Northern Devon Healthcare NHS Trust

RBZ

Community end of life care

Quality Report

Trust Headquarters, North Devon District Hospital
Raleigh Park
Barnstaple
Devon
EX31 4JB
Tel:01271 322577
Website:northdevonhealth.nhs.uk

Date of inspection visit: 5, 6, 7,17 & 18 August 2015,
Date of publication: 03/11/2015

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RBZ95	Bideford Community Hospital		
RBZ79	Exeter Community Hospital (Whipton)		
RBZ92	Holsworthy Community Hospital		
RBZ80	Honiton Hospital		
RBZ86	Seaton Hospital		
RBZ83	Sidmouth Hospital		
RBZ99	South Molton Community Hospital		

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

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

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

Summary of findings

Ratings

Overall rating for the service	Good 
Are services safe?	**Good** 

Summary of findings

Contents

Summary of findings

Overall summary

Overall rating for this core service Good O

We previously inspected Northern Devon Healthcare NHS Trust in July 2014 when we rated end of life care overall as good but found that provision of the service in relation to being safe required improvement. At this focused inspection, we reviewed the safety in response to our previous findings. We have rated safety as good.

At our previous inspection we found that Treatment Escalation Plans (TEPs) were not being completed in line with the trust guidelines. TEPs are plans that contain details of a patient's resuscitation status. For instance whether to be resuscitated or not following a cardiac or respiratory arrest (a heart attack or where a patient has stopped breathing). A new updated version of the treatment escalation plan had been introduced since then and we found the majority were being completed in full.

The trust had introduced new care documentation for the last few days of life, which included risk assessments and plans of care in one booklet. For patients who were near the end of life or receiving palliative care but not in the final days of their life, there was no specific advance plans of care where patient wishes were documented. This could lead to treatment or care the patient did not want or patients' wishes not being followed.

Staff we spoke with were passionate about end of life care and wanted to provide the best care to patients. Some staff had completed additional training in end of life care and were planning to disseminate this to other staff in their area or ward.

For patients in the community setting, we saw prescribed 'just in case' boxes of medication that enabled trained staff to give a single dose of certain medications to treat breakthrough symptoms including pain, nausea and vomiting. This was to enable patients to be comfortable and free from pain and other symptoms until they were reviewed by a GP or their syringe driver was renewed. (A syringe driver is a piece of equipment that administers a controlled dose of drugs automatically.) Staff were trained in the use of syringe drivers and their competence to do so had been checked before they were able to set up or renew syringe drivers.

During our inspection, we spoke with one patient who was using end of life services at home and another who was admitted to a community hospitals and with four relatives. We also spoke with one GP and 24 nursing staff at the community hospitals and community nurses' bases we visited.

Summary of findings

Background to the service

Information about the service

End of life care services are provided through community hospital inpatient beds and integrated health and social care teams of staff supported by external hospice care providers. Specialist palliative care services are provided through partnership arrangements between Northern Devon Healthcare NHS Trust and the North Devon Hospice (North Devon Community) and Hospiscare in Exeter (Mid and East Devon community), with cover arrangements for specialist palliative care consultant advice. End of life care is coordinated and provided through partnership arrangements across care teams consisting of multidisciplinary staff working from bases in the community hospitals, GP surgeries and other local bases.

Community nurses provide end of life care to patients in their own homes between 8am to 5pm. After this time, the urgent care nurses provided by the trust visit patients in the evening or during the night to make sure patients have access to a 24-hour service. Patients' relatives have access to a dedicated telephone line outside normal working hours to make sure they can access medical or nursing support quickly if a patient's condition deteriorates.

Palliative and end of life care includes nursing care, specialist palliative care, bereavement support, and mortuary services. This includes patients who are approaching the end of life (when they are likely to die within the next 12 months from advanced, progressive and incurable conditions, general frailty or sudden acute crisis in their condition).

Our inspection team

Our inspection team was led by:

Chair: Peter Wilde, Retired Divisional Director, University Hospitals Bristol NHS Foundation Trust

Head of Hospital Inspections: Tracey Halladay, Care Quality Commission

The team included CQC inspectors and a variety of specialists: a director of nursing a consultant in palliative care, a palliative care nurse and an expert by experience. (An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them – for example as a carer.)

Why we carried out this inspection

We inspected North Devon District Hospital to check if changes had been made in specific areas where we found breaches of regulations for the core service of end of life care during our comprehensive inspection in July 2014. The inspection was carried out between 5 and 7 August and on 17 August 2015.

