The Treehouse

Quality Report

The Treehouse
East Anglia's Children's Hospice
St. Augustine's Gardens
Ipswich
IP3 8NS
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Date of inspection visit: 14 January 2020
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Good ●
Are services well-led?	Outstanding ☆

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

East Anglia's Children's Hospices (EACH) operates The Treehouse - a dedicated children's hospice with five beds. Facilities include an outdoor play area with woodland walks, a sensory garden, a music room, an art studio, a hydrotherapy pool, a sensory room, a faith and reflection room, a refreshment and kitchen area, and dedicated play areas.

The Treehouse provides hospice care for children and young people. We inspected all services provided by the hospice.

We inspected this service using our comprehensive inspection methodology. We carried out a short-notice announced inspection on 14 January 2020.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

Our rating of this hospice improved. We rated it as **outstanding** overall.

We found areas of outstanding practice in relation to hospice care for children:

- There was a truly holistic approach to assessing, planning and delivering care and treatment to all children and young people who used the service. The service provided care and treatment based on national guidance and evidence-based practice, and managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.
- Staff consistently treated children, young people, and their families with compassion and kindness. Staff respected and maintained children and young people's privacy and dignity throughout their care. There was a strong patient-centred culture, and staff were passionate about meeting the holistic needs of each child, young person and their families.
- Staff provided emotional support to children, young people and their families to minimise their distress. Staff recognised and respected the totality of people's needs, and their personal, cultural and religious needs. Staff went the extra mile to meet people's emotional needs, and saw these as important as their physical needs.
- Staff supported children, young people and their families to understand their condition, make decisions about their care and treatment, and become active partners in their care. Staff ensured a family-centred approach to care, and were fully committed to working with people to make this a reality. Staff encouraged and empowered the people who used the service to have a voice and realise their potential. For example, we saw the service had developed a model and approach to care planning that firmly placed the child or young person at the centre. Staff and managers proactively undertook a comprehensive and regular review of the needs of all people who used the service, through the development of the holistic needs assessment process.
- The service planned and provided care that met the needs of local children, young people and their families. Staff worked with other healthcare providers to deliver care, including community providers and local organisations. Staff were passionate about meeting the needs of local children and young people, and were proactive in the development of flexible and tailored pathways for each service user. For example, we saw the service had developed a comprehensive transition programme with a local adult hospice to support the transition of young people from children's and young people's services into adult services.
- Staff went the extra mile to understand the needs of each child and young person who used the service, as well as the needs of their families and those close to them. The service was inclusive, and staff took a proactive approach to make adjustments to allow all children and young people to access hospice services. The service coordinated care with other healthcare

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organisations and providers. For example, we saw the service had developed a comprehensive long-term ventilator community outreach service, staffed by experienced nurses, who provided children and young people with dedicated and specialist advice within their own home and within the hospice.

- Leaders and staff actively and openly engaged with children, young people, families, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for children and young people. For example, we saw the service had developed a comprehensive network of local volunteers, which helped the organisation to meet the needs of local people, particularly with the development of their 'Help at Home' volunteer service.
- The service had a vision and a mission statement for what it wanted to achieve, developed with all relevant stakeholders. The vision was focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. For example, we saw the service had formed strong and lasting working relationships with other care providers and community organisations, and had taken a leadership role in the local healthcare environment to meet the needs of the local population.

We found areas of good practice in relation to hospice care for children:

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff received training to use them. Staff managed clinical waste well. When providing care in patients' homes, staff took precautions and actions to protect themselves and patients.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured they implemented and monitored any actions from patient safety alerts.
- Staff gave children and young people enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for patients' religious, cultural and other needs.
- Staff assessed and monitored children and young people regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Heidi Smoult

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for children	**Outstanding** ☆	Hospice services for children was the main service offered at The Treehouse. We rated the service as outstanding overall, because the service was outstanding in caring and well-led, and good in safe, effective and responsive.

Summary of findings

Contents

Outstanding ☆

The Treehouse

Services we looked at:
Hospice services for children.

Summary of this inspection

Background to The Treehouse

The Treehouse is a dedicated children's hospice, operated by East Anglia's Children's Hospices (EACH). It is one of three hospices operated by EACH, along with The Nook hospice in Norfolk and the Milton hospice in Cambridgeshire. EACH provides support for children and young people with life-limiting or life-threatening conditions, and their families and carers, across the counties of Norfolk, Suffolk, Cambridgeshire and Essex.

The Treehouse is a custom-built facility, which opened in 2012. It has five bedrooms for children and young people, and accommodation for their families. In addition to the bedrooms, the location includes an outdoor play area with woodland walks, a sensory garden, a music room, an art studio, a hydrotherapy pool, a sensory room, a faith and reflection room, a refreshment and kitchen area, and dedicated play areas.

The hospice delivers several services, including end of life care, day care, overnight accommodation, emotional support, counselling and well-being services, occupational therapy, physiotherapy, hydrotherapy, specialist play support and symptom management. The hospice provided additional services in patients' homes, including a long-term ventilation outreach service.

The location has had a registered manager in post since July 2015.

The service is registered to provide the following regulated activities:

- Treatment of disease, disorder and injury.

We have inspected The Treehouse four times since its registration with CQC in 2011. Our last inspection was in June 2015, where we rated the service as good overall. We did not issue any requirement or enforcement notices following the inspection.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors and a specialist adviser with expertise in children's hospice care. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspections.

Why we carried out this inspection

We carried out this inspection as part of our routine inspection programme.

How we carried out this inspection

We inspected this location using our comprehensive inspection methodology. The inspection was a short-notice announced inspection carried out on the 14 January 2020.

Summary of this inspection

Information about The Treehouse

The service is registered to provide the following regulated activities:

- Treatment of disease, disorder and injury.

During the inspection, we visited the hospice and its facilities, including bedrooms, clinic and therapy rooms, and outdoor facilities. We spoke with 15 staff, including registered children's nurses, healthcare assistants, therapists, support staff, and senior managers. We spoke with four trustees of the organisation and one volunteer. We spoke with three patients and relatives. During our inspection, we reviewed five sets of patient records and 10 sets of medication administration records.

There were no special reviews or investigations of the hospice ongoing by CQC at any time during the 12 months before this inspection. We have inspected the hospice four times since its registration. The most recent inspection took place in June 2015, during which we found that the hospice was meeting all standards of quality and safety it was inspected against.

Activity

In the reporting period from October 2018 to September 2019, the hospice provided care to 117 patients. This included:

- 21 children aged 0 to 3 years.
- 67 children aged 4 to 12 years.
- 24 young people aged 13 to 17 years.
- 5 young people and adults aged 18 to 65 years.

Track record on safety

In the reporting period from October 2018 to September 2019:

- The service reported no never events.
- The service reported no serious incidents.
- The service reported no duty of candour notifications.
- The service reported no unexpected deaths.
- The service reported no external reviews or investigation of the service.

Track record on complaints

In the reporting period from October 2018 to September 2019:

- The service reported 22 compliments.
- The service reported eight complaints.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Our rating of safe stayed the same. We rated it as **good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect children and young people, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff received training to use them. Staff managed clinical waste well. When providing care in patients' homes, staff took precautions and actions to protect themselves and patients.
- Staff completed and updated risk assessments for each child and young person, and removed or minimised risks. Risk assessments considered children and young people who were deteriorating and in the last days or hours of their life.
- The service had staff with the right qualifications, skills, training and experience to keep children and young people safe from avoidable harm, and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix to keep children and young people safe. Managers gave all new staff a full induction to the service.
- Staff kept detailed records of the care and treatment of children and young people. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured they implemented and monitored any actions from patient safety alerts.
- The service used monitoring results well to improve safety.

However:

Summary of this inspection

- Not all staff had completed all mandatory adult safeguarding training.
- The provider did not always undertake regular infection control audits.
- Staff did not always complete all medication administration records in line with their policy.

Are services effective?

Good

Our rating of effective stayed the same. We rated it as **good** because:

- There was a truly holistic approach to assessing, planning and delivering care and treatment to all children and young people who used the service. The service provided care and treatment based on national guidance and evidence-based practice, and managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.
- Staff gave children and young people enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for patients' religious, cultural and other needs.
- Staff assessed and monitored children and young people regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff were actively engaged in activities to monitor and improve the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Staff were proactively supported and encouraged to acquire new skills and share best practice. Managers proactively recruited and supported volunteers in their role.
- Specialists, nurses and other healthcare professionals were committed to working collaboratively and found innovate and efficient ways to deliver joined-up care to people who used services. Staff worked together as a team to benefit children and young people, and supported each other to provide good care. There was a holistic approach to planning people's discharge, transfer or transition to other services, which was done at the earliest possible stage.

Summary of this inspection

- Key services were available seven days a week to support timely patient care.
- Staff gave children, young people and their families practical support and advice to lead healthier lives, and proactively identified and helped those who required extra support.
- Staff supported children and young people to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support children and young people who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Are services caring?

Outstanding 

Our rating of caring stayed the same. We rated it as **outstanding** because:

- Staff consistently treated children, young people, and their families with compassion and kindness. Staff took actions to respect and maintain children and young people's privacy and dignity throughout their care. There was a strong patient-centred culture, and staff were passionate about meeting the holistic needs of each child, young person and their families.
- Staff provided emotional support to children, young people and their families to minimise their distress. Staff recognised and respected the totality of people's needs, and their personal, cultural and religious needs. Staff went the extra mile to meet people's emotional needs, and saw these as important as their physical needs.
- Staff supported children, young people and their families to understand their condition, make decisions about their care and treatment, and become active partners in their care. Staff ensured a family-centred approach to care, and were fully committed to working with people to make this a reality. Staff encouraged and empowered the people who used the service to have a voice and realise their potential.

Are services responsive?

Good 

Our rating of responsive stayed the same. We rated it as **good** because:

- The service planned and provided care that met the needs of local children, young people and their families. Staff worked with other healthcare providers to deliver care, including

Summary of this inspection

community providers and local organisations. Staff were passionate about meeting the needs of local children and young people, and were proactive in the development of flexible and tailored pathways for each service user.

- Staff went the extra mile to understand the needs of each child and young person who used the service, as well as the needs of their families and those close to them. The service was inclusive, and staff took a proactive approach to make adjustments to allow all children and young people to access hospice services, including people who were in vulnerable circumstances or who had complex needs. The service coordinated care with other healthcare organisations and providers.
- People could access the service when they needed it and received the right care promptly. The service prioritised end of life care and ensured all children, young people and their families could access all services when they needed them most. Delays and cancellations were managed appropriately, and people were kept informed of any disruption to their care or treatment.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint. The service could demonstrate where improvements had been made as a result of learning from reviews and shared learnings with other services.

However:

- The service had a number of cancellations for planned short breaks. Between October and December 2019, there were seven instances of short break cancellations by the service. The service were in the process of a service redesign to reduce short break cancellations.

Are services well-led?

Outstanding ☆

Our rating of well-led improved. We rated it as **outstanding** because:

- Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There was compassionate, inclusive and effective leadership at all levels. Leaders understood and managed the priorities and issues the service faced. They were

visible and approachable in the service for patients and staff. Leaders at all levels had the skills and experience to support the delivery of excellent care, and supported staff to develop their skills and take on more senior roles.

