Northern Devon Healthcare NHS Trust

RBZ

End of life care

Quality Report

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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 Northern Devon Healthcare NHS Trust	Good 
Are End of Life care safe?	**Requires Improvement** 
Are End of Life care effective?	**Good** 
Are End of Life care caring?	**Good** 
Are End of Life care responsive?	**Good** 
Are End of Life care well-led?	**Good** 

Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service

Overall, community end of life services were good. Services were found to be safe, effective, caring and responsive.

Our inspection of end of life community services included visits to community nursing services and community hospitals across a network of 17 community hospitals and nine integrated health and social care community clusters. At the time of our visit, we saw very few patients who were considered to be at the end of life.

We saw that patients and their needs were placed at the centre of their care. There was a high regard for safety and we saw that lessons learned included the sharing and the cascading of information to relevant professional groups across the trust. We viewed the use of Treatment Escalation Plans (TEP) that highlighted end of life care decisions, including do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions. We saw that the TEPs we viewed were mostly completed correctly, although staff told us they had experienced some inconsistencies with this and this was supported by the results of an audit we saw. Inconsistent completion of TEP forms could result in patient decisions about treatment and care being unclear to the staff caring for them.

We viewed evidence of effective end of life care services with evidence of an end of life care plan being introduced to replace the Liverpool Care Pathway. End of life link nurses had been introduced to community hospitals to raise the standard and profile of end of life care in community settings.

Patients, relatives and staff were positive about the services received and we observed staff caring for patients with respect and dignity. We observed services being delivered through multidisciplinary teams and good partnership working and we saw evidence of responsive care, particularly in relation to rapid discharge home when patients wanted to be cared for in the community at the end of their life. Staff told us that local leadership of services was good, but that they were not always aware of whom the trust-wide leaders were. However, we viewed plans for increasing trust-wide leadership visibility in community services.

Summary of findings

Background to the service

End of life care services within the community are provided across a range of community hospital and integrated health and safety community clusters. End of life care is coordinated and provided through partnership arrangements across care teams consisting of multidisciplinary staff who work from bases within the community hospitals, GP surgeries and other local bases.

Specialist palliative care services are provided through partnership arrangements between North Devon District Hospital and the North Devon Hospice (North Devon Community) and Hospiscare in Exeter (Mid and East Devon community) with cross cover arrangements for specialist palliative care consultant advice. We saw that a palliative care clinical nurse specialist was based at Ottery St Mary community hospital and was responsible for the provision of specialist end of life care advice and support for patients being cared for in the community.

Our inspection team

Our inspection team was led by:

Chair: Jan Filochwski recently retired Chief Executive from Great Ormond Street Hospital for Children NHS Foundation Trust

Team Leader: Mary Cridge, Care Quality Commission (CQC)

The inspection teams included CQC inspectors, specialist advisers in community nursing, a palliative care specialist nurse, a rehabilitation therapist, Allied Healthcare professionals, a sexual health nurse, community matrons and a GP.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme. The trust is an aspirant Foundation trust.

How we carried out this inspection

To get to the heart of the care that people who use this service experienced of care, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We carried out an announced visit on 2, 3 and 4 July 2014. During the visit, we held focus groups with a range of staff who worked within the service, such as nurses, doctors and therapists. We talked with people who used the service. We observed how people were being cared for and talked with carers and/or family members, reviewing the care or treatment records of people who used the service. These individuals shared their views and experiences of the core service. We carried out an unannounced visit on 7 and 8 July 2014.

Summary of findings

What people who use the provider say

We spoke with one patient, who was identified as being at the end of life and being cared for at home. The patient and a family member told us the care that they received was of a good standard and that they were happy with the service.

Good practice

- Throughout our inspection, we consistently saw staff delivering care with compassion and respect for patients' dignity.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should ensure that all TEP documentation is completed and stored so that all staff and professionals can be clearly informed of patients' wishes.

Northern Devon Healthcare NHS Trust

End of life care

Detailed findings from this inspection

The five questions we ask about core services and what we found

Requires improvement

Are End of Life Care safe?

