

Zoe's Place Trust

# Zoe's Place Baby Hospice

## Inspection report

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### Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

# Summary of findings

## Overall summary

This inspection took place on 11 August 2016 and was unannounced.

Zoe's Place Baby Hospice is registered to provide care and treatment to children aged between 0 and five years, who have a life-limiting or life threatening condition. Zoe's Place provides a range of services within its hospice from; short breaks for children, day care, support into children's services after the age of five and care after death. Support is also provided to parents and siblings through groups and events held at the hospice. Since the hospice opened in 2011 the services offered to children including the opening hours have gradually developed and increased. In January 2016 the hospice extended its opening hours to seven days a week. Specialist nursing care is provided at the six bed hospice. The provider Zoe's Place Trust runs another two children's hospices which are situated in Middlesbrough and Liverpool.

There was a registered manager in post who is the head of care. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were procedures in place to make sure children were kept as safe as possible. This included the reporting and following through of incidents and accidents to make sure actions supported each child's needs being met in the safest possible way when these had occurred. We found the procedures in place for following through incidents needed to be strengthened to further promote children's safety and wellbeing. The register manager immediately took action to ensure the incident procedures were as robust as they could be.

Staff had received training to support them in administering medicine to children to support their health needs. We identified some improvement to be made in the development of the risk assessment arrangements to support staff if a child experienced a severe allergic reaction. This was important to make sure staff had information to follow so children's safety was consistently managed and met.

Children showed through their facial expressions and body language they were happy and looked comfortable when staff supported them with their needs and during play. Parents had no concerns about their child's safety and were confident all staff knew their child's particular needs and what may place them at risk in order to keep them safe. Staff had received training in how to protect children from abuse. Staff knew how to recognise and report possible harm or abuse and would have no hesitation in speaking out if they witnessed abuse. Recruitment checks had been carried out to make sure staff were suitable to work with children and their families before staff started to work at the hospice.

Staffing arrangements made sure children's specialist care and needs were met at different times of the day and during the night. Children's needs were met in a timely way and there was ample time for staff to spend with each child as the numbers of staff were based on one to one support for each child. Parents were very

appreciative of how staffing levels were managed and reviewed as it had a positive impact upon the flexibility of their child's needs being met either on a day and/or respite care basis.

Children were supported by staff who had been provided with the specialist training they required before there was an agreement by the management team to make sure a child's needs could be effectively met. Staff practices reflected they were knowledgeable in the care they provided to each child during our inspection. Children's healthcare needs were further promoted by the sharing of learning experiences and the joint partnerships with external healthcare professionals so care and treatment remained effective for each child. Parents were appreciative of how staff made sure their child's needs were met which included staff knowing their child well and their little ways so parents felt confident to leave their child in the care of staff.

Parents were involved in the care and treatment of their child and they gave their consent to their child's care and treatment due to the young age of their child. This was in line with current laws around parents being legal guardians due to the age of the children the hospice services were provided for.

Children's feeding routines were followed by staff so their nutritional needs were met. Staff monitored children's health needs when they spent time at the hospice. They involved and worked in partnership with external healthcare professionals when required to make sure children's health needs were consistently met.

Staff felt supported in their roles and consistently remarked how privileged they were to be able to care and support children with life threatening and life limiting conditions as well as their parents. Children responded to the fondness and warmth of staff and this was also replicated by the relationships between staff and children's parents. Reassurance and comfort was provided to children and parents with children supported to have moments of fun and stimulation to enhance their time at the hospice. Staff were mindful of children's individual ways of expressing themselves so their activities of play were enhanced and their needs could be responded to in the right way for each child.

Staff understood the importance of their responsibilities in caring for each child with respect for their privacy and dignity. Staff practices reflected their commitment to closing doors when assisting a child with their personal care and bathing routines. Other staff knew not to enter closed doors without knocking and their colleagues inviting them in.

Parents were grateful of the support staff provided them and how staff responded to the difficult times they experienced with offers of day and respite care. Staff were motivated in encouraging parents to attend outings and events where they were able to share their experiences with other parents and make memories.

Parents were aware of how to raise any issues if they needed to and felt comfortable to do so. We heard from both parents and healthcare professionals who were complimentary about children's care and treatment.

Parents and staff believed there was a culture of homeliness, warmth and friendliness at the hospice where parents had complete trust in the management and staff team to care for their child. Parents and staff recognised improvements had been made which had had positive impacts for children with palliative and end of life care needs. These had been driven through by the management team who had arrangements in place to check and monitor the quality of the services offered to children and parents.

The registered manager was supported by the deputy manager, trustees and registered managers at the

providers other two hospices. They were open and responsive to the issues we found and shared with us how they planned to make the required improvements in the light of our findings. The registered manager and deputy manager showed they were constantly striving to make continual improvements. One of the examples provided was the extension of the opening hours of the hospice so children with life-limiting and life threatening conditions and their families' end of life care preferences could be met if they wanted hospice care.

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

We always ask the following five questions of services.

### Is the service safe?

The service was safe.

The registered manager took immediate action to ensure the safety measures in place for reducing similar incidents from happening again were strengthened to promote children's safety and wellbeing.

Children were protected from abuse by a staff team who were able to recognise and report possible and/or actual abuse.

Children had the care, support and supervision they needed to meet their needs in a timely way due to the continual assessment of the numbers of staff requiring to be on duty.

Children received their medicines from staff who were knowledgeable and competent to be able to do this so children's wellbeing was not placed at risk.

Good 

### Is the service effective?

The service was effective.

