Derian House Childrens Hospice

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection took place on 17, 18, 19, 20, 23 & 24 October 2017. The first day of the inspection was unannounced, which means the staff at Derian House hospice did not know we were coming. We last Inspected Derian House on 29 July and 2 August 2016. At the inspection in 2016 we rated the Hospice as 'Good' overall and 'Good' for the domains of Safe, Effective, Responsive and Well-led. We rated the Caring domain as 'Outstanding'. We made two recommendations following the inspection.

One recommendation was regarding processes around the disposal of drugs and the service level agreement in place for pharmacy provision. The other recommendation was ensuring that an appropriate consent policy was in place that met the guidance of the GMC and RCN and complied with the Gillick competency and that this was followed in practice. The Gillick competency is a term originating in England and is used in medical law to decide whether a child is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. At this inspection we found that our recommendation for the issues raised around medicines management had been met however a valid and appropriate consent policy was not in place and we found that consent was not always gained appropriately. We found this to be a breach of the Health and Social Care Act (Regulated Activities) Regulations 2014 in relation to regulation 11, Need for consent.

Derian House Children's Hospice provides palliative and end of life care for children and young people who have life limiting or life threatening conditions. The hospice is set in its own ground and provides accommodation for nine children in the main house and four young people in the lodge. There are four self-contained flats which are used by families. The hospice also provides a service for children and young adults in their own home. This is known as Derian at Home.

Bereavement support for parents and siblings is provided before, during and after end of life care and this support is not time limited. The hospice covers a wide geographical area including; Chorley, Preston, South Ribble, South Lakes, Fylde Coast, Wigan, Bolton, Rochdale, Blackburn, Burnley and Salford. This incorporates working with ten different Local Authorities to provide 24/7 End of Life support. Care consists of approximately 80% respite and 20% end of life care. Attendance at the hospice does vary due to the types of service offered. For the 12 month period prior to our inspection occupancy was averaging at just over 53%.

Derian House had a registered manager. A registered manager is a person who has registered with the Care

Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We were able to have a conversation with one young person during the two days we were at Derian House and also had discussions and contact with relatives. Via conversations and through observations we had no concerns with the safety of people using the service. We received positive comments from families with regards to the safety of their loved ones when they were being cared for by Derian House staff.

Fire safety issues had been highlighted as a concern prior to us undertaking our inspection via an anonymous whistle-blower. Lancashire Fire and Rescue Service (LFRS) had visited the hospice before our inspection and they had fed back to us their recommendations. We saw evidence from LFRS and the service to show these recommendations had been undertaken and that fire safety was of paramount importance to the service. Steps had been taken to address the issues highlighted to us prior to our inspection.

Suitable recruitment processes were in place and followed ensuring that people employed as staff or recruited as volunteers, were competent and safe to work with vulnerable children and young people.

Appropriate staffing levels were observed to be in place to meet the assessed needs of the children and young people receiving care and support. Due to the short term nature of the service and the fact that people's needs were different from week to week, rotas were designed to be flexible and accommodate this fact.

An infection prevention and control policy was in place at the hospice. During the course of our inspection we toured the premises, viewing a selected number of bedrooms and all communal parts of the hospice including bathrooms and toilets throughout all parts of Derian House. All areas were observed to be clean.

Children and young people's medicines were managed well including how they were stored, administered, recorded and disposed of. We observed medicines to be administered in a professional and appropriate manner. The hospice had recorded 30 medicines errors for the period of 2017 up to the date of our inspection. These had been dealt with appropriately and lessons had been learnt. Changes to the medicines policy were made following conversations we had with the management of the service.

Risk assessments were not always up to date, and therefore reflective of children and young people's latest needs. We have made a recommendation about this.

The staff we spoke with had a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. They understood how the legislation impacted the people who used the service. Whilst we did find issues with how consent was gained given the nature of the service offered at Derian House, we judged the hospice to be compliant in this area.

Children and young people were supported well with their nutritional and hydration needs. The cook we spoke with was knowledgeable of children and young people's needs as were the care staff we spoke with. Aside from one issue regarding the consistency of one person's diet, records accurately reflected needs in this area.

All the feedback we received from relatives, and from the one young person we were able to speak with, was extremely positive. We were told of a staff team that was caring, empathetic and professional. More than this, we were told countless stories of how the service was a sanctuary for families and one they could not

have coped without in times of extreme difficulty. This was true from a practical and emotional perspective. Some families still received support many years following the death of their loved ones.

We found care plans to be person centred and to contain a lot of accurate information about children and young people's general and specific needs. As with risk assessments, they were not always fully reflective of children and young people's most up to date needs. Work was continuing within the care team to engage with external partners to ensure that the hospice was included in all reviews of care and support to ensure that when children and young people accessed Derian House, the service had a fully up to date picture of people's needs.

The service had a robust and effective complaints system in place. The policy was on display and contained the details of external organisations as well as the hospice's internal procedures.

A wide range of activities were offered to the children and young people who accessed Derian House. Relatives we spoke with praised the service in this area and we saw that children and young people had a choice in how they spent their time at the hospice.

The services on offer to children and young people were constantly being developed or expanded in line with local demand. We saw several good examples of new services at different stages of development, as well as existing services being realigned or expanded to meet needs.

We spoke with 57 staff, across both the care and support side of the service, some of whom were ex-employees at the hospice. A large percentage of staff we spoke with, and had contact with, told us of a working environment which we judged to be extremely unhealthy and broken. We heard many testimonies, with specific details, about how staff were bullied, belittled and how they felt unable to raise these concerns within a safe environment. Whilst the hospice had a large range of auditing and monitoring systems in place they had not picked up and/or dealt with these and other issues. This was therefore a breach of the Health and Social Care Act (Regulated Activities) Regulations 2014 in relation to regulation 17: Good Governance.