- The service had a vision and a mission statement for what it wanted to achieve, developed with all relevant stakeholders. The vision was focused on sustainability of services, aligned to local plans within the wider health economy, and had a positive impact on quality and care. Leaders and staff understood and knew how to apply them and monitor progress.
- Staff felt respected, supported and valued, and focused on the needs of children, young people and their families receiving care. There were high levels of satisfaction across all staff, and staff were proud to work for the organisation. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where children, young people and their families and staff could raise concerns without fear.
- Leaders operated effective governance processes throughout the service and with partner organisations. The board and other levels of governance in the organisation functioned effectively and interacted with each other appropriately. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. Managers identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. Staff and managers quickly identified problems and addressed issues effectively and openly.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. The information used in reporting, performance management and delivering quality care was accurate, valid and relevant.
- Leaders and staff actively and openly engaged with children, young people, families, staff, equality groups, the public and local organisations to plan and manage services. They

Summary of this inspection

collaborated with partner organisations to help improve services for children and young people. The service took a leadership role to identify and proactively address challenges and meet the needs of the population.

- There was a fully embedded and systematic approach to improvement. Improvement methods and skills were available and used across the organisation, and staff were empowered to lead and deliver change. All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research. There was a strong record of sharing work locally, nationally and internationally.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospice services for children	Good	Good	Outstanding	Good	Outstanding	Outstanding
Overall	Good	Good	Outstanding	Good	Outstanding	Outstanding

Outstanding ☆

Hospice services for children

Safe	Good ●
Effective	Good ●
Caring	Outstanding ☆
Responsive	Good ●
Well-led	Outstanding ☆

Information about the service

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Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Summary of findings

Our rating of this hospice improved. We rated it as **outstanding** overall.

We found areas of outstanding practice in relation to hospice care for children:

- There was a truly holistic approach to assessing, planning and delivering care and treatment to all children and young people who used the service. The service provided care and treatment based on national guidance and evidence-based practice, and managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.
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Hospice services for children

committed to working with people to make this a reality. Staff encouraged and empowered the people who used the service to have a voice and realise their potential. For example, we saw the service had developed a model and approach to care planning that firmly placed the child or young person at the centre. Staff and managers proactively undertook a comprehensive and regular review of the needs of all people who used the service, through the development of the holistic needs assessment process.

- The service planned and provided care that met the needs of local children, young people and their families. Staff worked with other healthcare providers to deliver care, including community providers and local organisations. Staff were passionate about meeting the needs of local children and young people, and were proactive in the development of flexible and tailored pathways for each service user. For example, we saw the service had developed a comprehensive transition programme with a local adult hospice to support the transition of young people from children's and young people's services into adult services.
- Staff went the extra mile to understand the needs of each child and young person who used the service, as well as the needs of their families and those close to them. The service was inclusive, and staff took a proactive approach to make adjustments to allow all children and young people to access hospice services. The service coordinated care with other healthcare organisations and providers. For example, we saw the service had developed a comprehensive long-term ventilator community outreach service, staffed by experienced nurses, who provided children and young people with dedicated and specialist advice within their own home and within the hospice.
- Leaders and staff actively and openly engaged with children, young people, families, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for children and young people. For example, we saw the service had developed a comprehensive network of local volunteers, which helped the organisation to meet the needs of local people, particularly with the development of their 'Help at Home' volunteer service.
- The service had a vision and a mission statement for what it wanted to achieve, developed with all relevant stakeholders. The vision was focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. For example, we saw the service had formed strong and lasting working relationships with other care providers and community organisations, and had taken a leadership role in the local healthcare environment to meet the needs of the local population.

We found areas of good practice in relation to hospice care for children:

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff received training to use them. Staff managed clinical waste well. When providing care in patients' homes, staff took precautions and actions to protect themselves and patients.
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Outstanding ☆

Hospice services for children

Are hospice services for children safe?

Good

Our rating of safe stayed the same. We rated it as **good**.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received comprehensive mandatory training, which met the needs of patients and staff. Mandatory training covered key topics, such as resuscitation, infection control, safeguarding, moving and handling, food hygiene and fire training. The service delivered mandatory training through a combination of face-to-face and e-learning sessions.

Staff kept up-to-date with mandatory training and could monitor their compliance using an online system. The provider's education team automatically booked staff onto mandatory training courses, and provided staff with alternative dates if they could not attend the initial date. Managers monitored mandatory training compliance, and alerted staff via email when they needed to update or undertake additional training. Staff told us their managers supported them to undertake training, and gave them dedicated time to complete training.

We reviewed mandatory training completion for all care staff. The provider had a target of 90% completion for all mandatory training. At the time of our inspection, the compliance was:

- Moving and handling of children and young people: 100% (21 out of 21 staff)
- Resuscitation (including paediatric basic life support) and anaphylaxis: 95% (20 out of 21 staff)
- Infection control: 86% (24 out of 28 staff)
- Fire Training: 96% (27 out of 28 staff)
- Oxygen management: 85% (17 out of 20 staff)
- Data security and protection: 100% (28 out of 28 staff)
- Food hygiene: 100% (16 out of 16 staff)

The provider advised completion figures included staff on maternity leave, sickness and annual leave. The provider had arranged an additional training courses during February and March 2020 to cover resuscitation and anaphylaxis, oxygen management and infection control.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it. However, not all staff had completed all mandatory adult safeguarding training.

Staff received safeguarding training specific for their role on how to recognise and report abuse. We reviewed safeguarding training completion for all care staff. The provider had a target of 90% completion for all mandatory safeguarding training. At the time of our inspection, the compliance across each role was as follows:

Nursing staff:

- Safeguarding children level 3: 67% (10 out of 15 staff)
- Preventing radicalisation level 3: 67% (10 out of 15 staff)
- Adult safeguarding level 2: 67% (10 out of 15 staff)

Care assistant staff:

- Safeguarding children level 3: 75% (3 out of 4 staff)
- Preventing radicalisation level 3: 50% (2 out of 4 staff)
- Adult safeguarding level 2: 0% (0 out of 4 staff)

Other staff (includes well-being staff, occupational therapists and physiotherapists)

- Safeguarding children level 3: 56% (5 out of 9 staff)
- Preventing radicalisation level 3: 78% (7 out of 9 staff)
- Adult safeguarding level 2: 11% (1 out of 9 staff)

Volunteers:

- Safeguarding children level 2: 78% (29 out of 37 volunteers)

Regarding the safeguarding mandatory training modules that were below the provider's target completion rate, we saw the provider attributed this to the last-minute cancellation of a recent training session, due to trainer sickness, and had arranged an alternative session for March 2020. For volunteers, the provider advised this was due to long-term sickness of some volunteers, however they confirmed all returning volunteers would complete this training upon their return to the service.

We saw the service had attributed low adult safeguarding training compliance to its recent addition to the mandatory training schedule. The provider told us they

had mandated all staff to complete this by March 2020. This was in line with a change in the intercollegiate document entitled Adult Safeguarding: Roles and Competencies for Health Care Staff, published in August 2018, which states that all staff are required to complete adult safeguarding training to level 2 by August 2021.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had an executive board level lead for safeguarding, a safeguarding named professional and a locally-named hospice lead. Staff told us they would raise any safeguarding concerns with their manager or a senior member of staff on duty. Staff explained they recorded all safeguarding concerns in the patient's electronic notes, which other healthcare providers, such as GP services and hospitals, could access.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify children and young people at risk of, or suffering, significant harm and worked with other agencies to protect them. For example, staff explained they worked with other care agencies and social workers to investigate safeguarding concerns and protect patients at risk of harm and abuse.

The provider had a service level agreement (SLA) with a local NHS trust to provide the hospice staff with safeguarding training and a 24-hour advice line, should staff require expert safeguarding advice. Hospice staff told us staff from the NHS trust visited the hospice to undertake safeguarding debriefs with staff and attended regular safeguarding supervision meetings. These safeguarding supervision meetings occurred regularly throughout the year, led by a member of the hospice's safeguarding team, during which staff discussed current safeguarding incidents and learnings. All staff could attend any of these meetings, however managers expected each staff member to attend a minimum of two sessions per year.

We reviewed the hospice's policies for safeguarding children and young people and for safeguarding adults. We saw the service had reviewed both policies during 2019, and had a date for its next review along with a version control check. Each policy referred to relevant points of national guidance and legislation, such as the Mental Capacity Act 2005 and The Children Act 1989, and contained information of individual responsibilities for all key staff roles.

Staff followed safe procedures for children and young people visiting the hospice. For example, the provider ensured all staff and volunteers working for the service undertook a Disclosure and Barring Service (DBS) check prior to commencing work.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect children and young people, themselves and others from infection. They kept equipment and the premises visibly clean. However, the provider did not always undertake regular infection control audits.

Staff kept all areas of the hospice visibly clean and tidy, including clinical and non-clinical areas. We saw all areas had suitable furnishings, which were visibly clean and well-maintained. For example, we saw chairs had wipe-clean coverings, which allowed staff to clean them effectively after use.

We saw the service had appropriate children's toys, such as toys made from plastic and other wipe-clean materials. Staff told us they cleaned all toys immediately after use to minimise any risk of infection. If they could not do this immediately, staff placed all used toys in a dedicated box for cleaning.

We saw most areas of the hospice, such as corridors and the care floor, had appropriate floors which staff could wipe-clean. Although some areas had carpeted floors, such as certain bedrooms, the hospice steam cleaned and deep cleaned each room after use. The hospice was also going through an upgrade programme to replace all carpets with wipe-clean flooring as each carpet became unserviceable.

The hospice had a local infection control lead, as well as an infection control specialist adviser, which was provided under a service level agreement (SLA) with a local NHS trust. We saw under this agreement the NHS trust undertook infection control audits of the service.

Although we reviewed the results from the most recent infection control audit from 2017 and saw the service performed well for cleanliness, we did not see any infection audit undertaken for 2018-2019.

Staff followed infection control principles, including the use of personal protective equipment (PPE). We saw staff followed hand hygiene best practices, such as remaining 'bare below the elbow' and washing hands after each episode of patient care. We saw the service had hand sanitiser pumps available throughout the hospice, including on entrances to clinical and care areas.

During our inspection, we reviewed the results of the latest hand hygiene audit from November to December 2019. We saw four members of staff participated in the audit. We saw hand wash and sanitiser was available at all points of care in clinical areas and bedrooms. During the audit, all staff demonstrated correct procedure for hand washing, and were seen to wash their hands when necessary in accordance with the World Health Organisation (WHO) Five Moments for Hand Hygiene guidance. We saw during the audit where best practices were not being followed, such as by staff wearing stoned rings, this was escalated immediately, and action taken to ensure compliance. We saw the service implemented two recommendations following this audit, which included an order of additional hand washing posters and for local infection control leads to actively observe and commend on good and bad practices seen.

Cleaning records were up-to-date and demonstrated that staff cleaned all areas regularly. During our inspection, we reviewed the hospice's cleaning records and saw staff cleaned all care areas, including all patient bedrooms, after use. We saw the service had a schedule for the cleaning of all non-care areas, such as offices and staff rest areas.

For the reporting period from October 2018 to September 2019, the service reported no incidents of a healthcare acquired infection.