Children were provided with care and treatment from staff who received regular training to ensure they had the skills and knowledge to meet their specialist needs.

Parents' decisions regarding their child's treatment and end of life care had been sought.

Children's feeding routines and the support they required was well known by staff to make sure their nutritional needs were met.

Children's healthcare needs were met by staff who worked in partnership with parents and involved external healthcare professionals when required.

Good 

### Is the service caring?

The service was caring.

Good 

Children were supported by staff who were caring and knew the importance of their roles in making sure their caring practices respected each child's privacy and dignity.

Parents were complimentary about how staff were thoughtful and how they valued their mutual support as it meant they felt comfortable and at ease in their child staying at the hospice.

Staff were committed in providing the best care to each child during their life and at the end of their life which supported each child's individuality.

### **Is the service responsive?**

**Good** ●

The service was responsive.

Children needs were responded to by staff in a personalised way and very much involved parents so choices, preferences and goals could be met.

Children were supported by staff to have fun and enjoyment through age and need appropriate resources to enhance each child's time spent at the hospice.

Links were being made with community resources so the services offered at the hospice continued to expand and be responsive to children's palliative and end of life care.

The spiritual and religious needs of children and their families were supported. .

Parents knew how to raise any concerns and/or complaints they had and had confidence the management team would take action to resolve these.

### **Is the service well-led?**

**Good** ●

The service was well-led.

Parents were complimentary about how the management team was making on-going improvements and how they felt there was an inclusive and homely culture at the hospice.

Staff were proud of their work, achievements and felt supported by the management team to make sure the care each child received the best care.

Quality and monitoring checks together with the views of others were used to reflect continuous improvement and development

of palliative and end of life care offered to children and families.

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# Zoe's Place Baby Hospice

## Detailed findings

### Background to this inspection

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

This inspection took place on 11 August 2016 and was unannounced.

The inspection was carried out by one inspector, a member of the CQC medicines team and a specialist advisor. The specialist advisor was a paediatric nurse, qualified and experienced in working within a hospice in the field of palliative and end of life care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Questionnaires were sent to 17 community professionals seeking their views about the hospice services. Five questionnaires were returned to us. We took the responses we received into account when we made judgements in this report. We looked at the information held about the provider and the service including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the provider is required to send us. We used this information to help us plan this inspection.

We sought information about the quality of service from the clinical commissioning group (CCG). We also asked Healthwatch for their views. Healthwatch is an independent consumer champion who promotes the views and experiences of people who use health and social care. We did not receive information back from the CCG and Healthwatch had no information to share with us.

We used a number of different methods to help us understand the experiences of children and families who used the services. We spoke with three parents on the day of our inspection and a further three parents by telephone. We spent time with children and saw the care and support provided by the staff team at different parts of the day. We looked at three children's care, risk and treatment plans, advance care planning and medicine records.



We met and spoke with the deputy head of care, two care assistants/support workers, a qualified nurse and a housekeeper. Two healthcare professionals also shared their views and experiences of being involved with the care and support provided to children and parents by staff at the hospice.

We looked at a range of quality assurance audits, clinical audits, incident and accident records, meeting minutes for different teams and departments, and staff training and development records. We saw a variety of written feedback from parents and children including testimonies from parents. We also looked at the results of the provider's quality monitoring systems to see what actions were taken and planned to improve the quality of the service and plans for the future. The registered manager also sent further information to us as part of the inspection.

## Is the service safe?

### Our findings

There were various procedures in place to make sure any risks to a child had been identified and safety measures applied. These procedures included the reporting of incidents and accidents. We saw several incidents had been reported about how staff met the particular oral feeding needs of children. We looked at how these incidents had been followed through to make sure actions had been taken to reduce similar incidents happening. These actions had been partially followed through but more could have been done to strengthen the reduction of the risks to a child, such as additional staff training for all staff members. For example, care assistants had received training in one particular area of children's feeding needs however nurses had not. The registered manager said in hindsight nurses should have also received this training as the recent incidents involved nurses.

Additionally we saw incidents were discussed in staff meetings but had not consistently been followed up on an individual basis with the staff member involved. This was a further aspect of ensuring all actions taken were widened to make sure the risks to children were further reduced. Although there was no evidence children had been harmed by the procedural lapses in the following up of each incident, we discussed these incidents with the management team. They acknowledged incident procedures required improving and told us, in the light of our findings, they would review and tighten incident management procedures. This included following up with actions required, such as extra training and support for all staff to further reduce similar incidents from happening again.

We looked at the arrangements for treating a child in the event of a severe allergic reaction so risks were reduced to their wellbeing. We saw there were no medicines for emergency treatment available. Staff told us children usually brought in their own emergency medicine if needed. However, there was no risk assessment available to show the risk of not having immediate treatment available. This is not in line with the resuscitation council guidelines. Due to our findings the registered manager told us it was an oversight on their part as they should have written a risk assessment for staff to follow. This was to make sure if a child was to have a severe allergic reaction all staff practices would be consistent in keeping children as safe as possible in line with the resuscitation council guidelines. The registered manager took immediate action to ensure a risk assessment was in place.

Parents of children who used the hospice service had confidence in staff to keep their child safe. One parent told us, "I trust them (staff) with my [child's name]. I would not leave [child's name] with anyone." Another parent explained how staff knew their child as well as they did which, for them meant they knew the actions staff took to respond to their child's needs kept them as safe as possible. A further parent told us how staff were valued as each time they, "Hand over their baby we as parents have to have a massive amount of trust in the staff" to keep them safe.