How we carried out this inspection

This was an unannounced focused inspection to review the areas of concern that were found when we carried out a comprehensive inspection of the trust in July 2014.

We previously inspected Northern Devon Healthcare NHS Trust in July 2014 when we rated end of life care overall as good but found that provision of the service in relation to being safe required improvement. At this focused inspection, we reviewed the safety in response to our previous findings.

At our previous inspection we found that Treatment Escalation Plans (TEPs) were not being completed in line

with the trust guidelines. TEPs are plans that contain details of a patient's resuscitation status. For instance whether to be resuscitated or not following a cardiac or respiratory arrest (a heart attack or where a patient has stopped breathing).

What people who use the provider say

We spoke with three family members who felt their relative was receiving good care from the community nurses and their input towards their pain relief was listened to and acted upon.

At Seaton Hospital, results of their Family and Friends test were displayed on a noticeboard. One comment said "the care their relative had received in the final weeks of their life was excellent and the thoughtfulness towards the rest of the family".

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- Ensure all patient plans of care reflect the care being given by staff and care plans are updated as well as the daily evaluation of care section.
- Consider the use of advance planning for end of life patients who are not at the final days of their life, as patient wishes are not always being recorded in their care documentation.

Northern Devon Healthcare NHS Trust

Community end of life care

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

At our previous inspection in July 2014 end of life care was judged as requires improvement in relation to being safe, at this focused inspection we have rated safety as good. We found an improvement in the use of Treatment Escalation Plans (TEP's). For example they were completed in the vast majority of cases as per the trust guidelines. These plans included details of whether the patient was to be resuscitated following a cardiac or respiratory arrest.

An assessment of a patient's capacity to make these decisions was included in the recently updated Treatment escalation plan (TEP) version 10. The majority were being completed in full in line with the guidance. The TEP forms were stored where they could be accessed easily by staff who needed to review the information they contained. Staff told us doctors who worked in the community hospitals and community setting were now completing a TEP form if a patient required one and did not have one in place. The forms were also being reviewed in line with the policy if a patient had been transferred from another health care setting.

The trust had recently introduced new care documentation for the last few days of life. This booklet incorporated plans of care and risk assessments. Staff we spoke with told us they were still getting to know the new documentation and not all staff had used it at the time of our inspection. There was no specific advance plans of care where patient wishes were documented. This could lead to treatment or care the patient did not want or patients' wishes not being followed.

Patient plans of care did not reflect the care being given by staff and care plans were not updated alongside the daily evaluation of care.

Staff were trained in the use of syringe drivers and the staff we spoke with about these said they were competent in using them. Staff in the community had access to prescribed 'just in case' boxes of medication. These boxes contained a number of medications for trained staff to give to a patient if they were experiencing certain symptoms, for example, pain, nausea and vomiting. These could be used until the patient was reviewed by a doctor or until their syringe driver was renewed.

Detailed findings

Incident reporting, learning and improvement

- Staff told us they were aware of how to report incidents of harm or risk of harm and we saw evidence of

Good

Are services safe?

feedback to staff who had reported incidents. We saw electronic evidence from emails to staff about incidents and paper records of incidents being tracked and then used for learning in managers' supervision of staff.

- We met with one of the managers and asked about any changes or learning that had been implemented following concerns raised about end of life care in people's homes. They told us that following a complaint – and due to the demand for domiciliary care for all patients, including those receiving end of life care – the trust and local authority together had set up their own domiciliary care agency. All staff who worked for this agency would have a comprehensive training package to include end of life care.
- The trust had a care home support team who provided support, guidance and training for care and nursing homes. There was a plan to include this training for domiciliary care agencies if they were able to obtain additional funding.

Duty of Candour

- All staff we spoke with had an understanding of the term duty of candour and were aware of the regulation for Duty of Candour which sets out what providers must do to make sure they are open and honest with patients and their families when something goes wrong with their care and treatment.

Safeguarding

- All staff spoken with said they would contact the local authority for advice regarding safeguarding if they felt a patient was at risk of abuse. We spoke with staff involved in care for patients and they were able to describe different types and signs of suspected abuse – for example, neglect, financial or, physical abuse and so on. All staff in locations we visited had completed safeguarding awareness training.
- Information about how to make a safeguarding alert was easily visible on walls of wards and other places we visited in the community, such as doctors' surgeries.