Relatives we spoke with did not raise any concerns about the atmosphere or culture within the hospice. As with all the feedback we received from families conversations about the service were extremely positive. This included any conversations we had about how they perceived the culture of Derian House. This was very positive as it meant the issues staff were experiencing were not adversely affecting the care and support offered to children and young people using the service.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The Service was not always Safe.

People we spoke with told us that they or their loved ones felt safe when they were staying at or visiting Derian House.

Staff had a good understanding of the safeguarding process, however we found some issues that should have been referred to or discussed with the Local Authority safeguarding team.

Risk assessments were not always fully reflective of children and young people's latest needs.

There had been some issues identified with fire safety however these issues had been resolved at the time of our inspection.

Recruitment processes were robust and staffing levels were seen to be sufficient to meet the needs of people.

Is the service effective?

Requires Improvement

The Service was not always Effective.

Staff received formal support via supervision, appraisal and training. However, staff morale within the building was poor due to a negative working culture within some parts of the service.

The hospice did not have a consent policy in place and consent was not consistently sought across the service.

Consent issues aside, the hospice was working within the principles of the Mental Capacity Act 2005.

Children and young people's nutritional needs were met.

Is the service caring?

Good

The Service was Caring.

We observed staff interactions with children and young people and saw them to be very positive. We received nothing but

positive feedback from people, relatives and external professionals about the care provided at Derian House.

End of life and palliative care was provided with professionalism, empathy and dignity.

Staff had good knowledge of the children and young people they were caring for and this came across in observations and messages from families.

Is the service responsive?

Good

The Service was Responsive.

Children and young people's care plans were person centred and contained good detail. Some work was needed to ensure that care plans were fully reflective of people's most recent needs.

A robust and effective complaints system was in operation and people we spoke with knew how to raise issues.

A large amount of activities were on offer for children and young people who were involved in how they spent their time at Derian House.

The hospice responded to the needs of its local population by developing new services and expanding existing ones.

Is the service well-led?

Requires Improvement

The Service was not always Well-led.

We received an unprecedented amount of contact from staff working at Derian House with regards to a negative and unhealthy working environment. The systems in place were ineffective for staff who raised issues about the culture at the hospice.

Relatives we spoke with raised no concerns around culture therefore we judged that the working culture staff told us about, had not directly impacted children and young people using the service in a negative way.

A number of quality assurance systems were in place however we questioned their effectiveness given some of the issues presented to us by staff.

Positive working relationships were in place with a large range of external organisations.

Derian House Children's Hospice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 17, 18, 19, 20, 23 & 24 October 2017. We spent the 17 & 18 October on-site at Derian House and the remaining four days were spent talking with staff and some relatives of children who used the Hospice. The first day of the inspection was carried out by one adult social care inspector, a hospital inspector, a hospital inspection manager and a Specialist Advisor (SPA). The Specialist Advisor was a clinical governance specialist who had many years experience working within a hospice setting at a senior level. On the second day of the inspection three adult social care inspectors, one hospital inspector and a hospital inspection manager was in attendance and an inspection manager for adult social care attended for part of the day.

This inspection was initially planned as an unannounced focused inspection in response to a whistle blowing concern raising issues about fire safety and cultural issues within the hospice. We had liaised with Lancashire Fire and Rescue Service (LFRS) prior to our inspection about the fire safety concerns, and they shared with us a report they had completed following their own inspection on 4 September 2017. Their inspection had resulted in a small number of actions being suggested via a written schedule, which we saw had been completed during our inspection. LFRS had issued no enforcement notices following their inspection.

As a result of our discussions with staff at the hospice, and when reviewing other information we had, we changed the scope of the inspection to a full comprehensive inspection. This was to ensure that all areas of

the hospice service were inspected. This decision was shared with the hospice at the end of the first day we were on site.

We spent time observing staff interactions within the hospice, although there were not many children and young people staying at the hospice during the two days we were on site, due to pre-planned Behaviour Management training taking place at the time of our visit. On the first day of the inspection there was one child within the main hospice and on the second day of the inspection there were four children in the main hospice and two young people in the lodge. We were able to speak with one young person.

We spoke with or had email contact with 15 family members of children and young people. Over the course of the six days of the inspection we spoke with, or had email contact with 57 current and former employees of the service. The conversations with staff were face to face or by telephone and the majority of staff we spoke with were currently employed by Derian House. For those who did not wish to speak we communicated via email and social media. We have not included a full analysis of staff roles for the purpose of this report due to confidentiality purposes. We did however speak with the registered manager, clinical director, other senior managers and two members of the board of trustees and the Chief Executive Officer.

We looked at care records, in full or in part, for eight children and young people who used the hospice. We reviewed personnel files for six members of staff. We observed medicines being handled and discussed medicines administration with staff, as well as looking at medicines records. We also looked at a range of audits and quality monitoring across the service. Fire, maintenance, environmental and equipment safety checks were reviewed.

We reviewed six staff files to ensure that appropriate recruitment practices took place. We looked at staff training records, discussed training and support with staff and reviewed the hospice's training records and matrix.

Requires Improvement

Our findings

Only one of the children and young people who were staying at the hospice over the two days we were at the service was able to verbalise their opinions of their experience of staying at Derian House. However, we did observe staff interaction and spoke with relatives who visited the hospice via the telephone and social media in the days following our on-site visit. During observations we saw that staff were attentive and knowledgeable of children and young people's needs.

Relatives we spoke with or had contacted raised no issues in relation to the safety of their loved ones during their time at Derian House. We only received positive statements and messages. For example one relative told us, "When you have a child with complex needs it takes a lot of trust to leave your child in the care of others. We can honestly say we trust each and every staff member to care for [Name]. They are highly trained and always able to answer any questions we may have. It takes truly special people to do a role like they do." Another relative said, "We know [Name] is in very safe and caring hands and that means so much. You could not ask for any more. It really is a very special place with staff who are passionate about making a difference and they really do." The young person we spoke with told us, "Out of ten I would give (Derian House) ten." They had no concerns about staying at the hospice.