Staff showed they understood how to keep children safe from abuse. Staff we spoke with knew how they would recognise if a child was experiencing abuse. They were aware of the signs and symptoms a child may display which could indicate possible abuse. We found there was a clear framework for all staff which was aimed at reducing uncertainty about recognising and reporting concerns. A chart was displayed in the office

which reflected the steps staff needed to take when reporting abuse to external in order to protect children. One staff member told us, "We very aware of our responsibility to protect the safety of children, we know who to contact to report any concerns." We saw in the records we looked at where staff had worked with external agencies if a child was at risk of harm or abuse. For example, staff attending meetings to discuss a child's welfare with other professionals to ensure the safety of each child.

Parents spoken with told us they were involved in all the assessments of their child's needs. These included identifying the aspects of their child's safety and wellbeing which could possibly place children at risk. Each parent described how the safety of their child was taken into account on each visit to the hospice. Parents consistently explained to us staff discussed with them any changes in their child's care, health and medicine needs. One parent said, "I would not leave my child anywhere but at Zoe's the staff really know [child's name]. These are babies and are very vulnerable but at Zoe's I know [child's name] is in "safe hands." Another parent told us how the practices adopted by staff to ensure their child's needs were met helped them to feel they would be safe left in the staff's care, "They (staff) are always thorough in going through [child's name] entire needs and any changes, which is so comforting to know staff are fully aware of the care [child's name] requires before I leave them." We saw these practices in action on the day of our inspection as parents brought their child to stay at the hospice and staff spent time thoroughly going through all the child's needs to make sure of each child's safety.

We looked at how each child's needs had been assessed and the guidelines which had been developed for staff to follow to ensure risks to each child were reduced. In one child's care records there was information about the equipment they needed to promote their safety in the best possible way for them. On the day of our inspection we saw the child was receiving oxygen therapy via nasal prongs with extensive tubing which was trailing across the floor. We saw staff made sure the child received the care they needed to keep them safe which also supported their independence. Staff spoken with told us how risk factors, such as equipment which might be a trip hazard or a ligature risk were reduced to ensure everyone's safety. One example provided was how staff always stayed with children to reduce any known dangers from happening, which we saw happened on the day.

All parents appreciated the staffing arrangements as these made them feel confident in leaving their child. One parent told us, "When we have needed them, staff have been magically found and watched [child's name] around the clock when they were unwell, just like staff would their own child." Another parent said there were, "Plenty of staff" so each child has, "One to one care if this is what they need."

Staff were also positive about the arrangements in place to make sure children received the right care at the right time to meet their safety and wellbeing needs. One staff member told us, "There are always enough staff to meet each child's needs." Another staff member said, "[Registered manager's name] always made sure each child's needs are met safely whether this is by one staff or two. Nurses are always on duty."

There were sufficient numbers of staff to meet the needs of the three children who were in different stages of their stay at the hospice on the day of our inspection. For example, one child was going home after staying at the hospice for a period of time whilst another child came later in the day for their respite stay. We found there was a good skill mix on duty on the day of our inspection to meet the individual needs of the three children. We saw each child's individual needs were met at different times of the day to ensure their safety and wellbeing was promoted. For example, when staff administered medicine to one child this was done in an unrushed way so staff were able to watch for the child's own facial and body language signs. One staff member told us this was important to ensure children's safety when meeting their needs. They said this was because through a child's non-verbal communication staff were able to note if they were in discomfort. Staff were responsible for supporting activities and play. We saw there was sufficient staff to provide children with

a high level of interaction and support. We saw staff engaged children in art materials and they was also a sensory room, play room and garden with things for children to play with.

We found the management team had kept staffing numbers under review so the safety and wellbeing of each child was not placed at risk. One example was where the management team had made decisions not to accommodate a child staying at the hospice if there were not the right numbers of staff to be able to safely offer this service. There were also examples of the management team making every effort to gain additional staff when a family needed emergency respite care.

The registered manager told us in the provider information request [PIR], 'Recruitment process ensures all staff have references and DBS [Disclosure and Barring Service] checks prior to commencing post.' When we spoke with staff they confirmed these recruitment processes were followed. One member of staff described the recruitment process. They said they had completed an application form and had an interview. References had been sent for and a criminal record check carried out through the DBS. They said, "I wasn't allowed to start (working at the hospice) until they'd all been returned." These recruitment processes were in place to make sure only staff suitable to work with children and their families were employed.

Medicines people brought in to the hospice were used in addition to medicines prescribed by the hospice doctors. Medicines were checked when a child was admitted to the hospice by a nurse to ensure medicines were suitable to use. A nurse told us every time a child comes back to the hospice their medicines were re-checked.

One parent of a child in the hospice told us, "They (staff) look after medicines brilliantly. They ask about (the child's) medicines every time we come, about how (the child) takes them and at what time. I am more than happy with how the hospice looks after medicine."

A GP visited weekly to manage individual children's healthcare and medicine requirements. Staff at the hospice could contact the GP out of hours and were also able to discuss children in the hospice with a paediatric palliative care consultant at the local hospital.

Medicines were stored securely in locked cupboards or a fridge. However, on the day of the inspection, staff did not make sure that the keys to the medicines trolley were kept safe. The nurse took immediate action when we brought this to their attention so safety precautions were taken in regards to the medicine keys.

We checked the medicines prescribed on two medicine charts. Nurse's practices reflected a child centred approach was taken when supporting a child with their medicines. For example, nurses gave children their medicine when they needed it and not at set times.