Staff cleaned equipment after patient contact and labelled equipment to show when they had last cleaned it. Throughout the hospice, we saw staff affixed 'I am clean' stickers to each item of equipment or entire rooms to indicate when they had last cleaned it.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff received training to use them. Staff managed clinical waste well. When providing care in patients' homes, staff took precautions and actions to protect themselves and patients.

The service had suitable facilities to meet the needs of patients and their families. The hospice had six bespoke bedrooms for the care and accommodation of children and young people and their families.

The design of the premises and the environment followed national guidance. For example, we saw the department had step-free access throughout the hospice, including in outdoor areas, and had power-assisted doors in place to assist people with reduced mobility. The service had installed fire prevention equipment in the hospice, including fire extinguishers and fire-resistant doors. We saw emergency exits and evacuation routes were step-free and had extra-wide doorways, which allowed for the evacuation of patients and visitors who were bed-bound or used mobility aids, such as wheelchairs.

Access to the hospice was via secure key card access, which restricted access to facilities, particularly overnight when there was limited reception staff. Access to the care floor, accommodation and clinic rooms was via a separate key card access, which ensured only authorised staff and patients could access the facilities.

The service regularly serviced all clinical and electrical equipment. During our inspection, we reviewed 31 items of equipment, including televisions, hoists, beds, oxygen flow meters, fridges and portable electrical items, and saw all items were within any appropriate servicing date. We reviewed three suction pumps, three feeding pumps and a syringe driver and saw the service had serviced each item within the last 12 months.

Staff completed regular checks of specialist resuscitation equipment. During our inspection, we reviewed two resuscitation grab bags and saw staff had secured both with tamper-proof tags. We saw staff checked the contents of each bag on a weekly basis and recorded this in a separate log book. We reviewed the completion of this log book from October 2019 to January 2020 and saw staff had recorded every check.

Staff disposed of clinical waste safely. The service provided both domestic and clinical waste bins for staff and visitors to use, which they clearly labelled. Staff disposed of sharp objects, such as used needles and syringes, in clearly labelled, dedicated sharps bins. All sharps bins we inspected were within appropriate fill lines.

During our inspection, we observed the long-term ventilation outreach team on a patient home visit. We saw staff followed precautions when in the patient's home, including thoroughly washing hands on arrival before any patient contact.

Managers told us the service had a central equipment store, which all their three hospices accessed. If one hospice required a specialist item of equipment they did not have, staff told us they could request this via the facilities team, who would arrange for its delivery.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person, and removed or minimised risks. Risk assessments considered children and young people who were deteriorating and in the last days or hours of their life.

Staff identified children and young people at risk of deterioration and escalated them appropriately. If staff required specialist medical advice, staff could seek support through a service level agreement with a local GP surgery. Staff utilised the paediatric early warning score (PEWS) system to identify children at risk of deterioration. In addition, staff utilised an extended version for children with long-term ventilation needs who received non-invasive or invasive ventilation.

We saw the service had equipped each room with call points, from which staff or visitors could request routine and urgent medical assistance, in the event of the deterioration of a child.

Staff completed risk assessments for each child and young person, and reviewed these regularly, including after any incident. During our inspection, we reviewed five sets of care records and saw staff completed several risk assessments based on the child or young person's needs. For example, we saw this included environmental risk assessments, falls risk assessments and moving and handling risk assessments.

We saw the service completed risk assessments to support children and young people to use the hospice's facilities. For example, we saw the service maintained a complex risk assessment of the use of their hydrotherapy pool, which covered several aspects from fire risks to health and safety assessments.

Staff had access to 24-hour support if they had concerns over a child's care, including concerns over their mental health. In addition to escalation to senior nursing staff on duty, staff obtained safeguarding and mental health advice from dedicated 24-hour safeguarding advice line, and senior management support via local and senior management on-call arrangements.

Staff shared key information to keep children and young people safe when handing over their care to others, including between each shift. Each morning, all care staff attended a daily planning meeting, during which staff discussed the needs and condition of all children and young people resident in the hospice. Following this, staff discussed the planned needs and requirements of children and young people due to attend the hospice over the coming days for planned care, as well as children due for discharge to the service from specialist hospital services across the country within the coming days.

During our inspection, we observed a daily planning meeting and saw staff undertook a comprehensive and holistic review of the needs of children and young people. We saw this included clinical and non-clinical needs, as well as the needs of the child's siblings, parents and wider family. We saw staff recorded these discussions on electronic record systems, which staff who could not attend the meeting could access.

Nurse Staffing

The service had staff with the right qualifications, skills, training and experience to keep children and young people safe from avoidable harm, and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix to keep children and young people safe. Managers gave all new staff a full induction to the service.

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number of nurses, healthcare assistants and support staff. The service aimed for a minimum of one nurse and one healthcare assistant, who had enhanced

competencies that included controlled drugs checking, for every shift whereby a patient was resident. Managers flexed staffing levels to meet both the needs of the children and young people, and staff working arrangements. For example, managers explained they arranged for additional staff to work when more than one patient was resident. In addition, managers focused staffing at weekends to accommodate additional demand on the hospice, and when the service received an urgent end of life care referral.

We reviewed the staffing rota for nursing and care staff from 30 September 2019 to 5 January 2020 and saw there was a minimum of two members of staff rostered on each shift, with an increase of staffing levels during periods where they had arranged for children and young people to attend for short breaks.

Where there was no demand for the hospice's services, such as mid-week during school term time, the service occasionally operated planned closed days, whereby the service planned to close for a set period. This allowed managers to redeploy staff to support periods of higher demand. However, managers explained the service always prioritised and accommodated for any end of life care referrals, even over planned closed days.

The service had high vacancy rates in some staff groups. For the period from October 2018 to September 2019:

- The service employed 37 nurses, allied health professionals and other qualified staff. The service had eight vacant positions, which equated to a vacancy rate of 18%.
- The service employed seven healthcare assistants. The service had three positions vacant, which equated to a vacancy rate of 30%.
- The service employed nine other non-qualified staff. The service had two positions vacant, which equated to a vacancy rate of 18%.

During our inspection, we discussed the issue of high nursing vacancies in the service with managers, who explained they had experienced recruitment challenges in this area, particularly with recruitment of qualified paediatric nurses. Managers explained there was a national shortage of nurses, which particularly affected paediatric nurses, and even more so with paediatric nurses who wanted to specialise or had experience in paediatric palliative care. To combat this challenge, managers explained they had streamlined and adapted their recruitment process to encourage as many prospective candidates to apply. As part of this work, the service had worked with an external company to produce a professional recruitment advertisement video for use in online recruitment campaigns. The service had worked to remove any closure dates on their nursing vacancy adverts, which allowed for candidates to apply at any time throughout the year. Managers also invited all prospective candidates to attend a tour of the hospice and its facilities, and to meet with staff prior to submitting an application, which they hoped would encourage more candidates to apply.

To further minimise this impact, the service was working towards a model of upskilling healthcare assistants to undertake additional care duties. Managers explained their new care model allowed for healthcare assistants to deliver care to clinically stable children, under the supervision of nursing staff, which in turn allowed nursing staff to focus on the delivery of end of life care.

The service had high turnover rates in some staff groups. For the period from October 2018 to September 2019:

- The service reported it employed 12 new nurses, allied health professionals and other qualified staff, with six existing staff leaving the service.
- The service reported it employed 10 new healthcare assistants, with nine existing staff leaving the service.
- The service reported it employed one new non-qualified member of staff, with three existing staff leaving the service.

During our inspection, we discussed the issue of high healthcare assistant turnover rates with managers, who explained how several factors had caused this. Managers told us the turnover rate was in part due to two members of staff not attaining the required levels of performance during the six-month probationary period.

The provider had explored different ways to attract and retain staff. This included more flexible working arrangements and mirroring many of the staff benefits from the NHS Agenda for Change contract, such as matching NHS pay increments and annual leave allowances.

The service had low sickness rates. For the period from July 2019 to September 2019:

- The service reported a sickness rate for nurses, allied health professionals and other qualified staff of 3.9%.
- The service reported a sickness rate for healthcare assistants of 1.1%.
- The service reported a sickness rate for other non-qualified staff of 0.6%.

Managers limited their use of bank staff and requested staff familiar with the service. They explained the service operated a small cohort of bank nursing and support staff, which comprised primarily of staff who had previous substantive staff. Managers made sure all bank staff received a full induction and understood the service. As part of their induction process, the hospice's education team met with all new staff to discuss any training needs and to arrange a series of supernumerary and supervision shifts. Managers explained all bank staff provided evidence of competencies and training to the service. Where staff could not demonstrate this, the hospice delivered additional training to support staff.

If the service experienced staffing or resourcing issues which affected care delivery, managers told us the service held a joint meeting across all three of their locations, attended by each hospice's service manager and the provider's clinical team. If necessary, managers could flex their staffing resource to work at alternative hospice locations for a short-term basis, as all staff received training to work at each of the provider's locations. Managers explained they minimised the impact of this on staff, through offering staff overnight accommodation, use of pool cars, use of volunteer drivers and reduced working days to the affected staff.

Medical staffing

The service did not employ any medical staff. However, the service had developed a service level agreement (SLA) with a local GP surgery to provide staff with medical advice if required.

Records

Staff kept detailed records of the care and treatment of children and young people. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

The service stored most patient care records on a secure electronic system, which all authorised staff could access. To support this, the service stored certain records, such as emergency treatment plans, medicine administration records and fluid balance charts in paper files, which staff secured in a locked cabinet in a locked clinic room. This allowed staff to provide rapid treatment in the event of sudden patient deterioration.

Patient notes were comprehensive and provided an accurate summary of care. During our inspection, we reviewed five sets of patient records and saw all records were clear, comprehensive and provided a contemporaneous record of a child or young person's care. We saw staff had timed, dated and signed each entry. We saw records covered a patient's emotional, social, spiritual, physical health, mental health, learning disability, and behavioural needs. We saw records contained, where relevant, patient pain management plans, patient-specific information such as health passports, advance care plans, end of life plans, advance directives, and risk assessments.

We saw staff completed a patient holistic needs assessment (HNA) with each child, young person and their family upon their arrival at the service, which detailed any preferences, care needs and any future goals or desires. Staff completed reviewed these with each family annually, or after any significant family event, and reviewed the progress of any previously agreed goals. We reviewed completed HNAs and saw these were comprehensive, thorough, patient-centred and completed to a high standard. We saw each HNA included specific details into each child's care, including specific likes and dislikes, and saw staff firmly placed the child or young person at the centre of care.

The service utilised a nationally recognised electronic records system, which most hospitals, GP services and other healthcare providers used. This allowed for staff to share information directly with these services, with patient and/or parental consent, and enabled there to be no delay in care teams accessing patient records when they transferred patients to a new team.

The service undertook audits of records and care plans for children and young people who used the service. We reviewed a completed records audit from October 2018, in which managers assessed 10 random care records and plans from each of the provider's sites. In the audit results for The Treehouse location, we saw the staff mainly achieved compliance to policy; however, the audit had identified some areas for further improvement. For example, we saw that only 50% of the records assessed

detailed a service user's preferred method of personal hygiene, such as whether they preferred a bath or a shower, and that 60% of records contained details of any required actions for if a child awoke at night. However, we saw 100% of records assessed in relation to a service users' resuscitation treatment plan were compliant.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, staff did not always complete all medication administration records in line with their policy.

