an understanding of the Mental Capacity Act 2005 and issues around deprivation of liberty safeguards.
- We viewed TEP forms involving the recording DNACPR decisions and saw there were eleven where patients were not considered to have mental capacity or where their mental capacity was unclear. We saw one completed and one partially completed mental capacity assessment.
- In Newton Abbot hospital we viewed the records of one patient who had been assessed as not having mental capacity at the time the decision not to attempt resuscitation was made. However, at the time of our inspection the patient had capacity but the DNACPR decision had not been reviewed or any discussion with the patient recorded.
- We did not see records of best interest decisions being recorded in detail in patients notes in any of the cases where the patient did not have mental capacity or where it was unclear if they had mental capacity.
- In 44% of the records we reviewed there was no record of patient involvement and limited recording of the involvement of relatives.

Are services caring?

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

Summary

We rated community end of life care as good in terms of caring because:

- Patients and their relatives spoke positively about the care they received in the community.
- We observed interactions between staff and patients and saw that these 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 people and that there was a commitment to end of life care at all levels of the community service.
- One particular example of outstanding practice was the development of a carers course where people caring for loved ones with life limiting illnesses could access an ongoing support group. Feedback from this was positive and described by carers as helping them to feel valued and better able to cope with their situation.

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 being 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 highly satisfied with the quality of care they received and that staff treated them with respect and maintained their dignity.
- Specific feedback included a relative who told us the support they received from the community nursing team during the time that their loved one was dying had helped them to feel like they were being 'carried' and that staff had shown them incredible kindness.

- Results from the Friends and Family Test (FFT) showed that between the 1st -31st January 2016 the results for community services were above 97% for patients who would recommend the service to friends and family.

Understanding and involvement of patients and those close to them

- A training course for people caring for someone with a long term/life limiting illness in the community had been developed and was being delivered over a four week period. We saw feedback comments from participants that included positive statements around feeling more valued and better able to look after themselves while supporting their loved one at the end of life.
- Patients and family members we spoke with told us they felt involved with the care delivered.
- We saw that staff discussed care issues with patients and relatives and these were clearly documented in patient's notes.
- The end of life care plan used by the trust included prompts for discussing issues of care with patients and relatives.
- The Gold Standards Framework (GSF) was widely used in the community for patients in the last year of life. The GSF was designed to help involve people in the planning of their care.

Emotional support

- Staff told us they felt they generally had the time to spend with patients and provide the emotional support to meet their needs.
- We observed community nurses assessing people's emotional needs as a matter of routine when visiting them at home.
- Support was available from chaplaincy and psychology teams and staff we spoke with told us this was readily available to patients and their relatives at the end of life.
- There was a bereavement standard in operation within the trust. This included guidance for staff in both community hospital and district nursing roles with regard to supporting relatives and people close to someone who died. The standard states that a bereavement telephone call to offer condolences /and

Are services caring?

/or a bereavement face to face visit was available to family members of patients who had been supported by community nursing teams. Staff confirmed that this was the case and one relative we spoke with told us they had received a follow up call and a visit from staff.

Are services responsive to people's needs?

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

Summary

We rated community end of life care services as good for being responsive because:

- Staff we spoke with consistently told us that end of life and palliative care specialists were responsive to their needs in the community, including being quickly available to provide support to community nursing staff around complex care management. There was evidence of planning and delivering services which meet people's needs including those relating to the needs of an older population.
- Preferred place of care was recorded on the end of life care plan however data relating to this was not available at the time of our inspection although we saw there were plans to audit this.
- There had been issues sourcing appropriate care packages in the community for patients with complex needs who were candidates for rapid discharge. However, we saw that this had been discussed at board level and that staff worked hard to balance issues around safety and patient choice and where possible would make every effort to ensure patients were cared for in their preferred place.

Planning and delivering services which meet people's needs

- Services were planned and delivered to meet the needs of patient's and their relative's. Staff told us a priority was to ensure that patients were cared for in their preferred place of death wherever possible.
- We were told of a number of situations where staff had been able to ensure patients were cared for in their preferred place and where staff continued to monitor patient's preferences in relation to this. For example district nurses told us of a patient who had wanted to die at home, however became anxious once there and wanted to be in hospital. Staff arranged for the patient to be transferred back to one of the community hospitals.
- Where possible patients at the end of life in community hospitals were cared for in side rooms.
- Facilities were in place for families, including quiet rooms, reclining chairs and comfort packs.