Medicine incidents were reported and arrangements were in place to ensure they were investigated and an action plan was completed. This meant lessons were learnt and the risk of the incidents re-occurring was reduced.

The provider had a competency checking system for staff involved in medicines administration. This meant they were able to see if staff were competent to give medicines safely and if there were any training requirements. Some staff had also completed a certificate in understanding medicines from a local college. We were told other staff would be offered the opportunity to also complete the training.

## Is the service effective?

### Our findings

Parents told us they were confident staff knew how to meet their child's needs and they did this in a skilful way. One parent told us how staff had built up their knowledge of their child's particular health condition. The parent said this helped them to feel confident when leaving their child in the care of the staff. Another parent said staff were, "Very able and competent in the care they provide to [child's name]. They totally know the kids individually, from their feeding routines to noticing when something is not quite right with [child's name]." A further parent explained how staff knew how to meet their child's needs in the right way for them and checked whether there were any changes each time they came to the hospice. They said this practice helped them to feel confident in leaving their child at the hospice in the knowledge staff practices would, "Always be 'spot on' when taking care of [child's name]."

Staff had received a comprehensive induction which had improved over time which included new staff being provided with a mentor and attending training. A staff member told us, "My induction covered all the key areas and training, I had time to be introduced to the caring aspects of my role and responsibilities." Staff spoke positively about the support they received. Staff told us they felt they had opportunities to reflect on their practices and were supported with the emotional parts of their work. In addition staff told us they felt very well supported by the registered manager, the deputy manager and each other. One staff member told us, "The nurses are all fantastic at giving you the support you need." Another member of staff said, "I can talk to anyone. We support each other more than we realise." All staff received support through appraisals, regular one to one meetings internally and clinical one to one meetings externally.

The registered manager told us in the PIR, 'All staff have online mandatory training to complete and this is backed up with practical training sessions in the appropriate areas throughout the year.' We saw and staff told us they had opportunities to complete training courses to equip them in providing care to children who used the service. Staff practices seen during our inspection showed how knowledge gained was used to provide care and treatment. For example, staff knew how to care for a child who required oxygen therapy to meet their particular needs and how to stimulate a child's senses to enhance their quality of play.

Staff had additional training specific to the needs of children and young people. For example the provider had sourced specialist training in preparation for a child who was ventilated and their assisted feeding needs had changed. One staff member told us, "We care for children with very complex needs and at times these change and we have to make sure we are able to meet these. More specialist training is readily sourced for us all to learn about managing a child's specific needs." Another staff member said, "We learn from community professional's advice too so we know our care is right for the child." Parents we spoke with valued these positive approaches to staff learning about how to meet their child's particular needs. One parent explained to us how staff had been to their home to look at how their child's particular needs were met by community nurses. This action happened so staff would be confident to support their child at the hospice. The parent told us these practices were valued by them as they showed staff went, "Above and beyond" to provide their child with the right care to meet their needs. Staff spoken with also told us they enjoyed and valued the training they had received from other professionals as it supported them in caring for children with specialist needs.

We found staff training and the opportunities for staff to use their knowledge and skills were very much ongoing in line with the development of the hospice services and extended opening times. For example, we found from speaking with staff they had also gained skills and knowledge from the practical experiences of providing care for the first time. For example, a child who was known to hospice staff came to the hospice after they had died in hospital. When a child died they could rest until the time of their funeral in the special bedroom facilities provided known as the 'starlight room.' The special bedroom operated on a cooling system so the child was able to lie at rest until the time of their funeral. We heard from the deputy manager and staff how they met the child's particular needs at this time which included knowing the child required regular skin care. The deputy manager said this experience was a, "Massive learning curve" for everyone. The deputy manager told us to make sure the care provided was, "The best it could be" staff sought guidance where required from others. This included support from their colleagues at the provider's other two hospices as this was the first post death care of a child staff had experienced at this hospice.

Staff we spoke with told us they felt supported in their work to be as effective as they could be. For example, competency frameworks were in place which showed staff had been assessed and were competent to deliver care including palliative and end of life care and clinical care for babies and children. Staff members showed us how their competencies in different aspects of their caring roles were checked. We saw they were only 'signed off' as being competent once their practices had been assessed and they had achieved the required standards in the different aspects of their work. Staff felt these arrangements supported them in their roles to make sure their practices remained effective when meeting the needs of babies and children with life limiting and life threatening conditions.

Staff we spoke with explained to us they were not asked to do any aspects of a child's care and/or treatment they did not feel competent to do. This was also the case for nursing staff as we heard of one example where the management team changed the staffing rota's to accommodate a child's clinically complex needs. This was to make sure all staff were confident in meeting the child's needs.

Parents we spoke with told us their child's feeding routines were met by staff. This included how a child's other needs, such as their physical and health needs impacted upon their nutritional needs. One parent told us, "They (staff) know [child's name] feeding regime and it is written down for them to follow so I have no worries when [child's name] is at Zoe's." Another parent said, "They know [child's name] routine for the day and the times of their feeds which they are all clued up about."

In the PIR the registered manager told us, 'Staff complete online competency training to ensure they are competent in caring for children who required enteral feeding (feeding through a tube into the stomach). They then complete in house clinical competency document.' We saw staff put their training into practice when they supported children with their own nutritional feeds via enteral feeding devices during the day of our inspection. Staff were seen to be confident in the management of enteral feeding devices to ensure children's comfort was maintained while their nutritional needs were met.