Staff followed systems and processes to safely prescribe, administer, record and store medicines. The service stored all medicines in a locked clinic room, which authorised staff had access to. The service had appropriate facilities for storing patient medicines if a patient attended with a supply of their own medicines. The service also kept a stock of common home remedies and medicines, such as paracetamol. We saw staff stored each child's medicines in separate, clearly labelled boxes, and secured these in a dedicated cupboard, to which only the nurse in charge had access to. The service did not hold stocks of any controlled drugs, however had appropriate storage arrangements and records to safely store them if a child attended the service with controlled drugs.

We saw the service had dedicated fridges for the storage of temperature-sensitive medicines, and for specialist feed for children and young people. Staff monitored fridge and room temperatures daily, and escalated any anomalies to senior staff to rectification.

Staff stored and administered medicine gases, such as oxygen, appropriately. We saw each bedroom had piped oxygen available, with separate portable cylinders available for patients when moving around the hospice or in the event of a pipe failure. Medical gas cylinders were stored safely and securely.

As the service expected all patients to be admitted with a supply of their own medicines, the service rarely prescribed patients medicines. If staffed deemed it necessary to prescribe a patient a medicine, staff discussed this with the patient's GP or other healthcare professionals before prescribing. The service had four non-medical prescribers across their three locations, including matrons, clinical nurse specialists and consultant nurses. To facilitate the prescription of medicines, the service had developed a service level agreement (SLA) with a local GP surgery and pharmacy to obtain patient medicines if required. The service also had a second SLA with a local NHS community trust to obtain specialist pharmacy advice.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. If staff prescribed patients a medicine, they communicated any side effects to the patient and/or their relatives through the prescribing process. Staff reviewed patient medicines on every admission or contact, and followed processes for the return and destruction of any unwanted medicines.

We reviewed 10 patient medication administration records (MARs) and saw staff completed seven in full compliance to the provider's policy. However, we saw staff had not completed three MARs in line with the provider's policy. For example, we saw staff had not recorded a patient's weight on three MARs. We also saw staff had omitted a second 'checked by' signature on the front of two MARs, and saw staff had pre-filled in one MAR prior to the patient's admission. We raised these specific concerns to managers during our inspection for remediation.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Managers explained The Treehouse was responsible for managing any product or medicine alerts, including any alerts issued by the Medicines and Healthcare Products Regulatory Agency (MHRA). They told us if they received an urgent alert, senior leaders communicated this to all staff via an internal memo called 'care matters'. During our inspection, we saw an example of this as managers distributed a memo to all staff regarding a national alert affecting codeine phosphate, a common analgesia.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people

and their families honest information and suitable support. Managers ensured they implemented and monitored any actions from patient safety alerts.

For the reporting period from October 2018 to September 2019, The Treehouse reported no never events and no serious incidents.

Staff knew how to raise concerns and report incidents, serious incidents and near misses in line with the provider's policy. Staff told us they reported incidents using an electronic incident reporting form, which contained three separate sections. The incident reporter completed an initial information capture section along with an initial risk rating, based on the severity of the incident and likelihood of recurrence. Following the submission of the incident report, the system automatically notified service managers, who could begin an investigation.

After the incident occurred, the nurse or manager in charge undertook an initial investigation to gather required information and to speak with staff involved. If the care of a patient was involved, staff involved patients and their families in any investigation. Staff understood the duty of candour, and were open, transparent and gave patients and families a full explanation if and when things went wrong. To support this, we saw the service had a dedicated duty of candour policy. We reviewed a copy of this policy and saw the service had approved it in August 2018, and was within its next review date of August 2021. We saw the policy was comprehensive and detailed when and how staff should apply the duty of candour, and referenced national policies and guidelines.

Following the initial investigation, senior managers who were trained in incident reporting, reviewed the incident. If necessary, a further investigation took place, as well as a review of the initial risk rating of the incident to confirm staff had recorded this correctly. After all sections were complete, managers signed off the incident report as complete.

Managers debriefed and supported staff after all incidents including serious incidents. Managers explained how as part of every incident that affected staff, they supported staff to complete an individual reflection into the incident to identify any learning and training needs.

During our inspection, we reviewed three completed incident reports for incidents that had occurred at The Treehouse. We saw these were comprehensive, detailed and submitted by staff from all roles, including a healthcare assistant, team leader and deputy service manager. We saw managers had investigated each incident thoroughly and involved patients and their families where necessary. We saw each incident had a pre-investigation and a post-investigation risk rating.

Staff and managers met to discuss the feedback and look at improvements to patient care. Managers shared learning about incidents that happened elsewhere. For example, staff explained the service had developed a dedicated specialist long-term ventilator (LTV) outreach service, following a never event at another children's hospice.

Managers discussed all reported incidents at a weekly operational leadership team (OLT) meeting, during which they discussed incidents from across the provider's three locations and reviewed each incident's risk rating. Staff and managers discussed local incidents and any associated learning at weekly local multi-professional meetings. Managers discussed the most serious incidents at the provider's quarterly performance meeting, which the provider's trustees and senior managers from across the provider's three locations attended.

Staff received feedback from investigation of incidents, both internal and external to the service, and were aware of changes made following incident feedback. For example, staff told us of a change to the process for checking medicines in and out, because of a previous incident.

Safety performance

The service used monitoring results well to improve safety.

The safety performance data showed the service achieved harm-free care within the reporting period. For the reporting period from October 2018 to September 2019, the service reported no incidents of a healthcare acquired infection, no never events and no serious incidents.

Staff used safety performance data to further improve services. We saw there was an open culture to incident reporting.

Outstanding ☆

Hospice services for children

Are hospice services for children effective?

(for example, treatment is effective)

Good

Our rating of effective stayed the same. We rated it as **good**.

Evidence-based care and treatment

There was a truly holistic approach to assessing, planning and delivering care and treatment to all children and young people who used the service. The service provided care and treatment based on national guidance and evidence-based practice, and managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.

The service had developed several policies and procedures that staff followed to deliver high quality care to children and young people. We reviewed several of these policies and saw they referenced national guidance and best practices. The service undertook a series of clinical and non-clinical audits to monitor service performance and ensure the service followed national guidance. These included audits on infection control, controlled drugs procedures and nutrition care plans.

The provider had a holistic approach to care delivery, and aimed to review and evaluate every episode of care with the child or young person and their family. To support this, the provider created a detailed holistic needs assessment (HNA) for each child or young person and their family upon the commencement of any care with the service. This was a comprehensive care plan that detailed the needs, preferences and goals for each child or young person and their wider family, and helped staff to gain a greater understanding of their needs and aided them in providing care that met their needs. The service reviewed all HNAs annually, or when there was a significant change to a family's circumstances.

In addition to this, the service supported children and young people with having advance care plans and advance directives in place. This ensured they received the care and treatment they wanted as they entered the end-of-life phase. This was in line with guidance from the National Institute for Health and Care Excellence (NICE) in their July 2019 publication End of life care for infants, children and young people with life-limiting conditions: planning and management [NG61] and in the Every Moment Matters guidance by The National Council for Palliative Care, published in March 2015.

The provider was a member of two dedicated hospice charities, including a charity specialising in children's palliative care, with several senior staff appointed to roles within the charity, including in advisory and editorial positions. This allowed the provider to advise on national initiatives and proposed changes to national policy and legislation. For example, we saw the service had helped to commission several publications, including articles on pain management, the development and evaluation of a holistic needs assessment within children's palliative care, and on the characteristics of babies who unexpectedly survive long-term after withdrawal of intensive care.

In addition, the service was often invited to meet with other services, both nationally and internationally, to share best practices. This included attending national conferences arranged by professional bodies and organisations, such as the Royal College of Nursing.

The provider ran an internal library and information service, which monitored changes to national guidance and policy and presented any updates to senior leaders during operational leadership team (OLT) and quality and safety group meetings. The library service also held copies of all peer reviewed journals that organisational staff had written about the work of the hospice. This allowed the hospice to demonstrate its continued contribution to the best practice evidence base for children's palliative care.

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice. The service employed a dedicated lead for children and young people's transition services, which covered compliance to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The lead worked across the provider's three locations, and managed staff training, competencies and overall compliance to relevant legislation and codes of practice.

At care meetings, staff routinely referred to the psychological and emotional needs of children and young people, and their families and carers. For example, during our inspection we observed a daily planning meeting, which all key care staff attended. We saw staff discuss the emotional and well-being needs of each child in detail, as well as the needs of their siblings, parents and wider family.

Nutrition and hydration

Staff gave children and young people enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for patients' religious, cultural and other needs.

Staff made sure children and young people had enough to eat and drink, including those with specialist nutrition and hydration needs. Each child or young person had a comprehensive nutrition care plan attached to their electronic patient record. This covered all nutrition and hydration needs, including any allergies, preferences, method of eating and drinking, and desired quantities. This was in line with guidance from the National Institute of Health and Care Excellence (NICE) in their July 2019 publication End of life care for infants, children and young people with life-limiting conditions: planning and management.

To support children and young people with specialist nutritional needs, such as those who received nutrition via a naso-gastric tube, staff had developed comprehensive nutritional supplement plans in partnership with each child's dietitian. The service had developed a series of standard operating procedures to cover all methods of nutrition delivery. The hospice had formed effective working relationships with a local NHS acute trust to support the care of children and young people with complex nutritional needs.

The hospice had on-site kitchen facilities, staffed by trained chefs, who prepared meals and drinks for children, young people and their families. Kitchen staff received trained in meeting each child's individual nutritional needs, such as providing meals for children on blended diets. For children who were fed orally, kitchen staff prepared individual meals in accordance to each child's specific care plan, including adapting meals for any allergies or dietary, religious or cultural requirements. As meals were prepared on-site, kitchen staff could adapt meals at short notice if there was a change in their clinical condition or preferences.

For children and young people who are fed using a feeding tube (for example, a naso-gastric tube), the service used basic fluid input charts to monitor each child or young person's fluid intake. Where necessary due to patient condition or clinical presentation, staff had access to and used comprehensive fluid and nutrition charts.

Pain relief

Staff assessed and monitored children and young people regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed and monitored all children and young people to see if they were in pain, and gave them pain relief when they needed it, in line with individual needs and best practice. Staff used pain scores with children and young people to determine if they required any analgesia. For children and young people with communication difficulties, staff supported them to communicate with communication aids. This was in line with guidance from the National Institute of Health and Care Excellence (NICE) in their July 2019 publication End of life care for infants, children and young people with life-limiting conditions: planning and management.

In addition, staff had developed a comprehensive understanding of each child or young person's needs, and had formed effective relationships with their wider families. This allowed staff to understand when children and young people were in pain or needed further support.

Although the service required each child or young person to attend the hospice with a supply of their medicines, staff had access to a selection of common pain relief medicines, such as paracetamol, to support children and young people who were in pain and had not already been prescribed specific analgesia. If a child or young person required a different pain relief medicine, or had run out of their own supply, the service had developed a service level agreement (SLA) with a local GP surgery and pharmacy to obtain medicines.

Hospice services for children

Patient outcomes

Staff were actively engaged in activities to monitor and improve the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time, and to check practice against national guidelines. This included annual audits on infection control, medicine administration documentation, controlled drugs, nutrition and care records.