- The trust's 'one chance to get it right policy' detailed the anticipated needs in terms of the local population. This included the fact that Torbay and South Devon had a higher than average older population and the prediction that this will continue to increase. Priorities in relation to this document included promoting patient choice over where they die and the care they received, ensuring access to services and identifying patients in the last year of life.
- Guidance literature was available for patients and their relatives. This included a booklet about the end of life and what they might expect to happen.
- The end of life care team had designed a bereavement survey which was given to relatives to complete. We were told that results from the surveys had not been collated but that they would be in the form of an annual report.
- We saw documentation about advance care planning and some staff had attended training in the area. We did not see documented advance care plans in use in the community, however we did see nursing records as part of patients daily notes that included details of discussions around their wishes.
- A bereavement pack had been developed which included a bereavement booklet, information on sources of support for people who were bereaved and an experience questionnaire for relatives to complete and return.

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. Members of the end of life care team had all attended equality and diversity training.
- The chaplaincy service provided support and pastoral care for people of all faiths. We were told that chaplaincy staff were able to access leaders of different faiths in order to meet the spiritual and faith needs of patients and their relatives.
- Multi-faith prayer rooms were available for patients on the community in-patient wards.

Are services responsive to people's needs?

Meeting the needs of people in vulnerable circumstances

- A priority for the trust was to develop good quality end of life care based on the wishes and preferences of the individual and to improve care for patients in the community. This included support to people in vulnerable circumstances. For example, the end of life care team worked to improve end of life care education in local care homes for patients living in supported environments. This included patients with dementia.
- The environment in the community hospitals included the use of colour and contrast to improve the environment for patients with dementia.
- Staff told us they could access support and advice from the trust's learning disability nurse or the community dementia services. We saw that dementia and learning disability passports were in use.
- Staff told us they were able to access translation and interpreting services if required although we were not given specific examples of this and staff told us it was rarely necessary.

Access to the right care at the right time

- Community specialist palliative care was provided by the local hospice. Staff at Torbay and South Devon were able to access services by phoning the specialist palliative care team during daytime hours and via an advice line out of hours.
- Referrals were prioritised based on assessed patient need. Staff on the community in-patient wards and district nurses in the community told us that if a patient required urgent review the community palliative care team would respond very quickly. In addition support was provided by the trust's end of life care strategic lead. We were told the lead was very responsive to any need for support around patient care.
- Patients we spoke with told us staff were responsive to their needs. One patient told us that when they had been in pain while at home they had called the district nursing team and staff had been with them within minutes. Patients on the community wards told us that staff were quick to provide support.

- We saw that the development of a seven day service was an aspiration for the trust but we did not see clearly identifiable plans or timelines relating to this.
- Preferred place of care was recorded as part of the plan of care for the patient at the end of life which was generally commenced in the last few days of life. Preferred place of care was not recorded as part of the core care plan in community hospitals or as part of the district nurse complex assessment document for patients who may be considered to be in the last months or weeks of life.
- Staff consistently told us that fast track discharge was available and they were able to discharge patients home in a matter of a few hours. The exception to this was if there were difficulties in terms of social care support in the community. We saw that there had been some difficulties with meeting four hour rapid discharge targets in some cases where social care support was required. We saw that this had been discussed at board level and there was a focus on balancing safety and patient choice, particularly in relation to end of life care.

Learning from complaints and concerns

- Complaints and concerns were listened to and learning was used to improve services. The trust had a comprehensive complaints management system that included a format for reviewing contributing factors such as task, communication, training and resource factors.
- Complaints relating to end of life were referred to the end of life care strategic lead who would work with staff to identify the issues involved and learn from them. Trends and themes were easily identifiable due to this involvement, however we did not see any identified trends and themes.
- A specific complaint we reviewed related to family's concern about care at the end of life. We saw that issues had been identified including problems with accessing equipment and the training needs of staff. We saw that this had led to a review of training and revisions to include the use of bolus injections to manage patient's symptoms while accessing syringe drivers in the community.