Staff told us and we saw there was clear guidance to meet the nutritional needs for staff to follow for all three children who were at the hospice on the day of our inspection. One staff member told us these were used to guide the support each child required so their feeding routines were followed. We saw this was the case as during our inspection one child had a blended diet and we saw this was provided in line with their personalised plan. Eating plans we saw contained safe swallow advice and details about how the child should be supported. Staff had received food hygiene awareness training and reflected this in arrangements we saw to make sure the milk kitchen was effectively cleaned. We saw the feeds stored in the fridge were labelled appropriately as part of meeting each child's nutritional needs. Meals, snacks and drinks were prepared and cooked at the hospice in the provided kitchen facilities. We saw there was a nutrition policy

and operational procedures for staff on enteral feeding. Staff were expected to sign once they had read these to make sure their practices remained effective and in line with current procedures. We saw not all staff had signed these but action was being taken to ensure this was rectified.

The management and staff team liaised with parents and community services, such as the dietician and consultants to maintain children's meal routines. The registered manager told us in their PIR, 'We liaise with each child's dietician to ensure our information is current. All children have their own fluid chart, toileting and nutrition charts completed during their stay. We receive current consultant letters to ensure we are notified of any changes.' These arrangements assisted staff to act quickly to provide advice and support to those children whose nutritional or hydration needs were of a concern.

Parents spoken with told us when their child was staying at the hospice they were confident staff would meet and respond to their healthcare needs. One parent told us staff had a good awareness of their child's health condition along with the sign and symptoms which would inform staff if a doctor was required. We heard from parents, staff and healthcare professionals that staff had established good working relationships so each child's healthcare needs were consistently monitored and met. This included an on-call doctor service to support children's healthcare needs by providing medical advice and for assessment purposes so children received the care and treatment needed.

The comments we received from healthcare professionals who worked with staff at the hospice were very positive. One healthcare professional believed the services offered to families with children who had life limiting illnesses were, 'excellent.' They said children received palliative care which met their physical, emotional and social needs. They also believed staff provided clinical care so children's symptoms were managed and staff often identified previously unrecognised issues so care remained effective. Another healthcare professional told us staff effectively managed the care of children with long term ventilation needs and were experienced in doing this so the impact for children was good.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The MCA applies to children age 16 years and over. Children who used the hospice services were under 16 years of age and therefore the MCA does not apply. Instead a child needs to be assessed whether they have enough understanding to make up their own mind about the benefits and risks of treatment; (the child's ability to give consent). This is termed 'Gillick competence'.

Because staff at the hospice provided care and treatment to babies and children up to the age of five parents were their legal guardians. We looked at how consent was sought from parents in different aspects of the care and treatment their child received. Parents spoken with told us they were always involved in any decisions which affected their child's care or treatment. Consent had been sought from parents for their child's care, treatment and activities they may undertake while at the hospice. For example, taking children out and using other facilities, such as the hydrotherapy pool.

## Is the service caring?

### Our findings

On the day of our inspection we saw how the three children who were staying at the hospice received care which was completely centred on them. Each child received care in a loving and friendly way from staff whose practices showed they knew how to provide comfort when a child needed this together with happiness through tactile play. Staff were happy and smiling and used lots of encouraging friendly tones when speaking with each child. Children reacted to the care they received from staff through their facial expressions and body language which staff used as signals as to whether the care was right for each child. For example, when one child was shown brightly coloured paints and glitter placed onto paper we saw their facial expressions 'lit up' and their legs kicked to show their enjoyment of what they saw. Another child sat on a staff member's lap where touch was used and the child relaxed due to this interaction.

Staff were able to tell us how they managed children's pain and comfort and we saw this was recorded in their care plans. This included details of how children expressed pain or discomfort so staff would know how to identify when they experienced pain. We saw staff regularly comforted children and provided reassurance especially when care and medicine tasks needed to be carried out.

Parents we spoke with consistently described staff in positive terms and their comments reflected the caring practices we had seen during our inspection. One parent said all the staff really cared and their practices with their child were, "Stunning" and told us, "It is not just a job they care for [child's name] as if they were their own child or family member. It's a joy to see and a comfort to know staff are so caring and dedicated." Another parent said they were impressed at the way everyone who worked at the hospice, "Right from the cleaners to the care staff" knew each child and their parents. They went on to say, "It like a little home from home."

We heard from staff they had a strong commitment to supporting children and their families at different times in an emotional and practical way. For example, one parent described to us how staff had been there for them during a family crisis and it made a significance difference to how they coped at the time. Another parent's comments in their testimony read, 'They are there through the good times and the bad times, whether that's child related or you are just ready to pull your hair out and need a sit down with a cup of coffee, they accommodate and support you the best they can.' Staff spoke to us about their work with respect for each child and their parents. They were proud of the care they offered to very young children and their families to support them through the good and bad times.

Staff were also aware of the trust parents had in them to care for their child. One staff member told us the amount of trust it took to leave a baby or very young child with staff was, "Enormous for their parents" and staff never undervalued this. This recognition featured strongly in the comments we received from parents in how they placed their trust in staff to care for their child. Parents consistently told us they felt the service was special in that it was tailored to meet the needs of babies and very young children. This was especially evident in the positive feedback from parents who had strong feelings about wishing their child could remain at the service past the age of five. This was a testimony to the care and attention staff were committed to provide to each baby and child.