Managers shared information from audits, and used the findings to improve care and treatment. During our inspection, we reviewed two internal audit reports. This included an audit from May 2019 that related to controlled drugs procedures and an audit from November 2019 that related to a review of nutrition care plans. We saw that each report contained detailed information as to how the audit was completed, as well as any issues identified, and any remedial actions required. In the action plan, we saw each recommendation had a clear action associated to it, and a specific team or individual responsible for its rectification. Each audit contained a suggested re-audit date for when the audit required repeating.

The service monitored the results and completion of audits and their associated action plans through quality and safety group meetings, and agreed additional re-audits because of clinical incidents.

After each family had used the service for six months, the service contacted them to discuss the service and determine how well the family felt the service had achieved their outcomes and goals. During this engagement, families provided a rating between zero and five for how well they felt the service had met their desired outcomes. In the report, we saw 85% of families who used The Treehouse gave a rating of either four or five out of five - the highest score for any of the provider's three locations.

The service was often invited to share their best practices and model of care with other providers, both nationally and internationally. The service demonstrated continued contribution to the best practice evidence base for children's palliative care, through staff presentations at national conferences and successful submission of scientific journals. The provider had developed a library service, which held copies of all peer-reviewed published scientific journals, written by hospice staff about the service.

For example, we saw the hospice's consultant nurse, in partnership with one of the hospice's matrons, had published an article on buccal opioids for breakthrough pain in children with life-limiting conditions receiving end-of-life care in the International Journal of Palliative Nursing, and was in the process of publishing a chapter on the fundamental principles of effective symptom management in neonatal palliative care in a forthcoming textbook for nurses on neonatal palliative care.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Staff were proactively supported and encouraged to acquire new skills and share best practice. Managers proactively recruited and supported volunteers in their role.

Staff had the right qualifications, experience, skills and knowledge to meet the needs of children and young people. As of February 2020, the provider employed 19 children's nurses and clinical nurse specialists at this location, along with four additional adult nurses with paediatric competencies and one learning disabilities nurse with paediatric competencies.

Managers gave all new staff a full induction tailored to their role before they started work. Shortly after joining the service, all new staff completed a generic induction programme, which covered key topics of infection control, information governance and whistle-blowing. This also included a local induction of their main hospice, as well as the provider's other two locations. Following this, clinical staff undertook a role-specific induction with a clinical educator, during which they observed and assessed any existing skills, and identified any further training needs. Clinical educators supported all new staff through a six-week programme of supernumerary shifts to allow them to become familiar with the hospice environment and equipment.

Registered nurses self-assessed their competencies against the hospice's core clinical skills and knowledge framework, and were supported in additional training through the service's clinical educator.

Managers supported staff to develop through constructive appraisals of their work, during which staff had the opportunity to discuss any training and development needs. Each member of staff completed an appraisal with their line manager on an annual basis. During our inspection, we requested data regarding staff appraisals, which showed the below compliance:

- Nursing, allied health professionals and other qualified staff: 26 appraisals completed out of an eligible 27 (96.3%)
- Healthcare assistants: four appraisals completed out of an eligible four (100%)
- Other non-qualified staff: seven appraisals completed out of an eligible seven (100%)

In addition to yearly performance appraisals, managers completed at least six management supervision meetings with each member of staff to discuss performance, training and any other concerns. Staff attended a minimum of two dedicated safeguarding supervision meetings each year, during which the team discussed actual safeguarding incidents, as well as any concerns or queries relating to safeguarding processes.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Each week, managers held a local multi-professionals meeting with staff, during which they discussed any safeguarding concerns, incidents, complaints or other events affecting the service. The hospice operated with five separate staffing teams and a different team attended each weekly meeting. This ensured all staff had an equal and regular opportunity to attend each team meeting.

Managers identified poor staff performance promptly and supported staff to improve. Managers regularly met with each member of staff through organised supervision shifts. If they had concerns regarding a member of staff's performance, managers supported staff to improve through performance improvement plans. All new staff were subject to a six-month probationary period, during which the service required staff to achieve the organisation's required performance standards.

Managers recruited, trained and supported volunteers to support children, young people and their families who used the service. For the reporting period from October 2018 to September 2019, the service had 1,632 active volunteers across the organisation. This included volunteers working within each of the provider's three hospice locations, such as volunteers who covered reception desks or undertook gardening work, as well as volunteers working in the provider's charity retail shops located throughout East Anglia. In addition, the service worked with volunteers to provide a 'help at home' service, whereby they worked to help families in their homes.

All prospective volunteers underwent a formal interview with hospice managers, during which they discussed several topics such as safeguarding. The service required volunteers to complete a Disclosure and Barring Service (DBS) check, identity check and a medical questionnaire. Following this, all volunteers completed a two-day training and induction programme, which covered topics including safeguarding, information governance, manual handling, bereavement support and palliative care awareness, as well as a tour of the hospice's facilities. Managers supported all volunteers in their role and undertook a minimum of four supervised shifts with each volunteer, each year.

Multidisciplinary working

Specialists, nurses and other healthcare professionals were committed to working collaboratively and found innovate and efficient ways to deliver joined-up care to people who used services. Staff worked together as a team to benefit children and young people, and supported each other to provide good care. There was a holistic approach to planning people's discharge, transfer or transition to other services, which was done at the earliest possible stage.

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. Each morning, the service held a daily planning meeting, during which care staff of all roles discussed the condition and care requirements of each child in the hospice, as well as children due to attend the hospice in the coming days. During our inspection, we observed a daily planning meeting and saw these were holistic and

covered the needs of the child or young person, as well as their siblings, parents and wider family. We saw staff of all roles and specialities, including clinical and non-clinical staff, work effectively together to provide quality care.

Staff worked across healthcare disciplines and with other agencies when required to care for children and young people. We saw the service had developed effective working relationships with other healthcare providers, including local NHS acute trusts and community trusts, GP surgeries, social services and other hospices. Managers explained how the hospice had often facilitated family multidisciplinary meetings with other care providers or for sessions of specialist care, such as for speech and language therapy sessions (SALT), due to the care facilities available onsite.

The service had developed a partnership with a local adult hospice to support the transition for patients and families from children's and young people's services into adult services. From aged 14, the service started planning a young person's transition into adult services, and worked with their families and the adult hospice to achieve this. East Anglia's Children's Hospice (EACH) staff worked in the adult hospice for three dedicated days per month, as well as on additional bank shifts, to care for EACH service users in the adult hospice environment. To support this transition, both hospices held joint meetings with the service user's family to discuss their care needs. As both hospices used the same electronic patient records system, staff could share key care information between services when required. Managers explained how a charity specialising in children's palliative care had recognised their transition arrangements with adult services, and had regarded EACH's transition arrangements as one of the best examples in the country.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines, 24 hours a day, seven days a week. Managers told us they maximised the time the hospice was open through flexible staff working and other arrangements, to ensure children and young people could access the service when they needed support.

Staff had access to a safeguarding advice line, which was available 24 hours a day, seven days a week, should they require specialist safeguarding advice. For any operational issues, staff had access to a senior management on-call service, also available 24 hours a day.

The hospice had developed a service level agreement with a local GP surgery to provide staff and families with specialist medical advice. This agreement also included pharmacy access and allowed staff and families to obtain medicine from their pharmacy when this was needed. Managers explained how they registered a child's or young person's family as temporary residents, so all family members could access GP and pharmacy services whilst the lead child was accessing care at the hospice.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives, and proactively identified and helped those who required extra support.

Staff gave advice to patients and their families to live healthier lives, if they required support. Staff told us during the review of each family's holistic needs assessment (HNA), they discussed any goals or aspirations any member of the family had for the next year. Staff explained this had included individuals wishing to stop smoking or lose weight. As a result, staff had agreed this as a goal with the family, and had worked with other healthcare providers and community organisations to provide the families with the help and advice they needed to achieve their goal.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children and young people to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support children and young people who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004, and they knew who to contact for advice. Staff made sure children and young people consented to treatment

based on all the information available. They gained consent from children and young people for their care and treatment in line with legislation and guidance, and recorded this clearly in their records. Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. When they could not give consent, staff made decisions in their best interest, considering their wishes, culture and traditions.

Staff received and kept up-to-date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. All staff completed mandatory training on mental health, which included consent, safeguarding, capacity, best interests decisions and deprivation of liberty. All new staff to the organisation completed specialist e-learning modules. All staff who had contact with children or young people and their families completed level two face-to-face training on the Mental Capacity Act and Deprivation of Liberty Safeguards, with care and nursing staff completing level three face-to-face training and senior managers completed level four training.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could access clinical policies in physical reference folders or via electronic systems. If staff required specialist advice, the service employed a dedicated transition lead for children's and young people's services who specialised in the Mental Capacity Act and Deprivation of Liberty Safeguards. The hospice had a service level agreement with a local NHS community trust to provide staff with a specialist safeguarding advice line, which staff could access 24 hours a day.

Staff explained the service had developed detailed care records and treatment plans for all children and young people using the hospice. This allowed staff to understand each child or young person's treatment wishes, especially during occasions where they may not be able to consent or agree to treatment. Staff explained managers encouraged them to use the least restrictive option wherever possible. If staff deemed an item of equipment that restricted a child or young person's movement necessary, such as a specialist cot or bed, staff explained they risk assessed this prior to its use and implementation.

Managers monitored the use of Deprivation of Liberty Safeguards and compliance to the Mental Capacity Act, and made changes to practice where necessary. If staff implemented Deprivation of Liberty Safeguards urgently, staff explained they completed this in line with the patient's best interests. Staff and managers discussed the use of any deprivation of liberty at both their weekly local multi-professional meetings (LMPM) and central panel meetings. Senior managers with level four training assessed the use of any deprivation of liberty and decided whether any incident required referral to the local authority.

Are hospice services for children caring?

Outstanding ☆

Our rating of caring stayed the same. We rated it as **outstanding**.

Compassionate care

Staff consistently treated children, young people, and their families with compassion and kindness. Staff respected and maintained children and young people's privacy and dignity throughout their care. There was a strong patient-centred culture, and staff were passionate about meeting the holistic needs of each child, young person and their families.

Staff were discreet and responsive when caring for children and young people, and took time to interact with them in a respectful and considerate way. During our inspection, we observed staff delivering care to children and young people. We saw staff cared for all patients with compassion, and took account of their individual needs.

Children, young people and their families said staff treated them well and with kindness. During our inspection, we spoke with three relatives. One relative we spoke with described staff as "very helpful, polite and caring", and told us how staff were always helpful and explained things clearly to them.

Staff understood and respected the individual needs of each child or young person, including their personal, cultural, social and religious needs and how this related to their care needs. We saw how children, young people

and their families valued their relationships with the care teams, and saw how staff frequently went above and beyond to meet, and usually exceed, the needs of each child or young person using the service.

For example, staff explained they supported children to create a wish list of activities and experiences they wanted to complete, and aimed to facilitate as many of these as possible. They explained they supported one child to achieve their wish of visiting a restaurant with their family. In addition, staff explained they had contacted an international drinks company to discuss the possibility of their annual Christmas lorry coming to the hospice to allow the child to watch it pass. Staff told us they were successful in this, and although the lorry could not visit the hospice directly due to roadway sizes and restrictions, staff were able to take the child to a nearby location to allow them to watch the lorry pass by.