Staff we spoke with were aware of the hospice's safeguarding policy and knew how to report issues both within and external to the service. We saw that the service learnt from errors and incidents and that an quarterly 'Lessons Learned' report was produced and circulated to staff, such as when a medicines error or clinical incident occurred. The report was also discussed with care team leaders and senior managers on a monthly basis. This helped promote effective reflection on incidents that helped to assist with reducing the risk of reoccurrence. All staff were then able to learn from previous incidents, accidents, errors and where they were able to be shared widely, safeguarding incidents.

We however did see, within children and young people's care records and other documentation, some potential safeguarding issues that had not been reported to either the local authority or notified to the Care Quality Commission. This included a recorded overdose of medication. This person self-medicated and their daily notes indicated that they had drawn too much of their medication into the syringe being used. This had been witnessed by the member of staff on duty, recorded in the daily notes but not reported to senior staff on duty. The registered manager and care team management were unaware of this incident until we brought it to their attention. The registered manager informed us that they would address this issue with the member of staff who was identifiable as they had signed the daily notes. No harm had come to the individual as a result and the hospice put in place a risk assessment for the person.

We saw another concern where one person had managed to make their way out of an external door from the hospice on several occasions. This person did have a best interests decision in place that included them accessing the outside so they could have fresh air as this helped to calm them if they became agitated. The hospice and care management team were aware of this issue and the young person in question was not accessing Derian House at the time of our inspection. Steps were being taken, prior to our inspection, to address the physical ability of children and young people to egress the hospice via the door in question but this had to be done in conjunction with the overall safety of the building and considering the need to evacuate the building in an emergency. Again no harm had come to this individual and we were satisfied that steps were being taken to address the reasons and issues behind the incidents.

The registered manager told us that staff worked across both the hospice and the lodge at the time of our inspection although there were plans in place to move towards dedicated teams for both areas so staff could specialise with children or young people.

We discussed how the correct skill mix was factored into how rotas were developed given that people only accessed Derian House for a short period of time, and that the needs of people using the hospice varied considerably. The registered manager told us that staff had the skill set to care for all the children and young people that attended the service. However the experience of staff was taken into account as far as possible when rotas were devised. The registered manager also informed us that they could ultimately make the decision not to accept referrals into Derian House if they felt that they did not have the correct skill to meet any individual's needs, but that this was a rare occurrence. They did however accept that some children and young people with specialist needs, who did not access the service with any frequency, may not be able to attend the hospice if they did not have staff with the experience and competency needed.

We found that staffing levels were in place to meet the needs of the children and young people attending Derian House. However, there was some worrying evidence with regards to staffing levels that we discussed that we felt could be an issue going forward if trends continued. One issue was the current turnover of staff at the hospice. Both care and support staff turnover was higher than at the same period in 2016 and had shown a steady rise since the beginning of 2016 to the time of our inspection. For example for the months of July to September in 2016 staff turnover was 1.4% per month. For the same period in 2017 staff turnover was averaging 3.7% per month. In 2016 the total turnover of care staff was 16.9%. In 2017, up to the end of September care staff turnover was 22.5%, a rise of 5.6% from 2016 and the equivalent of 16 members of staff.

The hospice had been proactive in recruiting registered nurses, which has been a recognised national issue over the past few years. Actions included initiating an internal bank of nursing staff with pay incentives. The service had also engaged with NHS Education and recruited two clinical support workers who were undertaking a 'Trainee Assistant Practitioner' programme. Clinical Support Worker training had been reviewed in order for them to assist with the nursing role in a more proactive measure. The recruitment process had been reviewed for nursing staff as well as looking at targeting other areas of nursing such as learning disabilities, adult and mental health.

The registered manager could only comment on the care team as she had no responsibility for the support team and she told us that in comparison to other hospice's staff turnover was still good. She did recognise that there had been some issues with staff morale across the hospice. This coupled with the fact there had been a few changes of registered managers over the previous four to five years, resulting in a change in management styles, which could have contributed for the steady rise in staff turnover. The registered manager told us that from a care team perspective she felt that there were enough suitably qualified and competent staff to meet the needs of the children and young people using the service, and that morale

within the care team was good.

One of the issues raised by the Whistle-blower related to fire safety, we therefore reviewed the hospice's arrangements in this area. When the concerns were received by the Care Quality Commission (CQC), as the fire safety issues were presented as being non-compliant, we referred the issues onto Lancashire Fire and Rescue Service (LFRS). A Fire Officer visited Derian House on 4 September 2017 and confirmed that there were outstanding issues with relation to fire safety which meant that some people were at risk in the event of fire. We were sent a copy of LFRS's fire safety schedule that was compiled following the visit, and discussed it with the visiting Fire Officer. Prior to us inspecting the hospice the service told us that they were confident that the issues were being addressed and that the five items LFRS had highlighted within their fire safety schedule were being dealt with. During our inspection we went through the five items on the schedule with the temporarily appointed fire lead at the hospice.

The issues highlighted within the schedule did not include any major work or renovation and included items such as; ensuring escape routes were clear at all times, fire doors were fully maintained including the fitting of intumescent strips, ensuring that correct compartmentation was in operation to prevent fire spreading quickly and that exit signs were visible and complied with British standards.

We were shown a timeline report that the hospice had completed following the concerns being passed on to them by CQC. This included a number of completed actions prior to LFRS coming into the hospice. This ensured that any immediate concerns were resolved, such as ensuring that all escape routes were clear. This showed a proactive approach by the hospice once the issues were flagged to them. We were satisfied that the issues had been addressed and that the service was now compliant with fire safety.