Parents spoken with told us they felt involved in making decisions and planning their child's care. Some parents we spoke with told us they had discussed advanced care planning [ACP] for their child in the event their health deteriorated. One parent told us, "I am fully involved in all discussions about the care [child's name] receives at Zoe's." Another parent described how staff had taken time to speak with them about their child's individual routines and their little ways which were unique to them. For example, how the different sounds their child made meant something whether this was they were happy being cuddled and or enjoying having some fun. A further parent told us how staff had developed different ways of including them in their child's time spent at the hospice. For example, the play diaries and children's work which is displayed at the hospice and can be taken home. We saw and heard from staff they knew each child's preferences, favourite toys, objects of comfort and routines.

The comments parents had written reflected the positive emotional support and level of kindness and sensitivity shown to families as they experienced their journeys. One parent spoke about the friendships they had made with another parent whose child had similar complex care needs as their child had. They told us the parent's group meeting had been the platform which had supported them to share the mutual bonds which were centred on the experiences of their children's specialist needs. Another parent told us about how they appreciated the kindness shown by staff to children's siblings. From their own experience they described how staff included siblings in events and days out which they had enjoyed.

We saw the care and support offered to children and their families achieved very positive outcomes and showed each child and family mattered. One parent told us they were offered counselling to support them with sharing their feelings and thoughts. Another parent said they were supported by staff who were more than happy for them to telephone the hospice staff at any time even during the night. They said this level of thoughtfulness and understanding supported them to cope with the crisis in their life at the time in the knowledge their child's needs were met. One staff member spoke with compassion about the way the care provided to a child after they had died was personalised so all the little details about each child were maintained.

Children and families religious and cultural needs were respected and met. We saw there were religious artefacts for use by families which could be readily accessed in the reception area of the hospice. Following the death of a child staff continued to support the family with compassion and care. An important part of this was supporting family members with opportunities to create memory boxes in which families could keep important mementoes of their child and hand and foot print pictures. When staff spoke with us about their involvement in supporting families they spoke with compassion and empathy. One staff member told us, "It's such a privilege to care for children and their families. We offer support to families after a child's death and they can continue to attend events if they wish." The deputy manager also confirmed this with us but acknowledged for some families it was hard to come back through "The hospice doors or attend events" which staff were always mindful.

The registered manager told us in the PIR, 'If a family wish to stay in our parent's suite we are happy to accommodate them. Our parent's suite has a coded door to ensure they receive privacy and dignity at all times.' Parents spoken with knew about the parent's suite and consistently described to us staff were always welcoming, listened to their needs and they could visit at any time. Parents told us they could stay overnight with their child, or during the day until they had settled in which they valued.

Staff understood the importance of their responsibilities in supporting children so their privacy and dignity were respected. Because of the young ages of children staff knew their practices were relied on to ensure each child's dignity was upheld. One staff member told us when they attended to children's needs this was done in the privacy of their bedrooms when they stayed at the hospice. Bathrooms and toilet areas were

easily accessed and doors were closed to promote a child's privacy.

## Is the service responsive?

### Our findings

We saw the admission process for each child included looking at each child's clinical, emotional and social needs so these could be met and responded to. The needs of parents were very much part of this process as we consistently heard from parents how their goals were met which supported them in caring for their child. Parents spoke positively about how the services offered to their child were flexible and staff always tried their best to accommodate their needs. One parent told us, "With all the stress and hospital visiting [child's name] has Zoe's place, it is a little happy place and she is always smiling when we bring her in. We feel we are able to leave her in safe hands when we need a real break." Another parent said, "The hospice has been a life saver for us and they always meet [child's name] needs. He has a scrap book like all the other children and each time we collect him we get an update of what he has been doing!"

Parents spoke with us about how they valued the mutual supportiveness of the relationships they had formed with staff. One parent described to us how staff had spent time with them going through their child's particular routines and needs which had helped them to feel confident in their child's care needs being met in the right way for them. Another parents comments in their testimony read, 'They have this gift that they know we are more in the know than they are about our child's care. [Child's name] last very scary spell in hospital was the hardest time; we didn't know which way it was going. Zoë's place called every single day and staff visited. They ensured all our wishes in his end of life care plan were met. They kept mine, my family and [child's name] spirits up in our darkest hour.' We saw this happened on the day of our inspection as parents brought their child to the hospice and/or came to take their child home. It was clear from what we saw staff had invested a lot of time in getting to know each child and their parents. Conversations were held in relaxed ways where time was not an issue as parents remained at the hospice until they were ready to leave.

Care plans were detailed and personalised to each child and contained up to date information so each child's stay could mirror that provided at home. This included staff knowing what a child's favourite toy was, what helped to comfort each child and what their bathing routines were. Parents spoken with described staff as being very responsive to their child's particular needs and were confident staff followed their child's care plans. One parent described to us how staff, "Totally knew how to communicate" with their child and in doing so were able to comfort their child when this was needed together with what brought them happiness. We saw in practice how staff understood children's complex ways of communicating and responded to their verbal and non-verbal communication and gestures. For example, we saw toys which supported children with different sensory needs. One child had enjoyment from the music they heard from one particular toy and indicated through their body language this brought them such fun each time the song played.

All the care staff provided was caring, respectful and age appropriate and responded to the needs of each child. For example, the use of touch, infant massage and tactile brightly coloured art work to enhance each child's time spent at the hospice. Staff showed they knew the needs and preferences of the children they were caring for and one staff member told us about one child, "He is very active, likes playing and cuddles." We heard from staff and saw how another child enjoyed 'Tacapac', which is a form of sensory communication

through touch and music. The registered manager told us staff had received massage therapy training and had recently introduced this into children's evening routines. These different responses to each child's needs were reflected in the staff practices we saw on the day of our inspection and each child looked visibly comfortable and happy.

