

Zoe's Place Trust

# Zoe's Place Liverpool

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	<b>Inadequate</b> 
Is the service effective?	<b>Good</b> 
Is the service caring?	<b>Good</b> 
Is the service responsive?	<b>Requires Improvement</b> 
Is the service well-led?	<b>Requires Improvement</b> 

# Summary of findings

## Overall summary

This announced inspection took place on 8 & 9 August 2016.

Zoe's Place in Liverpool is part of the national organisation, Zoe's Place Trust. The service provides care and support for up to six children who have life limiting illnesses with special and complex needs to varying degrees. The service offers respite, palliative and terminal care to children aged from birth to five years. Families also receive support through the parent support next work and sibling groups. The organisations' website states, 'Zoë's Place offers our parents and carers a chance to recharge their batteries or to spend time with their other children'. Registered children's nurses and support staff (carers) look after the children during their stay. The organisational structure included a board of trustees and clinical lead manager who oversaw the three services, Zoe's Place Liverpool, Zoe's Place Coventry and Zoe's Place Middlesbrough.

There was a registered manager in post. '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'.

The hospice offered an in-patient palliative and respite care to children up to the age of five who had life-limiting or life-threatening conditions. There was also the provision of a day service from 10am-6pm during the week and a sibling support group. Referrals to the service were made from families, health professionals, hospitals or by contacting the hospice direct. Referrals to the service were dealt with promptly and parents were provided with a minimum of two nights respite care each month for their child. At the time of the inspection the hospice was not providing end of life care.

During our inspection we found a number of breaches in our regulations.

We looked to see if there were systems in place to ensure the proper and safe handling of medicines. We found medicines were poorly managed and current practices put people at risk.

Staff had a good knowledge of what constituted abuse and how they would report an alleged incident. Safeguarding policies and procedures were in place along with local authority guidelines for staff to follow. We found on inspection however that the safeguarding process had not always been followed to protect individuals from abuse. Incidents that affected children's welfare had also not always been reported to us in accordance with our regulations. This showed a lack of governance over monitoring around risk.

Although systems were in place there appeared to be a fragmented approach in respect of identifying and controlling risks to children's safety and concerns, reporting on incidents, lessons learnt and actions taken. This had the potential to place children at risk.

Children's care files contained a number of documents relating to their assessment and care. We found a

number of anomalies in respect of the care files we reviewed. Some care plans we saw described children's care though these were not always consistent or inclusive of all care needs. Care plans had not always been reviewed on every visit to reflect current care. There was a risk therefore that the staff did not always have the information they needed to provide care and support to children in accordance with their individual need.

We saw a number of quality assurance systems and audits to monitor performance and to drive continuous improvement. The concerns we identified at our inspection had not been picked up by the current governance system and auditing arrangements. This meant the governance was not as robust as it could be to assure a safe effective service.

Children were supported by sufficient numbers of staff to provide care and support in accordance with individual need. We saw that children received care and treatment from a multi-disciplinary staff team which included a registered manager, registered children's nurses, play leader, local doctors, paediatric palliative care consultant and a team of support staff (carers) and ancillary staff. Advice from health care professionals was sought at the appropriate time. Relatives told us the staffing numbers were good and the children received all the support they needed during their stay at the hospice.

The children at the hospice were of very young age and therefore consent to care and treatment was obtained from the parents. We saw evidence of consent forms completed by parents to ascertain their personal preferences, choices and wishes around their child's care. Staff talked with children about day to day activities such as, what they would like for lunch, arts and craft, using the play area and also about their care they were providing to ensure their inclusion. Relatives told us their views were listened to and their wishes were recorded.

Children's dietary needs were assessed and staff ensured meals were to their liking during their stay. Healthy meals were promoted with plenty of drinks and snacks at other times during the day.

The provision of family support was seen as an important part of the overall care. Parents told us how supportive the staff were of them and their siblings and they could contact staff at any time for advice. Parents said the support was 'first class'.

During our inspection we saw that the hospice was very clean and subject to robust infection control measures.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed and contracts in place for services and equipment. This included fire prevention. Night time security arrangements at the hospice included the main gates being locked and use of intercom for entry. CCTV cameras monitored the grounds and hospice entrances.

Environmental risk assessments were completed in place for areas which included the pool side, lounge/play area and kitchen to help ensure they were safe for children and others. The service had a health and safety lead and a health and safety committee to oversee safe working practices.