The senior manager walked us round the entire hospice site and talked us through the recent improvements that had been made to the building in terms of fire safety, as well as other developments such as training for staff. They told us that care team leaders were now undertaking daily walk rounds to ensure continued compliance. One of the issues highlighted at the LFRS visit was some intumescent strips missing from door frames which meant that smoke may not be contained effectively. As the majority of the children and young people who stayed at Derian house used wheelchairs this meant that the strips could become damaged, so this was part of the daily tasks care team leaders undertook during their walk round. The care team office located within the lodge part of the hospice had been closed off as there had been issues highlighted with the integrity of the glazing separating it from the bedroom corridor. The hospice was taking advice from a construction company prior to re-opening the office again to ensure it met with fire safety standards.

At each designated fire compartment within the building there was a 'fire station'. This included a high visibility vest, notebook and radio. Each staircase had an emergency evacuation chair and each building had an evacuation bag with foil blankets to keep people warm in the event of a full evacuation of the building. Emergency and external lighting as well as all fire alarms within the hospice buildings had been checked by an external contractor since the whistleblowing allegations were made to ensure that they were operating efficiently. Emergency escape routes were available in pictorial form for those children, young people and families who could not speak English.

We reviewed the hospice's compliance with electrical and gas safety via service certificates and found these to be in date and in order. We also reviewed other maintenance records for the building and equipment used, for example the passenger lift, hoists, legionella and fire-fighting equipment and found these records to be in place and well maintained. All staff received health and safety training as part of their induction and we saw evidence of this and staff we spoke with confirmed this to be the case.

Recruitment files were well organised and we found information within them accessible. All staff had the required pre-employment checks including Disclosure and Barring (DBS) and references. All files had the required information under schedule three of the Health and Social Care Act 2014 including photographic ID and confirmation of their home address. Application forms were completed and staff were interviewed for the role in which they were recruited. We found the recruitment process to be fair and equitable. Staff we spoke with told us they felt the recruitment process was appropriate for their role and had been carried out in a fair way.

At our last inspection we identified some areas that needed to be improved in relation to medicines management. The issues raised were with regard to the safe disposal of drugs and the service level agreement that had been in place not being between two legal entities. Both these issues had been addressed shortly following our last inspection and we saw evidence at this inspection to confirm this to be the case. A new service level agreement was in place and we saw no issues with how medicines were disposed of or stored at this inspection.

We had received a notification from Derian House prior to our inspection regarding a batch of medication that had gone missing from the service. The medication was classed as a controlled drug. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. The hospice were transparent in notifying the Care Quality Commission and were carrying out their own internal investigation into the incident which included interviewing nearly 30 members of staff.

We checked how controlled drugs were stored, administered, recorded and disposed of on the first day of our inspection. We reviewed these processes in both the main hospice and the lodge and found no issues in any of the areas reviewed. We also examined individual care records and spoke to the senior nurse on duty.

An up to date medication policy was in place that covered the majority of the key areas needed. However the policy did not cover self-medication or consent. We saw that a number of children and young people did self-administer their medication and when shadowing the nurse on the second day of our inspection we saw an example of how a person was reminded to do so. Following our inspection a new medication policy was introduced and signed off that included sections on self-medication and consent. During our shadowing of the medication round we observed this to be done in a professional and competent manner.

We saw that all medication errors were recorded. There had been 30 medication errors for the service at the time of our inspection for 2017. Across both days of our on-site inspection we had access to telephone support from a CQC pharmacist in order to gain specialist advice. This was only needed once during the second day of our inspection to clarify the issue around the number of medicines errors as stated above. Our pharmacist had no concerns with how the hospice were managing children and young people's medicines and how they recorded, learnt from and dealt with errors when we explained the processes to them.

We looked at how children and young people were protected by the prevention and control of infections. An infection prevention and control policy was in place at the hospice. During the course of our inspection we toured the premises, viewing a selected number of bedrooms and all communal parts of the hospice including bathrooms and toilets throughout all parts of Derian House. All areas were observed to be clean. Formal infection control audits took place with a recent audit identifying parts of the flooring to be a possible infection control risk. A more suitable surface was being sourced at the time of our inspection. The recent audit also identified the art work on display as a potential infection control risk so the possibility of projecting art work onto the walls was being considered. As some of the artwork had been completed by current and past children and young people at Derian house this course of action was only a consideration

due to the sensitivities of removing the art work however this showed the depth of the audits in place in this area. Spot checks were carried out to ensure good hand hygiene took place and that staff were wearing the appropriate uniform and personal protective equipment (PPE). Staff told us they had access to PPE such as gloves in the correct size and aprons. Staff also carried individual bottles of hand gel that was used alongside correct hand washing techniques.

We saw that children and young people had risk assessments in place that were in line with the risks associated with their assessed needs. However some risk assessments were not detailed enough and had this discussion with the registered manager and other members of the care team. As stated in this report within several sections due to the short term nature of children and young people's stays at Derian House there was some dependency on the input of other agencies into this process and this had, at times not always been easy to gain. However we felt that risk assessments needed to accurately reflect children and young people's up to date needs in order for them to be as effective as possible. We recommend that all risk assessments are reviewed and are reflective of the current assessed needs of each individual who accesses the hospice.

Requires Improvement

Our findings

At our previous inspection in 2016 we made a recommendation as the hospice did not have a consent policy in place, and care plans did not reference the Gillick competency for children and young people. The judgement from the case of Gillick v a Local Health Authority and the Department of Health in 1983 laid out criteria for establishing whether a child under a certain age has the capacity to provide consent to treatment; the so-called 'Gillick test'. This meant the service was not effectively gaining consent from the children and young people who accessed the hospice. At this inspection we found the hospice was still operating without an appropriate consent policy in place despite other documents such as care plans referring to it. We did see that a consent policy had been drafted following our inspection in 2016 but this had only been ratified in May 2017. It had subsequently not been circulated, and therefore not implemented by Derian House following this process. This was done shortly following our inspection but it was recognised by the service that given this was an issue raised at the previous inspection that this should have been completed much earlier.