By safe, we mean that people are protected from abuse

Community end of life services required improvement. We saw that treatment escalation plans (TEPs) were in use to prompt and record discussions around end of life care decisions. For patients receiving end of life care in their own home we found that information contained in TEP forms held by primary care staff, such as GPs, was not always readily available. This raised concerns that patients' wishes, as detailed in the TEP, may not always be respected. For patients in community hospitals TEP forms were available as they became the responsibility of the Trust.

Patient safety was monitored, with evidence provided of learning from incidents that included improving prescribing practices and competency assessments around the administration of medicines.

We also observed discussion at a community handover that indicated that there were some inconsistencies around when end of life discussions were initiated.

We were told that, while there were some staffing vacancies, caseloads were manageable in the community and that staff were able to delivery end of life care safely and responsively.

Incidents, reporting and learning

- There had been one Serious Incident Requiring Investigation (SIRI) report relating to a medication error involving a patient at the end of life at Axminster Community Hospital. We saw that the incident was reported and investigated, with contributing factors and root causes being identified through discussion and analysis. Learning from this was evident and guidance for GP prescribers and competency assessments for registered and non-registered staff administering and checking the administration of medicines had been implemented.
- We saw that this learning had been disseminated. For example, we saw a summary of a community nursing team manager meeting that included details of an issue relating to GP prescribing and concerns following a particular incident. The incident was reviewed within the medical directorate in the trust, escalated to the clinical commissioning group (CCG) and raised with the local GP group.

Requires improvement

Are services safe?

Cleanliness, infection control and hygiene

- We visited the mortuary at Tiverton and District Hospital, which was seen to be clean and well maintained. Records of temperature checks of mortuary fridges were seen to be kept within required limits.
- We were told that other community hospitals had arrangements with local funeral directors to collect the deceased within two hours of death.

Maintenance of environment and equipment

- Whilst accompanying a community district nurse on a home visit we saw that appropriate equipment was available in the patient's home. Staff told us there were no issues with accessing equipment when required.
- Where equipment was required in a patients home arrangements were made for items to be available when they were discharged home for their last days of life.

Medicines

- We saw an example of a medication error being reported and investigated, leading to an action plan being approved by the quality assurance committee (QAC). We saw that actions related to sharing and learning across different groups of staff included the provision of clear guidance for GP prescribers and the development of competency assessments for registered nurses and non-registered staff who acted as second checkers for controlled drugs.
- We spoke with staff from an out-of-hours community service who told us they carried 'just in case' bags with appropriate medication for end of life care and that they could gain access to emergency medication through the on-call GP service.

Records

- The use of the Liverpool Care Pathway was due to be phased out by 14 July 2014 and a new end of life care plan was being piloted on wards in the trust, including one of the community hospitals.
- We saw treatment escalation plans (TEPs) in use that included a resuscitation decision record. We also saw minutes of meetings where TEPs were discussed. The TEP forms we saw were generally completed correctly, although some staff told us they thought the forms did not always contain sufficient information.
- For patients receiving end of life care in their own home we found that information contained in TEP forms held by primary care staff, such as GPs, was not always readily available. This raised concerns that patients' wishes, as detailed in the TEP, may not always be respected. We saw minutes of a leadership meeting where this had been identified as an issue to be addressed. For patients in community hospitals TEP forms were available as they became the responsibility of the Trust.
- We viewed an audit of TEP forms that demonstrated improvements were required in terms of mental capacity assessments and the documentation of discussions.
- We attended a patient handover with the community nurses and found that two patients who were described as poorly and possibly requiring end of life care did not have TEP forms completed. Following discussion, the community matron stated this would be addressed. The explanation given for not completing these was that the patient had not reached end of life stage.
- We were told that the specialist palliative care teams in the hospital and community had access to a shared electronic patient record system.

Lone and remote working

- Community staff we spoke with told us that they followed the trust's lone worker policy. This was available to access on the

Staffing levels and caseload

- Some staff teams had current vacancies that could contribute to increased pressure on staff from time to time. However, generally, most staff told us that their caseloads were manageable.
- One member of the occupational therapy (OT) staff told us there was a high demand on OTs to be involved in end of life care. They said they needed additional skills and resources to help manage the dying patient, as this was an area they were increasingly dealing with.
- We were told that trust leads were exploring training options via the national cancer network regarding advanced communication skills for OTs, but this was not in place at the time of our visit. As part of action planning for the specialist palliative care team the need for provision of enhanced communication skills for palliative care staff in the trust was identified.