Staff told us they planned activities around what each child enjoyed and we saw on the day some very young children were supported in age appropriate play with toys which matched their different abilities. The sensory room provided a range of sound, light and touch objects to stimulate for children to enjoy. Spontaneous and planned visits to sensory sessions away from the hospice were also provided. Staff used music therapy so they could engage children in this. A range of planned events had taken place; such as visits to different places. Parents had provided positive feedback regarding the fun and play times staff involved their child in. We also saw staff promoted opportunities for families to share fun times together. One parent told us about their positive experiences of being with other families and sharing fun times. Another parent said they felt very much a part of the hospice and enjoyed helping to raise funds through different fun events.

Sibling support was being established. This initiative recognised the need to support the siblings of children who had a life limiting condition. The feedback from parents about sibling support was very positive. One parent told us, "They always involve the girls who get as much attention from staff as [child's name] does which is very heart-warming."

Parents told us they had complete choice and control of the service they and their child received from the hospice. Through the assessment, care planning and review process they were able to decide on the service they wanted and what they did not want. One parent provided us with an example of how they were offered respite care when there were other difficulties going on in their life. They told us they were able to contact staff through the day and night which made them feel more able to cope and assisted them to be at the hospital with their other child. Another parent told us about how staff at the hospice had assisted them in referring their child to another community agency so their other particular needs could be addressed. One healthcare professional told us how important the service was. They commented, 'Zoe's place has been a vital service for the on-going welfare of our families we look after in the community. We get very positive comments back from these families about how wonderful the staff are and how well cared for their children are.'

Staff attended daily handovers in which the medical, personal care and well-being of each child was discussed. Staff told us they were allocated to a child and read the care plans to ensure they were familiar with the child's needs and how these should be responded to. One parent described to us how staff knew their child so well and their health condition. They told us this had a positive impact for their child as when their needs changed staff were able to immediately respond to these in the right way and at the right time. In addition to this transition arrangements were considered once a child had reached the age of five so children's and parents needs could continue to be met within a hospice environment. However, we received consistent responses from parents they wished their child's needs could continue to be supported at the hospice which was clear evidence of how parents valued the care provided.

The management team had evolved and developed its provision to children and this had supported them in responding to the needs of children and families. We saw evidence of the management and staff team working with different professionals within the wider health community. For example, children could now be cared for at the hospice over a longer period of time as an alternative to care in hospital as a 'step down' facility was now offered to families. The registered manager commented upon the benefits of this service to children and families in the PIR. They commented, 'Working in partnership with the local community team it

has highlighted what a beneficial service this has provided to these children and families. This has enabled us to develop our clinical skills and provide respite care to long term ventilated patients.'

External professionals were also positive about the benefits of the expanding services and how they were responsive in offering children and families alternative ways of meeting their needs. One healthcare professional told us the 'step down' facility had significant positive impacts for children and families. These included children being able to move closer to home and were able to get to know the hospice so their needs could be responded to on a respite care basis following discharge. Another healthcare professional commented the service provided to children and their families was 'Absolutely invaluable' and supported families at times of crisis as they offered respite care at short notice. They also told us staff managed the care of children with long term ventilation needs and were experienced in doing this.

The management team were working with external professionals such as the hospital and/or community nurse specialists to make sure the services offered to children and families continued to develop. One example of this was promoting the hospice services so parents had choices of where they preferred their child to receive palliative and end of life care. The deputy manager told us about how parents had been to look around the hospice as the scan of their unborn baby had advised them there were complications. Although the hospice had not provided care at the very end of a child's life and/or for neonatal babies these were areas they wanted to now promote due to the extension of the hospice opening hours. These developments in how the service was able to respond to children and family's needs had also been welcomed by healthcare professionals.

Parents spoken with were appreciative of the way the management and staff team had lessened the feel of a hospital or institution by the little touches made. We saw some of the examples parents referred to. These included children's artwork being displayed on the walls and photographs of events and outings children had experienced as a way of sharing memories. Additionally we saw the sign of the week in Makaton had been displayed to meet and respond to the diverse needs of children. Makaton is a form of communication which uses signs and symbols.

The provider had a complaints procedure which was available to anyone who wished to make a complaint. The complaints procedures were displayed on the noticeboard. Parents spoken with told us they knew how to complain and would feel comfortable approaching the managers and staff if ever they needed to. One parent said, "If I had a complaint I know the managers and staff would listen and resolve any issues. I would feel very comfortable in talking with any of them about any issues I have." Another parent said, "I don't have any complaints. If there are any issues we talk these through at the time so they are dealt with." At the time of our inspection none of the parents spoken with raised complaints about the care and support their child was receiving at the hospice. The registered manager told us in the PIR they had not received any complaints but systems were in place to capture these and they would use these as part of the learning and development of the hospice services.

## Is the service well-led?

### Our findings

Parents consistently expressed very positive feedback about the hospice and the support they had experienced. One parent told us, "Without the support we get from Zoe's Place we would struggle to cope. They are all brilliant in what they do." Another parent said, "Such a fantastic place where everyone is so caring, it is our little safe haven."