The hospice provided suitable accommodation to meet children's individual needs. The layout of the hospice meant children had plenty of space to relax and/or enjoy play time. The hospice grounds were easily accessible and children had the use of a hydrotherapy pool and light therapy room.

Parents were offered accommodation at the hospice able to stay at any time. Children who died at Zoe's

Place or who died elsewhere could use the 'Snowdrop Suite' at Zoe's Place. This was a room where children who had died at the hospice or within the community or a local hospital could rest until their funeral.

Recruitment procedures were robust to ensure staff were suitable to work with vulnerable people.

Staff told us they were supported through induction, on-going training, supervision and appraisal. The formal training programme for staff included end of life qualifications as part of their professional development. The training records we saw confirmed this.

Staff were trained in the use of emergency equipment such as, oxygen and suction. Emergency medicine supplies and equipment were kept in close proximity to each child should they be needed in an emergency situation or to support a child if going to different areas of the hospice.

The service had an effective system for handling, recording and responding to complaints. The records we looked at showed how complaints were dealt with and responded to.

Our observations showed staff placed a high value on working closely with families and supporting them and their children in accordance with individual need. Parents told us they had close working relationships with the staff and knew their child was well cared for. They told us the staff were polite and showed genuine warm and interest in their child's health.

There was a clear management structure and staff said they were supported by the management team.

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

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

We always ask the following five questions of services.

### Is the service safe?

Inadequate 

The service was not safe.

The service was not following safeguarding procedures to protect children from potential harm or abuse.

We found systems in place to manage medicines were unsafe. Current medicine practices put children at risk.

Risks to children's safety were not always assessed with adequate control measures in place.

The hospice was very clean and subject to robust infection control measures.

Robust recruitment checks were in place to ensure staff were suitable to work with vulnerable adults.

There were enough staff on duty at all times to meet the diverse needs of the children they supported.

### Is the service effective?

Good 

The service was effective.

Mealtimes were family orientated with staff and children eating together. Children's nutritional needs were monitored and children were supported to eat a healthy diet.

Staff said they were supported through an appraisal, supervision and the hospice's training programme. New staff had a structured programme of induction training.

Parents provided consent to their child's care and treatment.

During our visit staff spoke with children about the actions they were taking so as to involve them as much as possible.

### Is the service caring?

Good 

The service was caring.

We saw that the staff had a caring manner. Each child was allocated to a specific team of staff who built up a relationship with the child and their family.

Families could come and go during their child's stay if they so wished and were fully supported by the staff team. Parents told us the staff were polite and respectful at all times.

Staff made sure care and support was given in a respectful and dignified manner, for example, personal care and children's clothing was changed in their room or the bathroom and medicines were given via feeding tubes in a discreet manner.

Following the death of a child family support continued by the staff for as long as needed, or for as long as the family wished.

### Is the service responsive?

The service was not always responsive.

Children's care planning lacked sufficient detail to help ensure their care needs were being met. Care plans had not always been reviewed on every visit to reflect current care.

Staff had a good understanding of children's care and treatment and how they and the parents wished them to be supported.

A process was in place for managing complaints and complaints were logged and responded to.

Arrangements were in place to seek the opinions of parents, so they could share their views and provide feedback about the hospice.

**Requires Improvement** ●

### Is the service well-led?

The service was not always well-led.

We saw a number of quality assurance systems and audits to monitor performance and to drive continuous improvement. The concerns we identified at our inspection had also not been picked up by the current governance system and auditing arrangements. This meant the governance was not as robust as it could be to assure a safe effective service.

The home had a registered manager in post. The registered manager had relevant and up to date experience and expertise to lead the service.

**Requires Improvement** ●

Feedback from parents and staff was positive about the management team.

There was a clear management structure which helped to promote the management and on-going development of the service.

Staff were aware of the home's whistle blowing policy and said they would not hesitate to use it.

We found that the hospice worked in partnership with other organisations at regional and national level which assisted in the monitoring and development of the hospice service.

Parents were involved with the service and could provide feedback as to how it was operating.

# Zoe's Place Liverpool

## **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.

The inspection took place on 8 & 9 August 2016 and was announced.

The inspection team consisted of an adult social care inspector, a pharmacist and a specialist advisor (SPA) with experience in end of life care.