Are services well-led?

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

Summary

We rated community end of life care as requires improvement in order to be well led because:

- There was no clear vision for end of life care or a trust wide end of life care strategy.
- Staff were unsure if the structures of two separate acute and community teams will continue or if the team would become one integrated team in the future and end of life care meetings across the trust had not yet been established.
- It was clear that leaders had encouraged appreciative, supportive relationships among staff delivering end of life care in the newly merged organisation. What was not clear was how the next step to an integrated end of life care service would happen or who would set out the timescales or shape of end of life care services.
- There were areas of risk that the trust had identified, however these had not been acted on fully. For example, problems around anticipatory prescribing were an ongoing issue and the trust had not fully addressed this or implemented measures to monitor changes.
- Additional quality issues the trust had not yet addressed included an audit of patient's preferred place of care at the end of life.

However:

- We saw evidence of strong local leadership and prioritisation of end of life care for example within individual teams and the end of life care team.
- There were well established governance and risk management processes in place.
- There was executive and non-executive representation for end of life care and we saw evidence that operational issues relating to end of life care had been discussed at board level.
- There was evidence of innovation in terms of training for healthcare assistants and lay carers and we saw that courses for staff working in care homes had received an innovation award from the Queens Nursing Institute (QNI).

Service vision and strategy

- Staff we spoke with spoke about a vision for high quality end of life care. The trust's policy document 'one chance to get it right' detailed priorities for achieving high quality end of life care. These priorities included early recognition of patients in the last year of life, patient choice, effective teamwork, ensuring access to services and promoting dignity and involvement in care.
- However, the trust had yet to develop an end of life care strategy to provide a framework for how they intended to achieve their vision. We were told the previous strategy was up to 2014 and since then the focus of the trust had been on the development of the new integrated care organisation
- The trust was clear that they were committed to ensuring those approaching the end of their lives were cared for in their preferred place of care and that care provided would be high quality, timely and appropriate to patient needs.

Governance, risk management and quality measurement

- Community end of life care reported within the structure of the Community Health and Social Care Divisional Board. The strategic lead for end of life care represented the service at both divisional and locality meetings. They fed back through the compilation of regular reports that were accessible to all staff and through representation at locality meetings where the development of end of life care services was discussed.
- We saw that there was close working with the acute hospital end of life/palliative care service and the hospice service with representative attendance at end of life care locality meetings and the use of a service level agreement with the hospice to deliver specialist palliative care in the community.
- We were told that since the inception of the new integrated care organisation (ICO) in October 2015 regular ICO end of life care meetings were planned, however only one meeting had taken place to date. We saw an agenda for this but no meeting minutes.

Are services well-led?

- Trust policies relating to community end of life care were planned to be integrated with the acute end of life care service in the future but at the time of the inspection all existing policies from the community trust had been carried over as an interim measure.
- Quality and risk information about the end of life care service was regularly reviewed at divisional level and we saw that monthly quality and safety professional practice reports were submitted which included a reporting section for palliative and end of life care.
- Mortality review meetings were undertaken regularly at each of the community hospitals. These were led by the clinical matron with input from the GPs and results fed back to the medical director.
- We were told that there were no identified risks relating to end of life care in the community, although there was evidence that risks had been identified on a risk register in the past. For example, one identified risk had been around difficulties community staff had in accessing training on syringe drivers. This was managed by the end of life care team by bringing syringe driver training back in house for delivery by the team.
- Minutes of trust board meetings (February 2016) included some reference to end of life care in relation to operational issues with completion of treatment escalation plans and with rapid discharge.
- There were areas of risk that the trust had identified, however these had not been acted on fully. For example, problems around anticipatory prescribing were an ongoing issue and the trust had not fully addressed this or implemented measures to monitor changes.
- Additional quality issues the trust had not yet addressed included an audit of patient's preferred place of care at the end of life.

Leadership of this service

- There was a trust strategic end of life care lead within the community and identified executive and non-executive leads. The director of nursing was the executive lead and a member of the trust board was the non-executive lead.
- We observed clear leadership for end of life care from the end of life care team and from ward and team managers within community services and community inpatient services. We saw that senior staff prioritised end of life care and that there was a commitment to

good quality end of life care. 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.