Within the care plans we reviewed for young people over the age of 18, it was at times unclear if their capacity had either been assessed or recorded accurately. This then made the issues of gaining consent difficult as it was unclear if the young person had the capacity to give consent. Consent forms that were in place were not used consistently across the service. For example, one person had given consent for activities and media but there were no other areas of consent gained. For another person the opposite was in place. We also saw an example of one young person receiving a medical examination with no formal consent gained and/or recorded.

Due to the lack of an implemented consent policy and the examples seen during the inspection where consent was not gained appropriately and/or documented correctly, this was judged to be a continued breach of the Health and Social Care Act (Regulated Activities) Regulations 2014, regulation 11, Need for Consent.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw the provider was working within the principles of the MCA for people who used the service given the nature of a hospice service and the infrequency of people using the service. The hospice had been working closely with the MCA and DoLS co-ordinator for Lancashire and a Barrister who had oversight of the best interest process within the hospice.

We discussed how the hospice took a multi-disciplinary approach to MCA and DoLS with the social care lead for the service at Derian House. They told us that they did, when appropriate work with children, young people and their families, in attempting to gain a consistent approach to enable children and young people to receive care and support in the least restrictive way. This, we were informed, was not always easy in terms of the engagement of people, families and other professionals. MCA, DoLS and transition workshops were being held to enable children, young people and families to meet with professionals to discuss this complex area. Fact sheets were also provided by the service to further assist in education and informing people about the MCA and DoLS. In some cases children and young people were not at Derian House long enough to support a formal DoLS application in which case we saw that Derian House worked within the main principles of the MCA to ensure people rights were protected. The social care lead for Derian House had established a North West Development Group to enhance the knowledge and practice in this area. The group consisted of colleagues from other hospices in the region, learning disability and mental health nurses, clinical support workers and youth workers.

We spoke with staff about the support they received from the service in order for them to carry out their roles effectively. The responses we received did vary dependent on the role of the staff member and in some cases dependent on who their line manager was.

None of the 57 staff we had contact with told us the issues they had directly affected the care and support of the children and young people at Derian House. Staff were adamant that this was the case and that if anyone suspected this had happened then the relevant statutory bodies would have been immediately informed. To support this view none of the relatives we spoke with or had contact with raised issues about staff morale or attitude. There was an acceptance when speaking to care staff that they were aware of some of the issues support staff had and that this had affected the morale of staff across the service.

In terms of formal staff support we found evidence that showed staff received supervisions, were annually appraised and attended training. Team meetings also took place across the various departments to assist with communicating key information and messages. As previously stated, we received markedly different responses dependent on where in the hospice staff worked other than with a few exceptions. Staff within the care team described a mainly supportive culture where staff could openly discuss issues. Staff within the support element of the service described a culture of fear, bullying and reprimand for those staff who did speak up. A number of staff told us there was a blame culture in operation.

It is difficult for confidentiality purposes to go into specific examples, however there were many accounts given to us from current and ex-employees of staff being belittled, berated and bullied, sometimes in open forums such as staff meetings. A number of staff were in tears when speaking with us and were visibly scared to do so. When we enquired with staff why they were frightened talking with us, they told us they were scared that their identity would be revealed by doing so. They were worried that they would be reprimanded for speaking out. A number of staff told us they would be 'punished'. Almost all the staff we spoke with who raised concerns with regard to bullying, named the same person within the service as the lead protagonist and this matched the information we were given by the anonymous whistle-blower.

The hospice did have a whistle-blowing telephone number so staff could pass on any concerns they may

have had anonymously. However, the whistle-blowing number was an internal number situated within Derian House's human resources department (HRU). This meant there was no independent response to staff who may have had concerns. Staff had told us they did not feel confident using this service. Staff employed within HRU would not have been able to use the service either if they needed to due to the fact that they ran the service.

Due to the weight of evidence given to us during the inspection, namely via the large and unprecedented amount of staff coming forward to speak to the inspection team, supported by the fact that the hospice's own staff survey had delivered a similar message, then the only judgement we could reach was one that the culture within the hospice's staff team was extremely unhealthy. Too many staff recounted similar experiences, whether they had personally been subject to bullying or having witnessed it first-hand, for the information not to have validity. As well as the initial fear of speaking with the inspection team, the other emotion staff told us they were experiencing was relief. They told us that they needed the information they were telling us to be heard and acted upon to ensure that the culture of the hospice was turned round.

We had a number of difficult, yet productive conversations, with senior staff at the hospice to ensure that the themes within the messages given to us were passed on to them. After some initial reluctance to accept some of the comments we felt the senior management team within the hospice, alongside the trustee board members we had contact with, acted quickly upon the issues passed on to them and accepted that a number of actions had to be taken to address them. This included, following our inspection, planning to bring in an external company to investigate the concerns staff had expressed both within the recent staff survey and during the inspection process in relation to culture.

Other developments had taken place that cannot be publicly reported on due to confidentiality reasons at the stage of writing this report, however, we were satisfied that the initial actions taken were positive and in the best interest of the hospice going forward.

We saw good evidence to show that new staff received a formal induction when starting work at the hospice, regardless of their role. This evidence was enforced when speaking with staff who informed us that they received a thorough and appropriate induction for the role they were employed to undertake.