Prior to our inspection we reviewed the information we held about the service. This included a Provider Information Return (PIR) sent to us by the provider. The PIR 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. We looked at notifications and other information the Care Quality Commission (CQC) had received about the service. We contacted the commissioners of the service to obtain their views.

We spoke with the registered manager, deputy manager, five members of the care staff, a student nurse, a play leader, two children and three parents whose children were currently receiving respite care. We also spoke with two visiting health professionals.

We looked at personal care records, five medicine records and five support plans for children receiving respite care at the hospice, four recruitment staff files and training and supervision records for staff. We viewed and checked records, policies, procedures and other records relevant to the quality monitoring and management of the service.

# Is the service safe?

## Our findings

At this inspection, we checked the medicines and records for five people (children) who used the service. We spoke with three members of staff including the registered manager and two registered children's nurses about the management of medicines.

New Medicine Administration Record Sheets (MARS) were written each month by the medicines management lead nurse and these were checked by the nurse who was looking after the child to check whether they were accurate. The medicines management lead nurse used the previous months MARS, clinic letters and information from the person's parent or carer to verify what medication the person was taking but the information was not always confirmed with the person's doctor. We found that the different sources used before admission did not always match, which made it difficult to make sure what they were taking during their stay was the medication that they should be taking.

A general practitioner (GP) visited the home twice a week to sign the prescription charts, but this could be after the child had been admitted and medication could be administered before being signed by the GP. One person had a medication to aid sleeping written on their MARS that was not recorded on the recent clinic letter. It was unclear whether this had been discontinued in clinic, and the hospice had not recognised the difference. The same person was prescribed a medication for epilepsy that had two different doses recorded in their notes. The hospice had to ring on the day of the inspection to confirm which dose was correct.

We were told that carers could administer liquid feeds (through or via a stomach or bowel tube) to patients if they were competent to do so but this was not included in the medicines' policy. Although we saw evidence of competency assessments in staff records there had been recorded incidents where competent assessed carers had put the wrong feed up, administered the feed into the wrong stomach tube or given it to the wrong person.

We looked at three people with a liquid feed prescribed by a doctor, and found these were not written on the MARS this is not in line with national guidance. When a liquid feed was administered the name of the person administering the feed, and the name of the feed being administered was not recorded, which is not in accordance with national guidance. Information from dieticians how feeds should be administered and volumes of water needed to flush the stomach tube was not being followed for two people. One of the two people had their feed administered twice a day and on one day, there was no record that the first dose had been given. It was unclear whether medicines were being given as prescribed by their doctor as the directions on the person's medication boxes was either different to what was on the patients' MARS or there was no label on the medication bottle as the medication box (that had the directions on it) had been left at the person's home.

One person was prescribed a fluid and food thickener to aid swallowing. Staff did not record when the thickener was used, which meant it was unclear whether fluids were being thickened to the correct consistency. Using the wrong consistency could increase the risk of choking.

We checked the storage arrangements for medicines requiring refrigeration. The fridge temperatures recorded were for the current temperature only and did not include minimum and maximum. Taking minimum and maximum temperature readings each day gives the assurance that medicines have been stored between two and eight degrees Celsius and are safe to use.

This is a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Children at the hospice were nursed in cots. The cots appeared to be strong and robust and all had a cot mechanism cord attached. We were told that the purpose of this was to allow staff to place the cot in an array of positions which was suitable to the child's comfort. However, we found that the mechanism cord was a coiled appliance that was attached to the frame of the cot and measured approximately one metre in length. On inspecting the appliance further, we found that the cords on each cot were within reach for children to grab the cord which had the potential to harm or result in an injury to a child.

Staff told us that there had been a past incident when a child had got the mechanism cord from the side of the cot. We saw this had been reported as an incident and action included locking the controls. However we saw on inspection that the cot mechanism cord remained in reach of the children.

We saw that staff completed risk assessments regarding safety checks for children's care and for the environment. The checking of the mechanism cords was not included and the service was unable to provide a risk assessment around the cot mechanism cords.

Due to the potential of causing serious harm to a child, we discussed this at length with the registered manager who agreed to address our concerns around the cot cords as a matter of urgency. The registered manager agreed to add the cord storage to the regular night checks and a risk assessment regarding the cot cords was put into place.

In respect of risks around children's safety we reviewed records for oxygen saturation monitoring. This measures the amount of oxygen in the blood to ensure the person is getting enough oxygen. In one instance we saw this safety check had not been recorded over a 24 hour period for one child. This meant there was no record to alert staff of any change in the child's condition at this time. We saw these checks had been completed at other times and were also undertaken during the inspection.