Medicines

- There were safe arrangements for the management of patients' medication.
- Ward stocks contained commonly used end of life medicines so they were available for prompt use when patients were admitted. We saw stock control checks were undertaken weekly on these and they were all correct.
- Staff told us they had received training in the use of syringe drivers (a pump used to deliver pain relief and other medication to a patient through the skin for a specific period) which ensured that they were competent to administer drugs in this way for patients who were at the end of their life.
- In the community hospitals, registered nurses said there were always two registered nurses available if required to set up or renew a syringe driver. If appropriate, the registered nurse could work with a competent healthcare assistant rather than another registered nurse. Community nurses were able to set and renew a syringe driver alone if they felt competent and had completed the training and competency assessment.
- Community nurses told us about a 'just in case' box of medication for use with patients who were at the end of their life. This was a prescribed box of a set list of medications in line with the trust's policy. This enabled community nurses or other healthcare professionals (such as GPs) to give patients a single dose of medication to treat symptoms including pain, nausea and vomiting. Staff showed us the policy for their use. A flowchart was included for staff to follow when deciding to use a 'just in case' box. A community nurse showed us the prescription a GP had written for one of these boxes that they were in the process of arranging for a patient.

Environment and equipment

- All locations we visited appeared visibly clean and tidy. Some hospitals we visited were of a more modern design and build than others. Staff told us the trust was planning to refurbish the environment at one of the older buildings.
- It was difficult to find the main entrance at Bideford Community Hospital due to inadequate signage. This could have made it difficult for people visiting the hospital to see patients or to receive treatment
- At South Molton Community Hospital, the defibrillator we checked was ready to use but not on charge, although plugged in. We brought this to the attention of the nurse in charge, who ensured the machine was put on to charge and advised us they would share this with the night staff who checked the equipment.

Good

Are services safe?

- At Seaton hospital not all paper records used for recording the checking of all equipment on the resuscitation trolleys was in place and up to date.
- All syringe drivers used for administering pain relief at locations we inspected were labelled with the last day they were serviced and all were within the specified period. All also had locked boxes to secure controlled drugs when they were being administered.
- The NHS National Patient Safety Agency (an agency established to improve patient safety in hospitals) recommended in 2011 that all Graseby syringe drivers should be withdrawn by the end 2015. Following the recommendation alternative appropriate syringe driver had been introduced into the trust. Staff told us they had been using these for a while and they were provided with training. A training update on the use of syringe drivers was due to be delivered by the trust. Community nurses at one location told us they had a number of syringe drivers at their base and these were maintained and serviced by the trust.
- Community nurses told us they had access to an equipment store for patients in their own home. This included beds and pressure relieving mattresses. These could be delivered the same or next day. For patients living in a care home this type of equipment was provided by the home.

Quality of records

- Not all patients' records were accurate and up to date with their assessed needs being reflected in their plans of care.
- For patients who were in the final days of their life the trust had designed and implemented a new care record. We saw three of the new final days of life care records in use and these were for patients in their own home these were up to date with the patients care needs. The new care record incorporated plans of care and risk assessments in one document. Staff told us these were new and they were still getting used to using them.
- Patients near the end of life or receiving palliative care and not in the final days of their life whose notes did not include the new care record, did not have a specific advance plan of care where patient wishes were documented. This could lead to confusion when treating patients. This could also lead to treatment or care the patient did not want or their wishes not being followed.
- We looked at four other patient records. We reviewed the care of a patient who was being cared for at Seaton Hospital. This patient had a syringe driver in place and required all support from staff with their care. Their care plans did not reflect the care and support being given to the patient as described in their ongoing evaluation that care staff completed for each shift. For example, the care plan for pressure ulcer care did not detail the dressings that had been used and no wound mapping had been completed. In the ongoing evaluation, on two occasions staff had written 'pressure areas intact' but this was not the case as the patient had two broken areas on their sacral area. The patient's pain management care plan had also not been updated to reflect the use of syringe driver. We spoke to a senior member of staff who told us they would review and update this patient's care records as a matter of urgency and look at using the new 'final days of life' care documentation. They also said they would share the learning from this with the rest of the staff team.
- We saw Treatment Escalation Plans (TEP's) in the community hospitals. We saw a total of 24 plans. These plans contained details about whether a patient was to be resuscitated or not. Some plans also contained details about patient's wishes in relation to the treatment(s) they did not want to happen if their condition deteriorated. We saw in 14 of the medical records we viewed, details of the conversation the doctors had with the patient or their relative about their decision to be resuscitated or not to be resuscitated had been documented. Three patients were waiting to be clerked in by GPs as they were new admissions to the hospitals. In two other patients' medical records, we were not able to read the doctor's handwriting so could not be clear if details about the TEP had been recorded. In the five remaining patients' medical records, we did not see any reference to the TEP or the discussions that had taken place. The majority of the TEP forms had also been reviewed when a patient had been transferred between health care settings or back to their home. A Mental Capacity assessment had been included on the up to date version of the TEP and where required these had mostly been completed where the patient had been assessed as not having capacity to be involved in the decision-making.