We looked at how the hospice supported children and young people with their nutritional needs whilst they were at Derian House. We spoke with one of the cooks on duty during our inspection. They told us they were given information in advance about each person's needs which included any known allergies, consistency of food, e.g. if anyone needed a soft or liquid diet, increased calories and any religious or cultural requirements. Children and young people's care plans contained information about their likes and dislikes and their food and fluid intake was measured if this was an assessed need. Nursing and care staff received the appropriate training for children and young people who needed specialised feeding techniques such as percutaneous endoscopic gastrostomy (PEG) or enteral. Appropriate information and guidance was also in place for children and young people with such assessed needs. We identified one issue where a child's nutritional needs had changed between visits and we found no evidence that this had been assessed. The incident was with regard to a child on a soft diet being offered inappropriate food. This issue again linked into the need for information from other agencies and professionals to be sought when individuals accessed the hospice.

Good

Our findings

Without exception the relatives we spoke with told us about a service that was invaluable to their family. One relative told us, "We simply could not survive without them and feel so lucky to be part of the Derian family." Other comments we received included one relative who said, "Derian staff are just wonderful. We can't imagine what it would be like to not have their amazing support. Staff are so caring and approachable and they make us feel so welcome. It's a home from home and feels like an extended family. They have helped us create some extra special memories and have also provided valuable counselling support." Another relative told us, "We cannot praise Derian House highly enough. The level of care they provide is outstanding. They go above and beyond to ensure not only [name], but our whole family is cared for. For us, it is like going from home to home and we feel privileged to have been welcomed in to the Derian family." We received many comments such as these, all praising the service, the hospice environment but especially the dedication, commitment, empathy and professionalism of the staff who cared for their children.

A number of relatives contacted us whose children had been cared for at Derian House, either at, or towards the end of their life. One relative who contacted us said, "We were truly looked after and able to enjoy a 'bubble' of happiness at Derian House, we would have been lost without Derian House and the wonderful team. The staff have supported us in many, many ways, and still do. They now provide counselling and sibling services, the care is on-going. We are and will always be thankful for our precious time at the hospice, making memories as a family with the most amazing staff."

One relative told us how the hospice had advised them when their child had passed away whilst away from their own home in another part of the Country. They told us, "They helped us to voice our preference to return to the hospice so that [name] could be in the Sunflower room, they made this possible. It meant so much to know that [name] was with the nurses who knew him. Upon arrival we were comforted and cared for. I cannot begin to imagine how this indescribable, torture would have been had we not have been at Derian House for the days after."

Derian House has two temperature controlled rooms which enable children and young people to lay in rest at the hospice. These rooms are called the Sunflower suites. The rooms can be used by families whether or not their loved ones have died within the hospice. As with the example given above, arrangements can be made to bring children and young people to the hospice until the necessary funeral arrangements have been made. Assistance is also provided for families both in terms of counselling, accommodation and practical issues. Pictures of sunflowers are placed within the corridors and building entrance to indicate to staff and visitors that a child or young person was at rest within the Sunflower suite.

It was evident from speaking with a range of relatives, professionals and staff working at the service that for many families Derian House was a genuine lifeline for them. This support carried on, for some, for many years after their loved ones had passed away.

The hospice has its own chapel, although there is no distinct religion referred to within the room. We saw evidence of people of all faiths utilising this room for peace, quiet and sanctuary. People accessed the room for a variety of reasons whether it be for remembrance, shortly following the final moments of their loved one's life or simply for some time alone. The chapel is full of photographs and messages of remembrance. At the time of our inspection correspondence had gone out to all the families whom the service was still in contact with, to explain that the room was at capacity in terms of being able to hold all the photographs of children and young people who had passed away. This was being carried out in a sensitive manner as staff at the hospice was more than aware of the importance of the chapel to many people. This evidenced that the hospice consulted with families when important and difficult decisions had to be made and it was done so in as sensitive a manner as possible.

We saw examples of advance care plans in place for those children and young people that needed them. Plans were detailed and showed that, where possible, children and young people had been involved in their design. Files were clearly marked to show that an advance care plan was in place.

The young person we spoke with told us that they had choices when they stayed at Derian House including what they ate, what time they went to bed and what activities they chose to do. Family members we spoke with told us that they were fully informed and involved each time that their loved one stayed at the hospice and that communication with the service was excellent. Relatives told us that information was given to them in a variety of ways including verbally, written and via information booklets and leaflets. We were also directed to the hospice's website which held a variety of information and was kept up to date. Newsletters were also produced quarterly and the hospice had a 'Facebook' page which contained links to information and upcoming events.

We found that children's dignity and privacy was considered at all times. When speaking to staff about this area they were very knowledgeable. Confidentiality was also maintained and staff signed a confidentiality agreement upon entering the workforce.

We did not review anyone's care plan who was receiving formal advocacy, however we were informed that if required this would be accessed and the hospice were aware of how to access advocates for children and young people.

Good

Our findings

We looked at eight children and young people's care plans and other associated documents such as assessments and daily records to ensure that they reflected the current needs of each child and young person accessing the service. We discussed care plans with a number of staff including the registered manager, who was also the clinical lead we also spoke with the operational lead and social care lead. As mentioned within several parts of this report, there had been a concentrated effort within the service to engage, or re-engage with statutory bodies and agencies in order to be kept informed of changes to children and young people's needs. As the children and young people who used the service at Derian House did so on an occasional basis, (usually between 14 and 21 days per year), the hospice staff were not always invited or involved in the care and support reviews for them. This had a potential effect on the ability of the service to have care plans that were up to date to reflect the latest needs of children and young people.

We did however see some very good detail within care plans and it was evident that a lot of work had gone into them. Each care plan we reviewed was person centred and there was evidence that children and young people and their families, when appropriate, had been part of the design process. Care plans contained a section entitled 'a book about me' which included personal details, a photograph and covered issues such as the best way the person communicated, likes, dislikes and what they enjoyed doing whilst at Derian House.