Staff told us of another example where a child who was approaching their end of life phase had expressed a wish of seeing the next instalment of a popular movie franchise, which was due for release shortly. A member of staff contacted local cinemas to discuss the possibility of the child attending a private screening. However, sadly the child deteriorated and became unable to leave the hospice to attend the cinema. To ensure the child's wishes did not go unfulfilled, the member of staff contacted the movie studio directly and arranged a private pre-release screening at the hospice.

The service operated a comprehensive 'help at home' volunteer service, whereby families could seek help and support with a variety of tasks within and around the home. This service aimed to allow parents and families to spend as much time as possible with their children, without needing to worry about completing household tasks. The service supported families with both regular tasks, such as grass cutting, gardening and dog walking, as well as longer-term wishes, such as redecoration, house modifications and entire house moves. Staff told us of one notable example whereby volunteers had donated over 50 hours of time to facilitate the discharge of a child, who was in their end of life phase, to return to their family home. Volunteers had donated their time to assemble furniture, install equipment, complete gardening work and undertake a thorough clean of the house for the family, which allowed the child to spend the last moments of their life in their own home.

Staff followed policy to keep care and treatment confidential. We saw staff kept all patient bedroom doors closed, and saw staff knock on all doors before entering to confirm the room was vacant and it was appropriate for them to enter. All staff were discreet and provided care to children and young people in facilities that protected their privacy and dignity. Staff considered the importance of a person's privacy and dignity at all stages throughout their care.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. Staff recognised and respected the totality of people's needs, and their personal, cultural and religious needs. Staff went the extra mile to meet people's emotional needs, and saw these as important as their physical needs.

Staff had a holistic approach to well-being, which included children, young people and their families, and provided them with emotional support and advice when they needed it. The service employed a dedicated health and well-being lead for each site, who supported both staff and service users to access well-being support.

We saw the service valued people's emotional and social needs as being as important as their physical needs. We saw staff responded compassionately when people needed help and support, and provided them with tailored emotional and well-being support to meet their needs. For example, the hospice employed experienced counsellors who provided tailored emotional support to meet each family's needs. This included individual counselling sessions, couple's counselling sessions, pre-bereavement and post-bereavement support.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their well-being and on those close to them. During our inspection, we observed the daily planning meeting and saw staff of all roles discussed the emotional and well-being needs of all service users, as well as their families and the staff providing care to them.

Each year, or after a significant change in a family's circumstances, the service undertook a holistic needs assessment (HNA), during which staff comprehensively discussed the needs of each child or young person and their family. This covered several different aspects, including any key care needs and any patient

preferences. In addition to this, staff discussed any goals or desires the family wanted to achieve over the next 12 months. We reviewed completed HNAs and saw these provided a holistic and comprehensive review of a family's emotional, social and care needs.

The service had a dedicated spiritual and religious room, called the 'Haven'. This was a multi-faith reflection room, which everyone could access whenever they needed to. The room contained support and information for all main religions, as well as well-being information. The service employed a lead chaplain, and had access to volunteer chaplains of all faiths to support service users of all religions, when they required support.

Staff supported children and young people who became distressed in an open environment, and helped them maintain their privacy and dignity. The hospice had several areas whereby staff could provide care for children and young people in private locations, such as in bedrooms, therapy rooms or quiet areas of the care floor.

The service held several events and memory days to provide support to children, young people and their families. These events included a 'carols by candlelight' service, a summer party and music festival called 'Treefest', a Christmas party, and an annual bereavement and memory day. The hospice's counsellors ran these memory days, and specifically planned them to provide bespoke support to bereaved parents and families of children and young people who had accessed the hospice's services. These events gave families a time to reflect and share their experiences with staff and other families, and seek support from the hospice's counselling team if they needed it. Each memory event followed a specific theme, with last year's event involving elephants, as 'elephants never forget'. Staff told us over 70 families attended the last event.

During our inspection, we reviewed the hospice's celebration book, which contained several achievements and examples of where staff had gone the extra mile to meet a family's emotional need. For example, we saw how staff had supported a child with hydrotherapy sessions, and had facilitated them to stand in the water with their mother and share a cuddle together. We saw this was important and emotional for the family, and saw how staff had worked to achieve this goal for the family.

Understanding and involvement of patients and those close to them

Staff supported children, young people and their families to understand their condition, make decisions about their care and treatment, and become active partners in their care. Staff ensured a family-centred approach to care, and were fully committed to working with people to make this a reality. Staff encouraged and empowered the people who used the service to have a voice and realise their potential.

Staff made sure children, young people and their families understood their care and treatment, and supported them to make informed and advanced decisions about their care. During our inspection, we spoke with three parents and relatives of children who had received care at the hospice. All three told us they felt staff involved them in decisions about the care and treatment of their child, and asked them for their consent before staff commenced any care or treatment. Two parents told us the service "always" contacted them for their consent, and if staff needed to prescribe any medicines, that staff always did this together with the parents, and explained what the medicine was for and any potential side effects.

Staff supported children, young people and their families to give feedback on the service and on their care and treatment. We saw the service sought feedback through several methods, including through holistic needs assessments (HNAs), family coordinator contacts, family newsletter comments slips, the provider's public website, complaints, concerns and compliments processes, event and activity evaluations, service evaluation projects, family forums, family lunch events, and research projects.

During our inspection, we spoke with two parents who explained staff were always available if they needed reassurance or wanted to raise any concerns over their child's treatment. All parents and relatives we spoke with knew how to raise concerns and complaints with the service, and told us they felt comfortable in doing so, however none had ever needed to with two parents saying it was because "the service is great".

We saw the service undertook a family satisfaction and experience survey in October 2019. For this, the service invited each family who used the service via text message, email or post to complete an online survey. Of this survey, we saw the service asked each family six

Hospice services for children

questions based on their care they received from the hospice. We reviewed the results of this survey and saw 17 families (46% of eligible families) responded to the survey invitation. Of these, 100% of families rated the service they received as excellent, very good or good, and 100% thought the service had listened to their needs. We saw 88% of families rated the service's response to their needs as excellent, very good or good. Ninety-four percent of families who responded said they would recommend the hospice to another family, and were satisfied overall with their hospice's services.

Staff spoke with children, young people and those close to them in a way they could understand, using communication aids where necessary. During our inspection, we observed staff delivering care to children and young people. We saw staff spoke to children with kindness and respect, and used language that was appropriate for the age of the children and young people they were with. Staff had access to communication aids and translators to support children and young people with communication difficulties. Staff explained that as they knew and understood the needs of each child or young person in detail, this helped them to communicate effectively with all children, and helped staff to understand when a child or young person needed additional care or support.

Children, young people and their families gave positive feedback about the service. During our inspection, we spoke with three relatives, who all recommended the service and spoke positively of the service. Two relatives, who had used the service for over two years, described the service as "great". They explained how the hospice had been their "lifeline" and how they "could not have coped without them".

Are hospice services for children responsive to people's needs?
(for example, to feedback?)

Good

Our rating of responsive stayed the same. We rated it as **good**.

Service delivery to meet the needs of local people

The service planned and provided care that met the needs of local children, young people and their families. Staff worked with other healthcare providers to deliver care, including community providers and local organisations. Staff were passionate about meeting the needs of local children and young people, and were proactive in the development of flexible and tailored pathways for each service user.

Managers planned and organised services to meet the changing needs of the local population. We saw the service had formed effective working partnerships with other care providers and community organisations. This enabled the service to outreach into the community and help support families who may not be aware of the hospice's facilities and how they can support the care of their child. For example, managers explained how they had formed good relationships with a local NHS acute trust, which allowed them to meet with families during their time of need, and start to put support in place for them.

Managers tailored the service to meet the needs of individual children and young people, and worked to deliver services in a way that ensured flexibility, choice and continuity of care. For example, managers told us of one situation whereby they worked with a child and their family, who at the time received care at a specialist NHS hospital. Managers explained they met with the family to discuss their care needs and support requirements, and worked to put transition care arrangements in place to allow the service to provide care locally. The service worked with healthcare commissioners to secure additional funding, which allowed for the service to provide care to the lead child, as well as accommodation to their family and siblings, for the entirety of their seven-month stay with the hospice.

Within the hospice, the service had worked with young people to help create ideas as to how to develop their space in the hospice, as well as to establish events and activities to meet their needs.

We saw the service took part in an independent review of the care service during 2016-17, which resulted in a

three-year service redesign programme, through which children, young people and their families were involved through several focus groups, workshops and feedback surveys

The service employed a lead chaplain and worked with several volunteer chaplains from all major faiths to ensure the service met the religious, cultural and spiritual needs of all children, young people and their families.

The service had systems to help care for children and young people in need of additional support or specialist intervention. For example, during our inspection we observed a home visit with one of the service's long-term ventilation (LTV) community outreach teams. This team worked across the provider's three locations, with an LTV clinical nurse specialist (CNS) and LTV nurse primarily based out of each hospice location. This team attended children and young people in the community who required long term ventilation support, and provided them and their families with help and support on the operation and function of the child's ventilator.

During our observation of a home visit, we saw the team discussed a wide array of points related to the child's care with the child's parents and wider family, including their current clinical presentation, the function of the equipment and the availability of any consumables and medicines. We saw the team systematically addressed all the child's needs and provided expert advice and support where required. For example, we saw the team provide advice to the family in how to support the child's planned transition from nursery care into primary school, including advice on how they could obtain a more portable ventilator for the child whilst they were at school. We saw the team discussed the family's current support arrangements, including any help they received from other community providers, and helped them to address any concerns they had. The team also discussed how the hospice can further support the family, including through planned stays.

The LTV community outreach team explained how they aimed to meet all the needs of the local children and young people they worked with. For example, the team explained how they had recently supported a child to transition to primary school, which had resulted with the team working with the school to support and advise on the recruitment of a new teaching assistant who was suitable to use the child's LTV systems.

The service had suitable facilities and premises for the services they delivered. The Treehouse was officially opened in 2012 and was built as a dedicated children's hospice. We saw the service had put significant thought into the design of the building to maximise its space, and had utilised feedback from children, young people and their families to ensure its facilities met their needs.

For example, the hospice had an onsite music therapy room, art therapy room, a hydrotherapy room and a sensory room, which allowed staff and therapists to deliver tailored care within the safety and familiarity of the hospice environment. The hospice had purpose-built accommodation and facilities to meet the needs of children and young people of all ages and conditions. We saw each bedroom had its own permanent hoist facility, which connected to adjoining bathrooms. This allowed for children and young people with reduced mobility to access bathroom facilities from the privacy of their own room.

Whilst at the hospice, all children, young people and their families could access any of the hospice's facilities, including a communal dining area, dedicated care area, therapy and clinic rooms, sensory rooms, outdoor play and recreation areas and on-site parking.

The service had a dedicated family room, complete with a sibling room, which adjoined one of the children's bedrooms. This allowed for a child or young person's parents and siblings to stay onsite and help in the child's care. From here, parents could also access a dedicated kitchenette and a private bathroom.

All areas of the hospice had step-free access, including all outdoor areas and woodland walks, which allowed for children, young people and other visitors with reduced mobility to access all areas of the hospice.

The hospice had a dedicated bedroom with specialist air conditioning and cooling equipment. This enabled staff to reduce and maintain the temperature of the room to a few degrees above 0°C, and allowed the service to provide specialist care to children and young people after they had died. Managers told us this service was particularly valued by bereaved families, as it allowed for their child to stay in a familiar, compassionate and caring environment for the period after their death, and allowed for the family to remain close to their child during this important time.