We were unable to locate a plan of care for a child who had a potential infection to their jejunostomy site. 'Jejunostomy feeding is a safe and effective method of giving liquid nutrition, fluid and medicines to people who need to be fed in a way that bypasses the stomach'. A GP review had been requested by the staff. We asked three members of staff for their thoughts around this and each one gave a different response regarding the frequency when care should be completed. We were unsure therefore the staff were following the recommended practice for washing the site of an enteral feed as this was not recorded. This could increase the risk of infection.

During the review of a child's care plan, we came across a written medical instruction from a consultant at the local children's hospital. The instruction detailed the higher and lower extremities of the child's blood oxygen levels and the required management should the child's blood oxygen levels fall outside of the required extremities. We viewed a care plan showing that the child's lower blood oxygen levels had fallen outside of the lower extremity. Although staff had taken some actions to ensure the child's safety the required management which was recorded in the plan of care had not been followed. We brought this to the attention of the registered manager who was asked to report this incident to the local safeguarding

team. The registered manager actioned this and spoke with health professionals involved with the child's care. The registered manager has since notified us that the actions taken at this time were safe however those involved with the child's care agreed that the plan of care needed to be reviewed and 'reworded' to reflect the course of treatment needed should this occur again. This was actioned promptly. This however showed a failure on how the service monitored risk to ensure children's safety.

This is a breach of Regulation 12 (1) (2) (a)(b)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had systems to protect people from abuse. A safeguarding policy for child protection was in place with local area safeguarding procedures for staff to follow. Contact details for reporting concerns to the local authority were displayed for staff to make a referral. Staff received child protection training and were aware of the role of external agencies in keeping children safe. This was confirmed when looking at staff training records and talking with the staff. Staff told us they would speak up if they had any concerns about a child's safety.

Staff had access to a policy of the month to refresh their learning. We saw this month's policy was around child protection and staff had signed to say they had read and understood the contents. Two staff were appointed the role of safeguarding lead to oversee safeguarding procedures.

When talking with the registered manager about keeping children safe we found some areas of concern affecting their welfare. These should have been safeguarded to ensure the safety and welfare of the child concerned. We also found that we had not always been notified of incidents affecting the welfare of children which had occurred at the service. This shows a failure in the way the service did not always report on any areas of risk.

The registered manager said they would notify us retrospectively regarding the incidents (this has now been actioned) and would seek to review the regulations and guidance available regarding notifications.

This was a breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Environmental risk assessments included the pool side, lounge/play area and kitchen to help ensure they were safe for children and others. The service had a health and safety lead and a health and safety committee to oversee safe working practices. We saw minutes from meetings held.

Parents told us they felt their children were safe when staying at the hospice and that there were sufficient numbers of staff to meet their child's needs without care being rushed or compromised. Parents reported that they had no issues concerning the hospice and that they felt confident when leaving their child in the care of the hospice staff.

Staff were trained in the use of emergency equipment such as, oxygen and suction. Emergency medicine supplies and equipment were kept in close proximity to each child should they be needed in an emergency situation or to support a child if going to different areas of the hospice, for example, the hydrotherapy pool or the grounds.

We looked at the staffing arrangements for the service and the registered manager told us that the hospice was providing a service for 48 children. Parents were provided with a minimum of two nights respite care each month for their child. At the time of the inspection four children were receiving care. The staff team on

duty included the registered manager, two children's nurses, a play leader, a team of support staff (carers) and ancillary staff. We observed a safe care model of one to one nursing during the day with either a registered children's nurse or health care assistant staying with each child throughout the day. This model changed overnight when the staffing levels were reduced to one registered children's nurse and two carers.

The registered manager informed us staffing levels were closely monitored. We saw that staffing numbers were increased to support children with more complex needs. Bank staff were used to fill any 'gaps' on the staffing rota and the hospice had 'regular' bank staff to provide continuity of care for the children. Staff we spoke with during the inspection told us there was sufficient staff on duty to meet the needs of the children they were looking after. We found children's care needs were taken into account within the staff rotas when making decisions regarding the required staff numbers, qualifications, competency, skills and experience.