Care plans contained a number of sections individualised to children and young people's stay, e.g. 'All about my stay', 'All about my day', 'All about my night' and if appropriate a section about any difficulties the person may have. For example we saw a section entitled 'All about my seizures'. Each of these sections gave detail, advice and guidance for each period, activity or potential issue. Generally care plans were seen to be of good quality and contain good information and staff we spoke with told us they found them to be useful.

The service had a robust and effective complaints system in place. The policy was on display and contained the details of external organisations as well as the hospice's internal procedures. Staff were knowledgeable in this area and were able to tell us how they would deal with a complaint or issues raised with them. A complaints file was held in the office and we saw that any complaints made to the service were dealt with in line with their own policy. It was clear that the service did not receive many complaints but in contrast received a huge amount of compliments. These were received via various methods and the ones we read very much reflected the positive messages we were told when speaking to and receiving messages from families.

There were a large amount of activities on offer for children and young people. Activities were displayed on the walls alongside art and craft work that had been done by the children and young people. On the first day of our inspection we saw one of the children in the art and craft room and it was clear that they were enjoying the activity. It was also clear from our observations that once they had had enough of the activity, it was their choice the go and do something else, and staff were happy to engage with another activity. There was also a music room for children and young people to use, as well as a sensory room and fully adapted hydrotherapy pool. The hydrotherapy pool was mentioned by a large number of families, as the adaptations to this facility meant that families could spend time together in an environment that they would ordinarily be unable to. Sessions were overseen by specially trained staff.

There were countless examples seen of external activities in addition to the activities available within the hospice. Positive risk taking was underpinned by individual risk assessments for activities to enable children and young people to experience different activities, from going to the nearby park for a walk to more adventurous activities. There was also an outdoor play area on site and a sensory garden which were utilised when the weather allowed.

The hospice had many links with external services to assist young people transitioning into adult services, We discussed individuals who had transitioned successfully. The fact that young people could access the hospice until they were 26 years old was seen to be a positive step in that it allowed transitions to happen in a much more graduated way.

We saw evidence that the hospice was responding to the changing or increased needs of its population. A number of new services or expansion of existing services, were at different stages of being introduced at the time of our inspection. This included the expansion of community, family support and young people's services, as well as introducing new services such as a health and wellbeing and neonatal service. This is evidence that the service was listening and acting upon the demands and needs of the children and young people in the area.

Requires Improvement

Our findings

We carried out this inspection following the receipt of information from an anonymous whistle blower. The main aspect of this information was with regard to the culture at Derian House. The information painted a picture of a service where staff felt vulnerable, bullied and unable to express their views freely without being reprimanded for doing so. Following conversations with nearly 60 staff our judgement was that the opinions supplied by the whistle-blower were shared by many of the staff we spoke with.

The vast majority of staff we spoke with did so at length and went into detail. Some were visibly upset and fearful of speaking to us. When we asked staff who did speak with us why they wanted the fact they had done so kept confidential, they told us it was because they were fearful of losing their jobs after speaking to us. As with the information within the 'Effective' domain of this report, staff did not feel supported by the service. Conversations with direct care staff and with support staff did generally differ in that, care staff were much more positive in their appraisal of the leadership at Derian House. However, all except a few members of staff were not surprised when we informed them of the main reason for our inspection. All the staff we spoke with were aware of cultural issues at the hospice even if they had not been directly impacted as an individual.

Much of the information we were told by staff related to a specific individual, although some other senior members of staff were mentioned. Similar information had been revealed to the hospice via the staff survey undertaken in July 2017. This had resulted in an internal review taking place and a report being produced by the board of trustees. We were given a draft summary of this review during our inspection. We were also given full access to the staff surveys and the analysis and summary that followed. We found, given the strength of the messages of discontent within the staff survey, that this review was insufficient to address the issues raised. We were given further assurance in the weeks following our inspection that further measures had been taken to look into the cultural issues raised. This included meetings at trustee level, discussions within the Senior Management Team and the commissioning of an independent investigation into the allegations of bullying made by staff to us and via the staff survey. At the time of this report being complied we had shared the general themes of the conversations we had with staff however we had not shared specific information due to the information being passed to us done so in a confidential and protected manner.

One issue raised by many staff, both within the staff survey and during discussions with Inspectors, was that it was difficult for staff to raise issues directly to the board of trustees due to the systems in place at the hospice. Two members of the board of trustees were present across the two days of our inspection however

staff we spoke with told us that other than a cursory greeting, they did not feel confident speaking directly to them. As with other issues it is difficult to give specific information, without revealing the identity of key members of staff, but this was a consistent message given to us.

We did see evidence of several meetings that trustees were part of where staff were able to attend but these were formal meetings at which conversations were felt not to be confidential. Trustees' details were on the hospice website; however contact details for trustees were not available so that people could contact them easily. The two trustees we spoke with told us that they had not been approached by staff with mentioning any of the numerous issues told to us. However one of the trustees did say they had engaged in conversations with one member of staff who had now left the service. The issues discussed resonated some but not all of the issues raised with us by other staff. We have written formally to the Trustees of Derian House regarding these concerns.

We were told during our feedback that contact methods for trustees would be placed on the Derian House website so staff, and indeed members of the public, were able to contact trustees directly as another measure of ensuring staff had somewhere to take any issues they may have. At the time of our inspection three new trustees had been appointed and this was seen as a positive measure in terms of bringing new people into the hospice.

The weight of staff wishing to discuss their concerns in this area was overwhelming both during and following this inspection. The ultimate conclusion following the inspection was that the working culture within the hospice overall was extremely unhealthy and this was supported by the testimonies of staff we spoke with, the results of the staff survey and the high turnover of staff over the preceding 12 month period. However, despite this none of the staff we spoke with told us that the care of the children and young people at Derian House had ever been compromised. This message was made very clear to us. Staff told us that if there was the slightest inclination that the quality of the care had been affected then this would have been reported to the relevant authorities immediately. Given the fact that no parent or relative raised the culture or atmosphere as an issue we felt confident that this was a true reflection of the service received by children, young people and their families.