Good

Are services safe?

- Community nurses told us GPs completed the TEPs and reviewed these when required. Discussions with the patient and families about the decisions made were also recorded. A GP we spoke with confirmed they completed the TEP's as per the direction on the form.
- We were shown, at two community hospitals, the TEP audit which was undertaken monthly. The TEP was reviewed against a series of questions on the trust's online form. Each patient was given an identifying number, which enabled staff to speak to the doctor concerned if they found issues with the TEP they were reviewing.

Cleanliness, infection control and hygiene

- There were infection prevention and control systems in place to keep patients safe. The ward areas we visited were visibly clean. There were hand gel and hand washing facilities available. Single rooms were available for patients to use who had infections to reduce the risk of cross infection to other patients.
- At South Molton Community hospital, the staff explained one patient who was being cared for at the end of their life was being cared for in a bay on their own as they had an infection. No signage was available to warn staff or visitors of this or the precautions needed if they wanted to enter the bay. Staff on the ward were aware of this and the nurse in charge said they had noticed no signage was in place. They said they were going to address this immediately after we had left.
- We observed community nurses had access to protective clothing when visiting patients in their own home, for example, gloves and aprons.
- At the community hospitals we visited, none had their own mortuary services. Each had a contract in place with a local funeral director who collected all deceased patients and held them until the families/ representatives had arranged their own funeral director. We saw the protocol the trust had in place for 'last offices' advising staff to inform undertakers of any relevant infection control risk.

Mandatory training

- Staff told us they had access to end of life training provided by the local hospice. The trust told us they had a memorandum of understanding with the local hospices to support staff development. They had learning pathways in place which were specific to locality and clinical case load. One nurse at a community hospital told us they had undertaken additional end of life training and they planned to disseminate this to other staff at next one to one supervision and planned group supervision.
- Some staff we spoke with were accessing end of life training provided by the local hospice and some staff had just finished additional modules through a University course. These staff explained that end of life care was not 'just' about care for people with cancer but also conditions that were life limiting for example heart disease, dementia and others. This was one of several occasions where a passion for end of life care and care in general was demonstrated by all grades of staff.
- All locations we visited demonstrated that they were monitoring the training that staff had taken or were planning to take. Copies of paper records were kept along with evidence that staff had met the competencies required as a result of their learning for statutory and mandatory training.
- At all locations we inspected, statutory and mandatory training achievement was displayed. Where full staff compliance was not evident in some topics there were action plans to address this which staff discussed with their managers during supervision sessions. Some gaps in the compliance with training were due to long-term absence of some staff. Some staff commented that on occasions, pressure of work prevented them from attaining 100% compliance.

Assessing and responding to patient risk

- Staff assessed risks to patients and responded to them well. We saw in three patients' records the use of the Adult Acute Escalation Proforma called 'SBAR' (situation, background, assessment and recommendation). One patient had an episode of vomiting large amounts and this had resulted in their Early Warning Score (EWS) being raised and as a result their observations increasing. The staff had documented this in their notes and actions they had taken. A doctor had been contacted for advice and medication was administered.
- A pain assessment tool was in use for monitoring patient's pain levels. Patients were asked what their pain was like and a score was given. One patient was receiving morphine-based analgesia and they told us they had no pain and that staff frequently asked them if they were in pain and required more analgesia. Staff told us they felt the new pain assessment tool, which

was included on the risk assessment format, was much better. As it had been removed from the medication chart staff felt they asked patients more often about their pain and not only at medication rounds as they had been doing.