- District nurses and staff working within the community inpatient units told us that the strategic lead was visible on a day to day basis. End of life care staff told us that the trust CEO had been to meet with them and had asked for their view on end of life care within the trust.
- We saw evidence of the end of life care team providing end of life care leadership across all services within the trust, extending to external services including GPs and care homes.
- Specialist palliative care was provided by clinical nurse specialists from the local hospice via a service level agreement. District nurses told us they met regularly with the clinical nurse specialists to proactively manage end of life care and that there was clear leadership for this. Staff on the community in-patient wards told us the clinical nurse specialists were quick to respond to referrals but that they did not consistently attend the wards or MDTs to proactively support ward based generalist staff in the delivery of end of life care.
- There was evidence of leadership for end of life care at board level with the director of nursing responsible for chairing the trust end of life care meetings.

Culture within this service

- Staff we spoke with demonstrated a commitment to the delivery of good quality end of life care. There was evidence that staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff as to the level of support they received from the end of life care lead.
- 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 people at the end of life in terms of the delivery of care.
- We observed good collaborative team working across community teams. Staff told us there were opportunities to learn and that the delivering of high quality end of life care services within the community was a priority.
- We were told that district nurses would generally double up on visits to patients with complex symptom

Are services well-led?

management needs, particularly where syringe drivers were in use. We observed this in practice. Staff told us that appropriate measures were taken to protect their safety when they worked alone in the community.

- There was a strong culture in place of enabling people to receive end of life care where they wished and we saw evidence that this had been discussed at board level in relation to factors affecting rapid discharge targets.

Public engagement

- The end of life care team had developed a bereavement survey which was given to relatives following bereavement. These were being collated by the end of life care lead although there was no data available at the time of our inspection.
- We saw that patients and those close to them were actively engaged and involved in decision making and we saw evidence that their views were listened to, for example to the extent of being able to influence change if they were unhappy with certain aspects of care.

Staff engagement

- Staff told us they felt actively engaged with the end of life care team and felt able to share their views with confidence in relation to being listened to. For example community nursing staff told us they were able to express their view in relation to their training needs and areas of performance where action had been taken to improve.
- Trust based end of life care staff were unclear about future plans for the service, stating that the focus had been on the trust wide integration and that ICO end of life care meetings were not yet embedded. However, they told us they had been asked for their views about the service when they recently met with the CEO.

Innovation, improvement and sustainability

- The end of life care team were focused on continually improving the quality of care and we observed a commitment to this within the general nursing teams we spoke with also.
- A particular area of innovation was the development of training programmes for healthcare assistants and lay carers in the community. We were told that the level three city and guilds training for healthcare assistants in end of life care had been initially developed to improve the care of people at the end of life who lived in care homes and reducing unnecessary admissions to hospital. However, the training was also open to healthcare assistants working within the trust, including those working in the community hospitals.
- End of life care staff told us they were hoping to offer a level five end of life care course to junior nurses although they did not have a clear plan in place for this at the time of our inspection.
- The lay carers training had been designed to provide support for people caring for someone with a long term/ life limiting illness in the community. It was a four week course and we saw evidence of positive evaluation and feedback from participants.
- We saw that the end of life care lead was fully involved and engaged in end of life care in the locality, regularly meeting and working collaboratively with members of the acute end of life care team and the hospice. Areas of improvement evidenced during the inspection included raising awareness of advance care planning and auditing the use of the five priorities of care for the dying person across the locality.

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

11 (1)

How the regulation was not being met:

The provider had failed to ensure that the requirements of the Mental Capacity Act 2005 were adhered to in situations where a person lacks mental capacity to be involved in discussions about do not attempt resuscitation decisions.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

12 (1) (2) (g)

How the regulation was not being met:

The provider had failed to comply with the proper and safe management of medicines as not all staff checking the administration of controlled drugs and the use of syringe drivers had been trained or competency assessed to do so.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

17 (1) (2) (c)

How the regulation was not being met:

The provider did not ensure that patients were protected against the risks of unsafe or inappropriate treatment

This section is primarily information for the provider

Requirement notices

arising from the lack of proper information about them by means of maintenance of an accurate record including appropriate information and documents in relation to Do Not Attempt Resuscitation decisions.