Relatives we spoke with only had positive things to say about Derian House. The majority of conversations we had with parents and relatives was with regard to the direct contact they had with staff and the positivity of these interactions and the 'amazing' support they and their children received. These sentiments ran through the whole hospice from support staff through to the management team that parents and relatives had contact with. We did not ask direct questions of relatives about the culture of Derian House. We did not share the initial purpose of our inspection with them which allowed people to tell us of their experience of Derian House as opposed to asking direct questions about the whistle blowing allegations. However no parent or relative shared any negative experience in terms of the culture, atmosphere or experience of the service at the hospice. Those parents that did touch upon this area, as with all their feedback, spoke positively and of a sanctuary for them and their loved ones and a caring, empathetic and professional environment.

The service had a number of quality assurance and monitoring systems in place to ensure that all aspects of the service were reviewed. We discussed with, and were shown by the hospice's quality, audit and standards lead, the systems they had helped introduce in the 18 months they had been at the hospice. They explained to us that they had strengthened and formalised the governance structure at the hospice and that this process had been challenging for some staff in that they were now more accountable. There were a number of new documents in place that assisted implementation such as a draft governance handbook that clearly explained the internal governance processes that scrutinise the work of the hospice and the approval

processes for them. We were also shown the newly updated Statement of Purpose for the hospice which laid out the aims and objectives of the service, who the hospice provided care and support for, the referral process and criteria, the facilities at the hospice as well as governance processes and operational, strategic and financial governance arrangements. This had been implemented on 1 September 2017.

We saw evidence, through formal minutes, of a number of meetings which took place on a regular basis. Staff we spoke with also confirmed the meetings took place and dependent on their role they attended meetings in order to keep up to date with developments and issues with reference to their own role and work and general developments within the hospice. We saw minutes for the Senior Management Team (SMT) and that they discussed pertinent issues to the service. For example within the SMT minutes of 12 September reference was made to the fire safety issues and the medication issues that had both been discussed with CQC. There was also reference to the staff survey results and some of the themes raised by them, such as 'alleged bullying'. Reference was made to processes in place for staff who experienced bullying but that these were 'not often used by staff'. The chair of the meeting, according to the SMT minutes, 'asked all to move forward and not dwell on the survey too much'. There was also reference to comments made within the staff survey as being, 'malicious and factually incorrect' and that legal advice was being sought in how to respond, report and act upon such comments. Therefore whilst the results and themes of the survey were discussed this gave further evidence that the serious allegations made within them were not given the attention they were needed to give staff confidence that their issues were being listened to and acted upon at this time. Indeed a defensive attitude was taken at this time given the conclusions at the SMT meeting stated the comments were 'malicious' in their intent.

Other meeting minutes we saw included; Finance and Investment Committee, Income Generation Committee, Clinical Governance, Staff forum and Health and Safety forum. As with the SMT minutes the health and safety forum discussed the recent fire issues within the meeting of 19 September and the remedial work and actions taken following the visit from Lancashire Fire and Rescue.

We were given a copy of the bundle of papers given to trustees prior to their meetings. The information was seen to be comprehensive in detail and included a report from the CEO and SMT. This document mentioned that '...staff morale is currently quite poor' and that the responses of the staff survey at the time of the report (September 2017) were '...particularly damning and highly critical' (of the leadership). Other documents and areas for discussion included safeguarding, health and safety, a review of the hospices risk register, future meetings and the review and sign off of minutes from income generation, clinical governance, finance and investment and parent forum meetings.

We did therefore see a wide range of systems in place to measure quality performance and other key areas of the day to day running of the hospice as well as planning for the future. However, as highlighted earlier within this report, these systems were unable to prevent the fire issues and the cultural issues within the service developing. Neither had systems and processes in place been able to address the consent issues we had highlighted at our previous inspection in 2016 or the issues highlighted with regard to the medication policy. This again we were informed, had been a delay in progressing the new consent policy which had been approved but had not been circulated to staff. As such we found these concerns to be a breach of the Health and Social Care Act (Regulated Activities) Regulations 2014 in relation to regulation 17: Good Governance.

We saw a good range of evidence to show that the hospice worked well with external agencies including other local hospices, clinical commissioning groups and local authorities. As Derian House works across a large geographical area, relationships were not always easy to build and maintain and we were told of several examples when the service had not been informed of review meetings for the children and young

people that accessed the service. One of the care team managers spoke with us about how they were working to with various bodies to ensure that they were kept informed of changes to people's needs and for them to be given the opportunity to attend or input into review meetings. Aside from the number of different agencies involved the fact that Derian House was accessed for a short period by children and young people meant that they could sometimes be seen as not being an integral part of the review process for some statutory bodies. However we saw good evidence to show that work was being undertaken by the care management team to encourage their involvement as frequently as possible. This then ensured that when children and young people did access Derian House that the service had an up to date picture of their care and support needs.

As well as the overall positive relationships with external agencies and bodies Derian House continued to have extremely positive relationships with the local and wider community. An extremely wide ranging and varied amount of outreach work takes place including fundraising events throughout the year. The reputation and standing of Derian House across the North West is very positive and this came through when reviewing compliments on social media, that the hospice had on record and from conversations we held with staff, relatives and other professionals.

Derian House were clearly displaying the latest inspection rating both on line and within the hospice building itself in line with their regulatory responsibilities.

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The hospice was still operating without an appropriate consent policy in place despite other documents referring to it and this being highlighted as an issue at the previous inspection. Consent was gained inconsistently across the service.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The wide ranging governance systems in place were seen to be ineffective in negating issues around fire safety and culture.