- We visited a patient who was receiving their medication via a syringe driver, with the community nurses. We did not see the patient as they were in the final days of life. The family spoke with us and the community nurse as they felt their relative was in pain especially when moving. The community nurse told us they reviewed the patient and felt their pain had increased. They showed us the prescription chart they were able to use to increase the dose of analgesia in the syringe driver. This was because the prescription was written so the community nurses could increase the medication within a set range. This was also the case for other medication contained in the syringe driver – for example, anti-sickness medication.
- Where patients required additional support and advice regarding their condition and treatment they were referred to the local hospice. We saw referral forms in one patient's notes. A clinical nurse specialist had visited this patient and advised the nursing and medical staff on how to manage some of the side effects they were experiencing due to recent treatment.
- The local hospice provided out of hours advice to nursing and medical staff. This was a formal arrangement between the trust and the hospice. Community nurses told us that if a patient's condition deteriorated and they required additional support and care they could contact the 'hospice at home' service, which provided urgent care until a care package could be set up.
- The urgent care team told us they audited their visits each month. This was to monitor how many visits they undertook and the reasons why they were called out. For July 2015, they undertook 57 visits to end of life patients for symptom management.
- We spoke by phone with the relative of a patient who was being supported at home by community staff for their end of life care. They told us all staff were very professional. An occupational therapist had visited to assess their relative and supplied a range of equipment to manage the anticipated risk of them falling, to provide support because they were not able to mobilise sufficiently and to promote their dignity when using the toilet. The relative on the phone ensured the patient was able to hear our discussion about how their care was being managed.
- Community nursing teams told us they met daily to discuss patients and any issues that had arisen from the morning visits. They used a paper record (a Safe Effective Handover Tool) to record risk, actions and solutions. Risks included the potential for staff falling on long uneven drives managed by increased awareness of staff, anticipating the need for two people to set up syringe drivers following morning visits to reduce the risk of medication and dosage errors and any lone worker risk issues usually managed by stipulating two staff to attend.

Staffing levels and caseload

- End of life care for patients in their own home was provided by community nurses who worked across the county. Outside of their working hours (8am to 5pm), the urgent care nurses provided support to these patients. They told us the community nurse contacted them with any updates and they also had access to records on the system and the patient's records in their home. Patients at the end of their life and their families had a dedicated line to contact the out of hour's doctors who would then contact the urgent care nurses.
- At South Molton one member of, staff explained how they were able to increase staffing if patients' dependency had increased – for example, for patients who were receiving end of life care, they did this by speaking with senior ward staff and requesting the additional staff after assessing the patients' needs.
- At Bideford, we saw evidence of appropriate number of staff per occupied beds, although this did leave some beds unoccupied. The nurse in charge confirmed it was not safe to take further admissions to those beds without an increase in staff.
- The staff rotas we saw provided evidence of the previous week's levels of staffing and current staffing, which we confirmed was correct with the number on duty and where staffing needed to be covered for anticipated absences. Staff we spoke with felt that there was sufficient staff cover to provide a service. During our inspection there was one person absent due to sickness and the shift was unable to be covered at that time. Staff on the ward were meeting patients' needs.

Good

Are services safe?

- Medical cover for each of the community hospitals we visited varied. Some had senior doctor cover provided by the trust Monday to Friday and they used the out of hour's service in the evenings and weekends. Other community hospitals were covered by the local GP surgeries. They visited at frequent intervals and staff told us they were able to call them during surgery hours if required. The out of hours service was also used for evenings and weekends. Staff told us the out of hours service were informed if they had a patient who was in the last few days of their life and the medical staff were able to have access to records about their on going care and treatment. Staff told us they did not have any difficulties accessing medical support.
- Community nurses told us visits to patients who were receiving end of life care were always their priority visits over for example, wound care visits. If they had a member of staff go off sick suddenly they would review their work load for that day and move visits if necessary. No one we spoke with said that there were any difficulties in obtaining support.
- The community nursing teams told us about and showed us minutes of the four weekly 'Gold Standards Framework' meetings they attended with the GP's. The Gold Standards Framework helps teams to deliver more effective care at end of life and is informed by patient and carer preferences. This usually leads to improved quality of: life, death, dying and bereavement.
- The minutes showed that some patients were already having early discussions or 'advance care planning' and end of life planning. The Gold Standards Framework meeting minutes clearly outlined the different stages of end of life care for different patients and when they chose to engage in starting the conversation about end of life care. The patients had diagnoses of cancer and other life limiting conditions for example motor neurone disease. The framework not only supported patients and their families or carers but also helped nurses manage and prioritise caseloads more effectively. The recording of minutes included the planning and resources needed to support work with patients and families. They also enabled nurse and other staff involved to identify patients who needed more immediate support and those who had less critical needs.

Managing anticipated risks

- The urgent care team had a four by four vehicle to use in bad weather so they could maintain visits to patients. They were also able to use volunteer drivers who had four by four vehicles to take them to their visits if the staff were concerned about the weather conditions.
- After our inspection last year, the trust sent us an action plan in which they said they had trialled 'lone working devices' but we found that these were not being used due to the difficulties in mobile phone signal coverage. The urgent care team told us they had trialled these devices but had received no feedback. They told us they had a system in place to monitor where staff were if they were visiting patients alone and they told us the system worked. The trust told us following the inspection that a business case about lone working devices in the community was presented to Executive Directors Group on 24 June 2015.