Good

Are End of Life Care 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

Community end of life services were found to be effective.

The Liverpool Care Pathway was being phased out by 14 July 2014 and a new end of life care plan was being introduced. We received good feedback from staff, relatives and one patient about the quality of end of life care available in the community and we saw evidence of holistic assessments and evaluation.

End of life link nurses were present on the wards at Ottery St Mary Hospital to ensure that end of life care was effective and that there were daily visits from the specialist palliative care nurse to this service.

Evidence based care and treatment

- We were told the Liverpool Care Pathway was due to be phased out by 14 July 2014 and that an end of life care plan was being piloted at the time of our inspection.
- The current end of life care plan incorporated aspects relative to national guidance, such as recognition that the patient was dying, advance care planning decisions, symptom management, involvement of the patient and their family and consideration of the patient's spiritual and emotional wellbeing.
- While we did not see the end of life care plan in use in the community. We were able to review the new care plan format and saw that it included an assessment of recognition that the patient is dying, a treatment escalation plan, advance care planning decisions, symptom management and communication with the patient and family. We also saw assessment guidance around spiritual and emotional wellbeing, feeding and hydration.

Symptom management

- We saw trust-wide guidelines on symptom management in palliative care that had been written by the consultant in palliative care. The guidance incorporated the World Health Organization's (WHO) pain ladder and was due to be reviewed and updated at the time of our visit. We saw that the review had been incorporated into the action plan of the palliative care team.
- A specialist palliative care nurse based at Ottery St Mary Hospital told us that end of life care delivered by the ward staff was of a high level.
- We spoke with one patient and their family, who gave us positive feedback about the care they received. and we saw nursing staff giving good symptom management support and advice to them, alongside a good holistic assessment of their needs.

Nutrition and hydration

- Nutritional and hydration assessment tools and care plans were in place for patients where a need had been identified.
- As part of the community nursing clinical effectiveness dashboard monitoring, evidence of nutritional care plans, as well as their implementation and ongoing review were included.
- We saw one example in the community where a nutritional chart was inconsistently completed. However, additional clinical records were completed comprehensively and signed by staff.

Patient outcomes

- We viewed communication that was sent via email to all staff informing them of the change to the care of the dying guidance and documentation.
- Patients we spoke with told us they were happy with the care they had received. One family member told us they had received support from the Rapid Response team to set up end of life care at home for their relative. They told us they were very happy with the service they received and that their relative had died at home as per their wishes.

Competent staff

- The hospice palliative care clinical nurse specialist visited the wards on a daily basis for any concerns with patients who had been or were yet to be referred to them. They were able to be a resource and point of advice and support to ward staff.

Good

Are End of Life Care effective?

- There were end of life link nurses who were based on the wards in the community hospitals in line with a trust-wide initiative. End of life link nurses attended training and were supported by the specialist palliative care team.
- The palliative care clinical nurse specialist told us that additional training was available through a reciprocal arrangement with North Devon Hospice. We saw information relating to training courses available to staff.
- We saw an implementation plan for competency assessments of registered and non-registered staff in community hospitals in relation to administration and checking of controlled drugs. This initiative was developed in response to a medication error that had been reported and investigated as a Serious Incident Requiring Investigation (SIRI).
- GPs were responsible for medically reviewing patients at the end of life in the community hospitals. We viewed an example of lessons learned from a SIRI being used to provide clear guidance to GP prescribers, to reduce the likelihood of recurrence.
- We were told by the palliative care consultant that a half-day training session for GPs was planned for shortly after our visit and that an audit of treatment escalation plans (TEPs) would be shared, to ensure learning around end of life decision making.
- Community nurses told us they had access to trust policies and other information through the trust's intranet, although they told us that, from time to time, they would have connectivity issues in the community, which could make it difficult to access information.