The registered manager was supported by a deputy manager and primary nurses were given their own caseload of children. The role of the primary nurses was to oversee the children's care, working in close partnership with families and health professionals involved in each child's care.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with children. We looked at four staff files and asked the registered manager for copies of the appropriate applications, references and necessary checks. We saw these had been carried out to ensure staff employed were fit and suitable to work with children.

There was a cleaning schedule in place and in terms of infection control/prevention we found that the internal environment was cleaned to a very high standard. We witnessed ample supplies of Personal Protective Equipment (PPE) and hand gel throughout all areas of the building. We observed staff washing their hands before and after contact with the children to help prevent and control the spread of infection. Infection control policies and procedures were available and a staff member was appointed the lead role for overseeing the control of infection.

A schedule of planned maintenance ensured the environment was well maintained. Service contracts were in place for services such as, Legionella and water treatment, fire system including emergency lighting and fire alarms, gas and electric service and portable appliance testing. A test of the emergency lighting took place during the inspection as it was difficult to ascertain when this test had last been carried out. This test was found to be satisfactory and the registered manager has since confirmed previous emergency lighting checks had been undertaken and a new checking procedure has been introduced on a monthly basis for fire safety. A fire risk assessment was in place and staff had received fire awareness training. A fire drill was last conducted in July 2016. Other service contracts included moving and handling equipment, bathing equipment, oxygen concentrators and suction machines. These contracts were all current.

The registered manager told us about the night time security arrangements at the hospice, this included the main gates being locked and use of intercom for entry. CCTV cameras monitored the grounds and hospice entrances.

## Is the service effective?

### Our findings

Parents of children at the hospice told us the staff provided very good care and support and they were comfortable discussing their child's health with staff.

The hospice offered an in-patient palliative and respite care to children up to the age of five who had life-limiting or life-threatening conditions. There was also the provision of a day service from 10am-6pm during the week and a sibling support group. The registered manager told us there was no set catchment area and that referrals for the service were received from the North West area. Staff told us how they worked flexibly to accommodate all requests made by parents for their child's admission to the service.

Following admission children had full access to care and medical treatment by the hospice's medical and nursing team and staff worked closely with a paediatric palliative care consultant at Alder Hey Children's hospital and other professionals such as, dieticians, speech and language therapists, physiotherapists and community teams to support children in accordance with their individual care requirements. The medical needs of the children were assessed by eight local general practitioners (GPs). The GPs conducted a surgery at the hospice twice a week and three times a week by telephone. They were also available at other times should a visit be required. An out of hours service GP service was available through UC (urgent care) 24 and also by attending Alder Hey Children's Hospital.

We looked at how children were supported with their nutrition and hydration. Meals were not cooked on the premises they were sought from an external catering company and prepared in advance. Staff were able to prepare 'on site' light snacks and drinks and these were offered to children during our inspection. The staff joined children at meal times and this was seen as a very social time with plenty of laughter and chatter. Staff offered children plenty of encouragement with their meals and oversaw their dietary requirements. Healthy meals were promoted with plenty of drinks and snacks at other times during the day.

A number of children received enteral feeds and this is the delivery of nutritionally complete food via a tube directly into the stomach, duodenum or jejunum. The registered manager told us that many of the children who used the service had dietician involvement. We saw evidence of this recorded.

We looked at staff training and how staff were supported to carry out their job. New staff received an induction and this was tailored to an individual job role and current practice. New staff were shadowed by a more experienced member of the team as they became familiar with the children needing care. The corporate induction provided a detailed overview of the service and what was expected from staff. The registered manager was aware that if a new member of staff was appointed who had yet to undertake any formal qualifications in care then they would be enrolled on the Care Certificate. This is 'an identified set of standards that health and social care workers adhere to in their daily working life'. The Care Certificate requires staff to complete a programme of training, be observed by a senior colleague and be assessed as competent within twelve weeks of starting. All care staff at the hospice had a formal qualification in care such as, NVQ (National Vocational Qualification)/Diploma or equivalent. Other NVQ courses undertaken by staff included leadership and management.

Formal training in palliative care was ongoing for nursing staff up to degree/masters level. Nurses were being supported with their nursing revalidation with the Nursing Midwifery Council (NMC). The registered manager told us the nurses who worked at the hospice had access to literature to promote their learning and development.

Staff had access to a training programme some of which was 'in house' and other training was outsourced. We saw that staff had attended a wide range of courses including, resuscitation, first aid, medicines, safeguarding children, enteral feeding, ventilation, tracheostomy care, oxygen management, health and safety, moving and handling, sensory training, baby massage and Makaton. Makaton is a 'language programme designed to provide a means of communication to individuals who cannot communicate efficiently by speaking'.