Parents told us they felt the management and staff team promoted an inclusive culture built upon trust and mutual respect. One parent told us they were pleased about the care and how the service was managed and how siblings were included being invited to fun days. They went on to say, "They care about the whole family which is very important" to them. Parent testimonies were similarly positive as they captured the impact on families and what the service meant for them. One parent's comments read, 'I cannot express how I feel knowing [child's name] is loved and cared for at Zoe's like he is. The peace of mind is second to none!! Which means when [child's name] is at Zoe's, I can breathe and totally enjoy my time with [sibling's name] knowing [child's name] is so happy, interacting with new friends in a very safe environment and medically he is looked after too.' Another parent commented, 'If I had to sum Zoe's Place up in three words, they would be 'Hope, Strength and Normality.'

Parents described to us how they felt involved in the services provided at the hospice and were encouraged to provide their views and make suggestions. Parents told us how they attended meetings, constantly talked with staff each time they came to the hospice and could write their views down in questionnaires. One parent provided us with an example where they spoke with staff about their child's needs and by doing so staff felt more confident in meeting these. Another parent said they felt the management and staff team had listened to parents and children's need which had been demonstrated by the opening hours being extended. We looked at the minutes from the parents meeting. These showed how other suggestions made by parents had been responded to so the services continually improved and reflected the needs of those which used them. One example was where parent's response to the idea of lockers had been responded to by children having wash bags. It was evident parents thought highly of the service as they had asked in meetings if children could use the service beyond the age of six.

There was a clear focus on putting children and their families first, identifying with them their goals and how they wished to be supported. Staff spoke passionately about their role and spoke about the 'privilege' of working with families of children with life limiting and life threatening conditions. There was a clear focus on placing each child and their families at the heart of the care by giving parents the choice and control when talking through their goals both during the life of their child and at the end of their life. One staff member talked about their experiences of wanting to provide each child with the, "Very best care and "Always striving to make each day special as you never know if it is the last one." Another staff member described how they were motivated to use their skills and knowledge and with the expansion of the services this would support them in doing this. They went on to say, "It is so special being with each child and helping families to share and make memories." Staff practices also reflected the service vision and values which included putting the child at the centre of any care and support and support for their families. This was evidenced in the complimentary feedback from parents and external professionals. Healthcare professionals valued the

collaborative working by offering respite care to children at short notice in times of crisis and the support provided to children on long term ventilation.

Staff told us they felt supported by the management team in their roles. One example of how the management team had developed opportunities of shared learning and development was the arrangements where staff worked alongside community nurses. Staff described how this had benefitted their care practices in providing specialist care to meet the needs of children with life threatening and life limiting illnesses. This was also confirmed by one parent who told us staff from the hospice came to their home to develop their skills in their child's particular needs and specialist equipment to prepare staff in meeting their child's needs.

Staff spoken with knew about their role in reporting concerns they had about the care children received. We consistently heard from staff they would not hesitate to use the provider's whistle blowing procedures if their concerns were not addressed internally.

A registered manager was in post who was experienced and skilled in paediatric palliative care. Although the registered manager was not at work on the day of our inspection parents and staff spoke about them in terms of being visible and available to them which they appreciated. The registered manager was fully supported by the structure of the organisation which included the deputy manager, trustees and registered manager's from the providers other two hospices. This was important due to the on-going development of the hospice services which included promoting these within the wider community so children and parents had choices around end of life care.

We found the registered manager showed they had an accountable and responsible leadership style. One example which reflected this was the comments we received after our inspection visit from the registered manager in which they told us, 'I do feel we need to improve our incident reporting system and how we follow up each incident I have spoken to our clinical lead and have asked for this to be discussed at the next head of care meeting.'

The deputy manager showed they worked in partnership with the registered manager as they were able to tell us about all aspects of the services offered together with areas for further improvement and development. They described their relationship with the registered manager as a supportive one. The management team had ambitions to expand the hospice services further to meet the needs of children who were reaching the end of their lives where the family expresses a preference for hospice care. To achieve this ambition and to continually strive to make further improvements the deputy manager provided us with examples of how this goal would be achieved. The examples included the continued progression of partnership working with the local hospitals, the wider community and palliative and end of life care training for staff.

The provider and management team had arrangements in place to assist them to check on the quality of care provided to children which included the feedback from parents and external professionals. The outcomes from all these different sources was consistently captured and presented to all the staff team and trustees to assist in a collective approach in helping to drive improvements. The management team used feedback to influence and improve their services. One example was the extension to the opening times of the hospice to provide children and parents with greater access to services to meet their needs. We had consistent feedback from parents and healthcare professionals how they had valued this. This was because the longer opening hours provided increased flexibility of offering parents their preferred planned dates for respite care together with providing emergency respite care in times of crisis.

The management team worked in partnership with other organisations to make sure they followed current practice and provided a quality service. For example, they attended meetings as part of the West Midlands Paediatric Care Network to develop their practice and contribute to the development of best practice in their service. The management team had also developed links with health and social care providers and professionals to promote good practice through shared training and learning events. This collaborative way of working had also supported the management team to continually review the quality of their service and help it to develop further to meet the needs of children and families. Records showed there had been an increase in the number of children and families using services at Zoe's Place indicating the variety and flexibility of the services offered was reaching more families. The management team actively found ways of sharing best practice and expertise as they continued to develop the palliative and end of life care for babies, children and families. Parents we spoke with all believed the services they received had made a significant impact on their lives as a family and that of their child. One parent told us the hospice was a "Little family setting where staff become friends and support you through the little drama's in life so you always leave Zoe's feeling better able to cope." Another parent said, "I cannot express enough how much Zoe's means to us as a family. It helps us to have some normality in our lives knowing [child's name] will have all the care and attention they need from staff who know [child's name] so well."