Multi-disciplinary working and working with others

- The specialist palliative care service was provided jointly by the Northern Devon Healthcare NHS Trust and the North Devon Hospice in the north of the county and by Hospiscare in the south of the county.
- There was an integrated specialist palliative care team who covered both acute and community end of life services. The team operated within a service-level agreement in place between North Devon Hospice and Northern Devon Healthcare NHS Trust.
- The specialist palliative care nurse employed by Hospiscare was based at Ottery St Mary Hospital, where hospice beds were provided.
- We were told that combined multidisciplinary meetings were held, where all patients at the end of life were reviewed and discussed, including those discharged back into the community.
- End of life care plans were seen to incorporate medical and nursing assessments and action plans. We were told that these care plans were being piloted on two wards in the acute hospital and also at South Molton community hospital.

Co-ordinated integrated care pathways

- End of life care was coordinated in the community with support from the palliative care clinical nurse specialist. There were well coordinated services from the Rapid Response team in relation to a patient wanting to go home in the last days of life.
- The palliative care clinical nurse specialist told us they liaised with GPs and district nurses around patient admissions to the community hospitals, telling us that the standards of end of life care they had seen were very good.

Good

Are End of Life Care caring?

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

Summary

We observed a good deal of compassion and care delivered by community staff, including good interactions with patients and families. We observed nursing staff on community visits delivering care while being mindful to treat people with dignity and respect. We also saw there were good bereavement support services available. Compassionate care

Compassionate care

- We spoke with patients and family members, who told us that the care they received was of a high standard and that staff were caring in their approach. One family member told us they had nothing but praise for the support they had received in caring for their relative at home.
- We observed district nurses visiting people in their homes in Bideford and saw that they demonstrated a good deal of compassion and understanding of people in their care.
- Observation of district nurse visits in other areas also demonstrated that staff interacted well with people and were caring in their approach.

Dignity and respect

- We observed staff treating patients with dignity and respect both in the community hospitals and in patients' own homes.
- The Devon, Torbay and Plymouth Primary Care Trust (PCT) cluster was in the top 20% of PCT clusters for respect and dignity shown always by hospital nurses, care home workers and hospital doctors. The PCT cluster was also in the top 20% of PCT clusters for patient care and support that included patients receiving enough help with nursing needs.

Patient understanding and involvement

- We saw evidence that patients were supported to receive end of life care in their preferred place of care (PPC) and that Rapid Response teams were on hand to support people to be cared for at home when possible.
- We saw that treatment escalation plans (TEPs) were used to document decisions around cardio-pulmonary resuscitation and other advance care planning decisions. We saw that the forms included space for detailing discussions with patients around decisions and their wishes, although audit reports indicated these were not always completed correctly.

Emotional support

- The local bereavement support services were offered through the clinical nurse specialist in palliative care and a local volunteer scheme.
- The clinical nurse specialist also told us they worked with the hospital matron to provide support and debriefing for staff.

Good

Are End of Life Care responsive to people's needs?

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

Summary

We observed good multidisciplinary coordination of end of life care services, including arrangements for responsive rapid discharge home when a patient wished to be cared for in the community at the end of life.

We saw that mortuary services were responsive to the needs of individuals and the service as a whole. We were told that information sharing and partnership working enabled services to work well together to meet the needs of people receiving end of life care in the community.

Access to care close to home as possible

- We saw evidence of multidisciplinary coordination to ensure that patients were cared for as close to home as possible and were told, in many cases, patients had the support to be cared for at home if that was their wish.
- We saw coordination between services with a specialist palliative care nurse, a Rapid Response team and other specialist staff, such as occupational therapists and district nurses working together to ensure patients had appropriate access to care.

Access to the right care at the right time

- We saw evidence of community services working together to ensure services met the needs of patients.
- Relatives told us they were happy with the responsiveness of community services to support them to care for a family member at home during the last days of life.

Meeting the needs of individuals

- We did not meet any end of life patients in their own homes in the community at the time of our visit, but we saw evidence of end of life care plans being piloted that included holistic assessments and identification of individual needs.
- We were told that mortuary services were responsive to people's needs and that in community hospitals where there were no mortuary services there were arrangements in place for local undertakers to remove the deceased within two hours of death.