Staff told us their competencies were assessed following training and that they attended clinical skills updates. We saw the hospice was closed on set days to enable staff to ensure full attendance. Staff files evidenced training certificates and clinical practice checks, for example, tracheostomy care, ventilation and gastrostomy tube feeding, as part of assuring staff competencies. The training programme and monitoring of clinical practice held to ensure staff had the knowledge, skills and expertise to care for the children safely. Staff leads were appointed in clinical areas such as, ventilation, to provide staff support.

Staff told us they were supported through a good training programme and they received appraisals, internal supervision and clinical supervision from an external provider. They also told us they felt clinically supported by the hospice's management team. A staff member said, "We get plenty of support, there is always someone to talk to the help you." We saw dates of supervisions meetings held with the staff.

The registered manager told us that if a child needed to be transferred to hospital, a nurse would accompany the child. This ensured that a nurse the child was familiar with stayed with them to support them and provide detailed information to any health care professionals.

The children at the hospice were of very young age and therefore consent to care and treatment was obtained from the parents. We saw evidence of consent forms completed by parents to ascertain their personal preferences, choices and wishes around their child's care. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA) 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS); DoLS only apply to a person aged 18 and over. The MCA Code of Practice makes reference to other safeguards that need to be considered if an issue arises around depriving someone of their liberty under the age of 18, such as the powers of court under section 25 of the Children's Act 1989.

Staff talked with children about day to day activities for example, what they would like for lunch, arts and craft, using the play area and also about their care they were providing to ensure their inclusion

Children had the use of a large lounge with a soft play area and a designated arts and crafts area. In addition the hospice had a light sensory room for relaxation and/or stimulation, a hydrotherapy pool and an adapted bath to support children safely. The hydrotherapy pool was not in use at the time of our inspection due to on-going maintenance work. There was plenty of space for children to enjoy some quiet time if they did not wish to join in with the organised play. There were well-tended gardens including a sensory garden and paths for wheelchairs. The hospice had a minibus for outings.

Parents were provided with accommodation on the first floor of the building should they wish to stay

overnight. The parents' suite had a coded door to ensure privacy at all times. There was also a room for private consultations with families and health professionals. Parents and staff had access to a chapel on the first floor of the building. This was not part of the hospice but all members of the public were made welcome.

## Is the service caring?

### Our findings

Parents spoke positively about the respectful care given by the staff. Their comments included, "It's a God send" and "It gives me time to live my life." Parents told us their children received good care and communication from the nursing and medical staff. They told us their opinions and views were sought regarding care and treatment.

We saw that the staff provided child and family centred care. Each child was allocated to a specific team of staff who built up a relationship with the child and their family. Families could come and go during their child stay if they so wished; there were no restrictions on visiting. When parents visited we saw staff providing a very warm and caring welcome, plenty of reassurance was offered and displaying genuine interest in the family. Parents were encouraged to bring items in from home to help their child settle in and staff told us they tried to keep to the same routine as the child had in their own home so as not to cause anxiety or too much disruption to their 'normal' routine.

The service had a committed and motivated staff team with experience and knowledge to support children with their care and treatment. Staff told us how much they enjoyed working at the hospice. We found that all staff demonstrated a very caring approach to the children and it was easy to see the dedication of the care team. The care interactions we observed were also respectful and age appropriate and met the needs of the individual. Children were relaxed at ease with the staff and there was plenty of laughter. Staff made sure care and support was given in a respectful manner, for example, personal care and children's clothing was changed in their room or the bathroom and medicines were given via feeding tubes in a discreet manner. Staff took time with children to explain the support they were giving. We observed extended care provision such as massage, use of the soft play area, music and arts and crafts.

We viewed literature available about the hospice for people and their families to read. This included care following the death of a child and a service user guide which provided information around the eligibility criteria, staffing, health and safety, care, accommodation, complaints and practical advice relating to respite visits. The hospice also has its own website for people to access.

The hospice had a room called the 'Snowdrop Suite'. This was a room where children who had died at the hospice or within the community or a local hospital could rest until their funeral. The room operated a cooling system and there was also a facility for relatives to take their child to the relatives' room should they prefer to spend time with their child in a more private area. The suite could be personalised for each child and the death of a child was marked in a remembrance book in a chapel situated in the building.