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Meeting people's individual needs

Staff went the extra mile to understand the needs of each child and young person who used the service, as well as the needs of their families and those close to them. The service was inclusive, and staff took a proactive approach to make adjustments to allow all children and young people to access hospice services, including people who were in vulnerable circumstances or who had complex needs. The service coordinated care with other healthcare organisations and providers.

Staff were proactive and went the extra mile to understand the needs of each child and young person. Staff made sure children and young people living with learning disabilities or mental health conditions received the necessary care to meet their needs. Managers explained when each family first used the hospice's services, staff met with them to complete a holistic needs assessment (HNA). This was a comprehensive assessment that covered the care needs of the lead child or young person, as well as any care, support and well-being needs for the child's siblings, parents and wider family. As part of this, staff discussed any goals or wishes the family had, and worked with the family to achieve these. Managers explained staff reviewed each family's HNA at least once per year, as well as after any significant circumstance affecting the child and their family. We reviewed HNAs as part of our inspection process and saw these were comprehensive, detailed and person-centred.

Staff coordinated care with other healthcare organisations and providers. For example, we saw the service had an established transition programme in place with a local adult hospice to support children and young people as they progressed into adult hospice services.

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss. Staff had access to specialist communication aids to help children and young people become partners in their care and treatment. Managers made sure children, young people and their families could get help from interpreters, translators and signers when needed. For example, managers explained the service had recently sourced a translator to support a family to use the service who did not speak English as a first language, and ensured staff could request translators and interpreters to support service users when required. We saw the service had developed specialist easy-read versions of its information leaflets, such as a family information sheet on raising concerns and complaints, to support people living with a disabilities or communication difficulties.

The service made sure patients received a choice of food and drink that met their cultural and religious preferences. The hospice had an onsite kitchen and dining area, staffed by a dedicated chef. Managers told us chefs frequently met with children, young people and their families to discuss nutrition and hydration needs, and could provide specialist meals to meet all cultural and religious preferences.

Access to the right care at the right time

People could access the service when they needed it and received the right care promptly. The service prioritised end of life care and ensured all children, young people and their families could access all services when they needed them most. Delays and cancellations were managed appropriately, and people were kept informed of any disruption to their care or treatment. However, the service had a number of cancellations for planned short breaks.

Managers monitored the service and made sure children, young people and their families could access services and receive treatment when they needed it most. The service operated a needs-based assessment system, whereby the service met with each family on a yearly basis, or after a significant change in their circumstances to determine their care and support needs. Following each assessment, managers discussed each family's needs during weekly locality multi-professional meetings, and worked to provide them with care and support tailored to their needs. Depending on the circumstances, this could include access to hospice facilities and therapy sessions, such as hydrotherapy, art or music therapy, or the facilitation of planned short break stays.

Managers explained they had worked heavily on improving the responsiveness of the service to ensure children, young people and families could access all services when they needed them most. Managers told us the service historically struggled to accept and process

referrals received during evenings and weekends, and often had to defer these to be reviewed during the next working day, which caused significant delays at times in people accessing their services.

However, managers had focused hard on improving this, which had resulted in a service that could often respond to a family's need quicker than some statutory services. For example, managers told us of one example whereby a child had sadly died at a local acute hospital. Even though this was late in the day and approaching a weekend period, within two hours the service had attended a multidisciplinary meeting to discuss the after death care of the child, and in the two hours following this, the hospice had taken over the care of the child and had started providing after death care for the child and support for their family.

The service reported they did not have a waiting list for any targeted well-being interventions.

Managers worked to keep the number of cancelled planned short break stays to a minimum. The service offered families planned short break care four weeks in advance, and confirmed this seven days prior to each stay. However, the service always prioritised its end of life care provision, and worked with other families to achieve this. Managers explained they ensured each family had alternative arrangements in the event the service had to cancel their child's planned short break stay due to an end of life care referral. Where managers cancelled short break care, particularly due to the service prioritising the care of an urgent end of life patient, they ensured the hospice was open and honest with each family, and clearly explained the reasons why they had cancelled their child's care. Although managers told us this was always a challenge, families were usually understanding and appreciated why the service had to do it.

The amount of short break care available was dependent on staffing levels and other demands on the hospice. We reviewed data on the closure occurrences of the hospice from October to December 2019. For October 2019, we saw there were eight closures, of which two were unplanned (one attributed to staffing; one attributed to end of life care provision at another site). For November 2019, we saw there were no closures, both planned or unplanned. For December 2019, we saw there were eight closures, of which one was unplanned (attributed to end of life care provision at another site).

We reviewed further data on the number of short break cancellations for this period. We saw the service cancelled two short breaks in October 2019, five in November 2019 and none in December 2019. The service did not close the hospice when any children or young people were resident.

We discussed the number of short break cancellations with managers, who explained they had worked to minimise these. They explained the service was in the process of establishing a more flexible staffing model, through which managers could allocate dedicated members of nursing staff to any of the provider's three hospices based on where the demand was greatest. They hoped this would minimise the number of short notice cancellations, particularly when the service received an end of life care referral, as these flexible staff members could provide this additional cover at short notice without the need to cancel planned care.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint. The service could demonstrate where improvements had been made as a result of learning from reviews and shared learnings with other services.

People who accessed the service, including parents and relatives, knew how to complain or raise concerns. During our inspection, we spoke with three parents and relatives, who all told us they knew how to raise a complaint or a concern with the service, and told us they would feel comfortable to do so.

The service clearly displayed information about how to raise a concern. We saw the provider had a dedicated section on their public website, which contained details of each hospice locations, along with dedicated telephone numbers and email addresses through which people could raise both complaints and concerns. The service had developed a series of family information sheets, including a dedicated information sheet on compliments, concerns and complaints, which people could obtain from the hospice reception.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and received feedback from managers after the investigation of each complaint. During our inspection, we spoke with staff who explained they followed a complaints process if they received an expression of dissatisfaction from a child, young person or those close to them. They explained they would inform their line manager or the nurse in charge of the incident, and would record this on the provider's electronic incident system if appropriate. Staff told us they received feedback from complaints and incidents through shared learning days.

Managers investigated each complaint seriously and identified any themes or trends. Managers ensured they involved children, young people and their families in the investigation and resolution of all complaints. Managers told us the service recorded all complaints on an electronic incident system and aimed to acknowledge all complaints within three days of receipt. Managers explained all complaints were recorded and investigated in the same manner as an incident, and told us the manager responsible for the patient's care would contact the patient or their family to discuss and involve them in the investigation. Managers told us they discussed all incidents at operational leadership team meetings, where senior leaders decided whether the complaint required a formal investigation.

For the reporting period from October 2018 to September 2019, the service reported a total of eight complaints, of which two were managed under their formal complaints procedure and six were managed through local resolution. The service upheld four complaints, which referred to care delivery, access to short break services, communication, equipment and belongings.

For the same reporting period, the service reported a total of 22 compliments, with trends in how staff have gone the extra mile to meet a family's needs, the professionalism of the service, the compassion and empathy of staff, and on the service's responsiveness to their needs.

Are hospice services for children well-led?

Outstanding ☆

Our rating of well-led improved. We rated it as **outstanding**.

Leadership

Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There was compassionate, inclusive and effective leadership at all levels. Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. Leaders at all levels had the skills and experience to support the delivery of excellent care, and supported staff to develop their skills and take on more senior roles.

We saw the service had an experienced and embedded leadership structure, both at a local and a senior level. At a local level, an established local leadership trio, which consisted of a clinical lead, an emotional and well-being lead and a service manager, led the hospice. All three leaders formed part of the provider's operational leadership team (OLT). We saw the service manager had been in post since 2015, and was line managed by the assistant director for quality and care, with the hospice's clinical lead line managed by the acting director of care.

The provider operated a senior leadership team that comprised of clinical and operational leaders. The acting director of care and assistant director for quality and care reported to the director of care, who reported directly to the acting chief executive officer (CEO). The senior leadership team operated a management executive (MEX), that comprised of the acting CEO along with the deputy CEO, director of care, director of finance, director of income generation and director of workforce. The MEX reported directly to the board of trustees.

During our inspection, we interviewed four members of the board of trustees, including the chair of trustees, and saw the board had experience across several areas that covered financial, clinical and business experience. We

saw several trustees held positions on the boards of other charitable organisations. We found the trustees had a good oversight and overview of the organisation, and understood the challenges it faced.

Although we noted some members of the senior leadership team were in seconded or acting roles, such as the acting CEO and the acting director of care, the board advised they were working to recruit the most appropriate person for each position and did not want to rush to fill the role with someone who may not fulfil their requirements. In the interim, the board continued to monitor and have oversight of each role and the wider organisation, and were satisfied with the current interim leadership arrangements.

All staff we spoke with during our inspection spoke highly of the local and senior leadership teams, and told us all leaders were visible and approachable. One member of staff told us they "liked their style of leadership" and appreciated how all leaders "made an effort" to interact with all staff. Another member of staff told us that management had been "very supportive" of their role, and had provided them with personal support during a challenging period.

Vision and strategy

The service had a vision and a mission statement for what it wanted to achieve, developed with all relevant stakeholders. The vision was focused on sustainability of services, aligned to local plans within the wider health economy, and had a positive impact on quality and care. Leaders and staff understood and knew how to apply them and monitor progress.

The service had developed a clear vision for what it wanted to achieve, which was to "aspire daily to lead the way in providing world-class care for children with life-threatening conditions" and that "every child deserves support, alongside their families, whenever and wherever they need it". In addition to this, the service had developed a mission statement, which was "to improve the quality of life and well-being of every child and family under [the hospice's] care, by providing individual and comprehensive services at all times". To complement these, the service had developed four values of "empathy and understanding", "commitment to quality", "open and respectful" and "make it happen".

During our inspection, managers told us the service had developed these in partnership with staff, stakeholders, children, young people and their families through staff and family workshops held in 2018. This had resulted in the creation of their value of "make it happen", which during our inspection, staff told us resonated with them and had encouraged them to overcome any barriers whilst caring for a child or young person.

The service worked with other providers and organisations to support care delivery, in line with national programmes aimed at coordinating palliative and end of life care. This was in line with guidance from the National Palliative and End of Life Care Partnership in their 'Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020' publication.

We saw the service had developed several strategies to help it achieve its overarching goals. For example, we saw the service had a dedicated education strategy, which detailed how the organisation planned to deliver high quality supervision, management support, learning, training and professional development opportunities for their staff. In addition, we saw the service had developed a dedicated strategy and framework for their approach to emotional health and well-being, which helped the service support service users according to their level of biopsychosocial-spiritual need and potential risk factors. We reviewed this and saw this was comprehensive, and referenced the provider's overarching mission statement.

Managers explained as part of each staff member's annual appraisal, they required staff to give examples of how they had demonstrated each of the hospice's values.

Culture

Staff felt respected, supported and valued, and focused on the needs of children, young people and their families receiving care. There were high levels of satisfaction across all staff, and staff were proud to work for the organisation. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where children, young people and their families and staff could raise concerns without fear.

We found there to be a culture of openness and transparency throughout the hospice, including from clinical and non-clinical staff, and from local and senior

leadership teams. We saw staff and managers of all levels demonstrated and embodied the service's vision and values, and worked at their full potential to provide the highest level of care to children, young people and their families.