Moving between services

- The specialist palliative care teams in the hospital and community had access to a shared electronic patient record system, which meant that they were able to share information about patients between specialist staff and services.
- Community staff told us that patient choices and preferences were recorded in patient notes and shared via the Adastra End of Life Care Register (EOLCR) electronic system (an electronic palliative care coordination system – EPaCCS – which enables service providers across care boundaries to share information about patients nearing the end of their life, helping to improve care delivery and coordination), which was visible to the ambulance service and GPs.
- We saw evidence of multidisciplinary meetings where information was shared across services and we saw that patients were asked about where they preferred to be cared for during the last days of life. We saw examples where patients were moved between services, as per their wishes.
- We saw evidence of effective and responsive rapid discharge services that ensured patients had services in place at home when discharged for end of life care in the community.

Complaints handling (for this service) and learning from feedback

- We did not see evidence of complaints specifically relating to end of life care during our visit.

Good

Are End of Life Care 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 observed good arrangements in place for multidisciplinary team and partnership working across services in the community. Staff told us there was good leadership at local-level, although they were not always aware of trust-wide leadership. We viewed plans to increase trust-wide leadership visibility that included the community
services.

Specific leadership initiatives relevant to end of life services included the phasing out of the Liverpool Care Pathway and the introduction/pilot of a new end of life care pathway.

Vision and strategy for this service

- We viewed a strategy for the hospital palliative care team that focused on service development and continued implementation of national guidance and recommendations across the acute and community hospitals within the trust.
- We were told that the hospital palliative care team worked in partnership with the North Devon Hospice and Hospiscare to provide specialist palliative care services across the acute and community hospitals.

Guidance, risk management and quality measurement

- We viewed guidance on palliative care symptom management written by the specialist palliative care consultant based at North Devon District Hospital. We were told that this guidance was available to staff on the trust's intranet.
- We viewed a number of quality audits that were relevant to patients at the end of life, including a monthly clinical effectiveness dashboard. The dashboard reflected data collected by community nurse team leaders in relation to aspects of care, including: care planning, nutrition, pressure ulcer prevention, holistic care and issues around capacity and consent. We saw that the results were distributed to managers and leaders and we viewed minutes of matron and team leader meetings where issues were addressed.
- We viewed audits of Treatment Escalation Plans (TEPs) that included identification of the areas where improvements were required. We were told that the palliative care consultant had taken responsibility for overseeing the audit and liaising with relevant clinicians when areas for improvement were required.

Leadership of this service

- During our visit, we saw that leadership was good and staff were positive about their immediate and team leaders. We heard varied opinions about the trust-level leadership, with some staff knowing the board had visited their areas of work and who they were and other staff not knowing who the board were and had no knowledge of any interaction with them.
- We saw that specific end of life leadership in the community was provided by cross-cover arrangements between North Devon District Hospital, Hospiscare and the North Devon Hospice. This included shared planning arrangements and the input of specialist medical and nursing staff.
- We spoke with a clinical nurse specialist who was based at Ottery St Mary Hospital, who told us they provided end of life care leadership and support to staff alongside the hospital matron.

Culture within this service

- During our visit, staff, patients and relatives told us the quality of end of life care was good.
- We were given examples of responsive care situations where people at the end of life were cared for in line with their wishes, including situations where staff demonstrated a 'can do' approach to rapid discharge home for patients at the end of life.

Public and staff engagement

- We did not see evidence of public and staff engagement specific to end of life care, but we viewed plans across the trust to gain feedback from bereaved relatives that included the development of a questionnaire and the establishment of a model for contacting bereaved relatives.

Good

Are End of Life Care well-led?

Innovation, improvement and sustainability

- The introduction of an end of life care plan in place of the phased out Liverpool Care Pathway had been developed with input from ward staff and we viewed communication about this and information available to staff involved in end of life care. We were told the end of life care plan was being piloted at the time of our visit, although we did not see patients receiving end of life care at that time.
- We were told that community ward link nurses for end of life care had been introduced as part of a trust-wide development for end of life care services.