During our inspection, all staff we spoke with told us they felt comfortable in raising incidents and concerns to their manager and other senior leaders without fear of retribution. Staff told us all leaders were visible and approachable, and had an open-door policy if they needed to discuss anything. Staff told us they felt comfortable in going above their line manager if they needed to, and had no concerns in raising any issues with their senior leadership team, including the acting chief executive officer (CEO).

Managers explained the hospice's values of openness and respect, commitment to quality, empathy and understanding and making it happen underpinned its culture, and formed the standard of behaviour the service expected from all staff. Senior leaders worked to promote an open culture from board level to staff level. For example, the service held yearly management executive (MEX) briefings to update all staff from all roles on current and long-term strategies.

Staff told us they all worked together as a team to meet the needs of children, young people and their families who received care, and that there was not a "them and us" culture between staff and the management teams. One member of staff told us it was "really good" to work there, and especially enjoyed the hospice giving them "time to be with patients". They said they felt comfortable raising any issues or suggesting improvements to the service, adding that "everyone [was] very supportive".

We spoke with a volunteer for the service, who described it was a "happy and lovely place to be", and told us they felt valued, supported and respected by the service.

Managers and the hospice's emotional and well-being teams had implemented a package of well-being services to support staff. This included access to internal and external counselling services, employee assistance programmes and chaplaincy services. Managers discussed individual staff needs through their daily planning meeting, and provided all staff with debrief sessions after any upsetting incident. Managers actively encouraged the development of working relationships within each team through regular team-building events. This included four dedicated locality days each year, where all staff within the service came together, as well as the service's annual summer and Christmas parties, where all staff came together to celebrate the service with the children, young people and their families.

Governance

Leaders operated effective governance processes throughout the service and with partner organisations. The board and other levels of governance in the organisation functioned effectively and interacted with each other appropriately. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had robust governance structures in place at all levels of the organisation. In addition to the operational leadership teams at each hospice location, which comprised of a service manager, clinical lead and well-being lead, the service had several care quality and safety groups. This covered several specialist areas, which included nursing practice, medicines management, clinical practice, infection control, physical therapies and care records.

These leadership teams escalated any issues that arose to the strategic leadership team, which comprised of the director of care, medical director, nurse consultant, assistant director of service and quality and a well-being lead. This team reported into the management executive (MEX) team, which comprised of the acting chief executive officer (CEO) along with the deputy CEO, director of care, director of finance, director of income generation and director of workforce.

The MEX fed into several committees and sub-committees, including a clinical governance board committee, finance and income generation board committee, human resources board committee, audit and compliance board committee, investment sub-committee and fundraising sub-committee. These committees, along with the MEX, reported directly to the board of trustees, led by the chair of the trustees.

We reviewed the agenda and minutes of three clinical governance meetings from December 2018, March 2019 and June 2019. We saw several members from the board of trustees, along with the CEO and other directors

attended each meeting. We saw each meeting followed a similar agenda, which covered any declarations of interest, minutes of the last meeting, care quality visit report results, any policy updates and any other business. We saw that any agreed decisions or points of action were clearly listed, which allowed those who could not attend to easily see the outcome of the meeting from the meeting minutes.

Managers explained how a member of the board of trustees undertook quarterly care quality visits for each location. These were informal inspections, whereby a trustee visited a site and checked several criteria across the four over-arching topics of 'is the hospice welcoming?', 'is the hospice safe?', 'will the team care for me and involve me in my care?', and 'is the hospice well organised and calm?'. Following the inspection, the trustee gave feedback to the team, including any recommendations for improvement or areas of immediate concern.

We reviewed a recent completed internal inspection report and saw the trustees had completed this in full. We saw additional comments had been enclosed, detailing how "it was a pleasure to visit The Treehouse", and that "as a trustee, I am reassured that we are providing a high-level of care and support for CYPs (children and young people) and their families".

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. Managers identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. Staff and managers quickly identified problems and addressed issues effectively and openly.

The service managed a corporate risk register, which contained a list of all current risks that affected the service. We reviewed a copy of this dated 17 October 2019 and saw there were 12 active risks. We saw each risk entry was detailed and contained a raw risk rating, a current effectiveness rating, a risk owner, review date and target risk rating. We saw under each overarching risk entry, the service had developed a series of individual controls, which the service rated according to their effectiveness. In addition, each control had dated comments as to its current progress and implementation, along with any gaps in assurance.

Although the service did not operate a local risk register, managers told us they could suggest and raise potential risks that they felt required adding to the corporate risk register. We saw some of the active risks included staffing, finances and mandatory training.

We reviewed the board of trustees meeting minutes from January, March and August 2019. We saw several trustees attended each meeting. We saw the meeting minutes were detailed and covered several areas, including the recruitment of any new trustees, any matters for decision, approval of the minutes of the previous board meeting, and any other matters not covered elsewhere. During one meeting, we saw the trustees completed an annual review of strategic risks and the risk management policy.

The service monitored and managed its performance to several performance indicators via a balanced scorecard report. We reviewed a copy of this reported dated 7 September 2019. We saw this was a comprehensive report, which covered several areas of performance, including referral volumes, service user experiences, training, workforce information, staff survey results, audit results, incidents, learnings, complaints, compliments and financial performance.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required. The information used in reporting, performance management and delivering quality care was accurate, valid and relevant.

The service primarily used a secure electronic system to store and record the medical records and care plans for children and young people. We saw this service kept this system secure and restricted access to only staff who required it. For any paper-based medical records, such as

emergency treatment plans and medication records, we saw staff kept these in a locked cabinet within a locked clinic room, that only authorised personnel had access to.

The service provided mandatory training to all staff and volunteers on information governance processes, which also formed part of staff and volunteer induction programmes.

We saw the service submitted appropriate data and notifications to external bodies and organisations as required, including statutory notifications to Care Quality Commission (CQC) following specific incidents, such as the death of, or serious injury to, a service user.

We saw the service recorded performance information across a range of key metrics, including several clinical metrics and financial performance, for presentation and trustee, senior leadership and management meetings.

Engagement

Leaders and staff actively and openly engaged with children, young people, families, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for children and young people. The service took a leadership role to identify and proactively address challenges and meet the needs of the population.

We saw the hospice ran several engagement events throughout the year to enhance and develop relationships with the children, young people and families who used their service. We saw this included a 'colour tangle' art group for adults, dad's and male carers' curry night, regular siblings' days, and dedicated 'playdays' for children under five.

We saw the service held a Christmas event each year, whereby children could visit Santa within the hospice grounds. Staff explained how they and their volunteers decorated outdoor areas with festive decorations, including sleigh donated to the hospice. This event allowed children and young people, who may find large crowds intimidating or distressing, to meet with Santa individually in a familiar environment, with familiar staff. Managers explained this was an extremely popular event with families, and often booked up within a matter of hours from tickets becoming available.

The service actively engaged with children, young people and their families, as well as staff, stakeholders and other local organisations to shape their services. We saw the managers used feedback from families, including from feedback from complaints, concerns and compliments to make improvements to the service. For example, managers explained the service used feedback and evaluation forms following events, such as annual bereavement memory days, to analyse the impact it had on families, and used this to develop future events to better meet their needs. Within the hospice, the service had worked with young people to help create ideas as to how to develop their space in the hospice, as well as to establish events and activities to meet their needs.

We saw the service took part in an independent review of the care service during 2016-17, which resulted in a three-year service redesign programme, through which children, young people and their families were involved through several focus groups, workshops and feedback surveys. During 2018 when the provider worked to update their vision, mission statement and values, the service completed several workshops and events to engage with children, young people, the families and other stakeholders to develop a set of values that were special to all people involved in the service.

The service ran a dedicated family forum, which helped to shape the type and frequency of certain events. In addition, the service had worked with members of this group to develop specific communications, following feedback from families on previous communications.

Managers undertook several surveys with staff throughout the year to determine what worked well, and what did not work as well. From this, managers could work to identify themes and trends, and work with staff to address these concerns. As senior leadership meetings occurred regularly across all of the provider's three hospice locations, this gave senior leaders and care managers regular opportunities to meet with and discuss the service with staff of all roles, including non-clinical staff and volunteers. The service held three whole team days, and one provider-wide locality day each year, where staff from the provider's three locations could all come together to meet and discuss the service.

Learning, continuous improvement and innovation

There was a fully embedded and systematic approach to improvement. Improvement

methods and skills were available and used across the organisation, and staff were empowered to lead and deliver change. All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research. There was a strong record of sharing work locally, nationally and internationally.

We saw staff were passionate about improving the service and the quality of care they provided to the children, young people and families who used the service. We saw managers encouraged and supported innovation and learning. For example, we saw the service had created a dedicated ideas email inbox, through which staff and service users could submit ideas and suggestions directly to the operational leadership team.

Managers explained they worked to ensure the service continued to meet the needs of the children, young people and families who used the service. They explained they had recently focused heavily on the responsiveness of the service, to ensure families could always access the service when they needed it, even if this was late in the day or over a weekend. Managers told us previously the service struggled to accept referrals received out of hours or over weekend periods, as they often had to defer these until the next working day for review. However, over the past year, the service had worked hard to improve this, and had now developed a service that could often respond quicker than some statutory services to provide care and support to children and their families.

We saw hospice staff actively contributed to academic research into children's palliative care. For example, we saw the hospice's consultant nurse, in partnership with one of the hospice's matrons, had published an article on buccal opioids for breakthrough pain in children with life-limiting conditions receiving end-of-life care in the International Journal of Palliative Nursing, and was in the process of publishing a chapter on the fundamental principles of effective symptom management in neonatal palliative care in a forthcoming textbook for nurses on neonatal palliative care. Managers explained by focusing on continuous improvement and innovation, and focusing on how they delivered care, the wider children's hospice and palliative care sector now saw the provider as a sector leader on a local, national and international stage.

Outstanding practice and areas for improvement

Outstanding practice

We found the following areas of outstanding practice:

- The service had developed a comprehensive transition programme with a local adult hospice to support the transition of young people from children's and young people's services into adult services. From aged 14, the service held joint meetings between the young person and their family, and the adult hospice provider to develop the young person's future care needs. To support the young person through this transition, staff from the service worked at the adult hospice provider for three dedicated days per month, as well on additional bank shifts, to care for young people in the adult hospice environment.
- The service had developed a comprehensive long-term ventilator community outreach service, staffed by experienced nurses, who provided children and young people with dedicated and specialist advice within their own home and within the hospice. Staff and managers continually reviewed this service against other care providers to ensure it met the needs of the children, young people and their families.
- The service had developed and operated a model and approach to care planning that firmly placed the child or young person at the centre. Staff and managers proactively undertook a comprehensive and regular review of the needs of all people who used the service, through the development of the holistic needs assessment process.
- The service had formed strong and lasting working relationships with other care providers and community organisations, and had taken a leadership role in the local healthcare environment to meet the needs of the local population.
- The service had developed a comprehensive network of local volunteers, which helped the organisation to meet the needs of local people, particularly with the development of their 'Help at Home' volunteer service.

Areas for improvement

Action the provider SHOULD take to improve

We found the following areas of improvement:

- The provider should ensure staff complete all medication administration records in line with their policy.
- The provider should ensure all staff complete all mandatory adult safeguarding training.
- The provider should consider undertaking more regular infection control audits.