The hospice staff were trained to provide one to one support for families for children with terminal conditions and following the death of a child. Staff told us they continued to support families for as long as needed, or for as long as they wished. A number of families return to the hospice to talk with the staff following the death of their child. A staff member said, "We do our best to help families, we are here for them as long as they need us." At the time of our inspection there were no children receiving end of life care.

The registered manager informed us the services of an advocate were not required at this time though should this information be required it would be accessed.

## Is the service responsive?

### Our findings

We looked at the care and treatment provided by the staff and to help us assess this we viewed five children's care files which contained a number of documents relating to their assessment and care provision. Daily evaluation recorded an overview of the nursing and medical care given by the staff on each shift.

Our observations and discussions with staff showed the staff provided the care and support in accordance with each child's individual need. Staff told us they had very good staff handovers at shift change to discuss each child's plan of care and treatment. In respect of care needs we saw evidence of care plans to support care practices, for example the use of a suction machine and care of a tracheostomy site. This documented the care needed for staff to follow.

We found however a number of anomalies in respect of the five care files we reviewed. This was mainly due to reliance on historical information being followed by the staff which at times was incorrect as the child's needs had changed. Some care plans we saw described children's care needs though these were not always consistent or inclusive of all care needs. There was a risk therefore that the staff did not always have the right information they needed to provide care and support to people in accordance with children's individual need.

The admission assessment of a child showed they required oxygen 24 hours a day. However, the child was seen to be playing in the soft play area and was not receiving oxygen. We immediately raised this with the child's primary nurse who informed us that it was an old statement. They told us the assessment needed updating as the child did not require oxygen 24 hours day at this time. They told us the plan of care would also be updated to reflect the current care provision.

Staff were supporting children with personal hygiene, though there was no plan of care to support this care need. Staff were applying a cream to a child who had a red area of skin. Although staff were aware of where to apply the cream, there was no plan of care to support this care need. Most of the children at the hospice required support with all care needs from the staff.

This is a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The hospice offered respite care 24 hours a day, seven days a week. The registered manager told us about services they provided including conducting home visits to assess the needs of the children who were referred and also arranging an admission if a parent was experiencing an emergency situation and requires additional support. We looked at the referral system for admission to the hospice. The hospice did not take children for respite care if they were suffering from any acute condition, such as an infection, that might affect their health. The following was recorded in the PIR, 'Our referral process ensures that we respond quickly to a referral and invite the family to visit the hospice as soon as possible. All children who are referred are discussed at the next monthly panel meeting'. Once the referral had been accepted families

were offered an opportunity to visit the hospice to make sure it would meet the needs of both the family and the child. A letter was then sent to the child's GP and/or consultant to gather information about their clinical needs to help assess their care and treatment on admission. This information was also used to formulate a plan of care.

The service provided rapid response to children's changing needs. We saw evidence of this by looking at care the files and also when a child was taken ill during the inspection. Clinical intervention by the staff took place promptly to stabilise the child's condition. Staff remained with the child to assure their observations were 'normal' and the child comfortable. The family were then informed of the medical treatment given and recorded in the child's daily records. Care records also showed evidence of GPs conducting medical reviews.

The hospice had a link nurse for transition from the hospice service if an alternative placement was needed. Staff worked closely with parents to ensure an appropriate service was found.

We spoke with a visiting health professional who told us the staff contacted them at the appropriate time when there was a change in child's health or well-being. They said the staff were very knowledgeable regarding the needs of the children they supported.

The hospice provided respite care for children though staff were aware of advance care planning which could be incorporated to support children and their parents around their wishes and wants in respect of place of care, clinical care, psycho-social support, spiritual wishes and care around end of life through to bereavement. There were no children at the hospice at the time of our inspection that needed this care.

We saw there was a clear and comprehensive system that enabled families to bring a complaint to the attention of the hospice should they feel it was needed.

Parents we spoke with had nothing but praise and expressed they had no complaints about the service; they knew there was a complaints procedure should they wish to raise a concern. Details of how to raise a complaint were displayed and parents provided with a complaint leaflet for their information. We looked at the complaint log and reviewed two complaints received. These had been investigated and responded to in accordance with the hospice's complaints procedure. We saw in respect of one complaint the actions taken by staff to minimise the risk of re-occurrence.

The hospice was able to offer appropriate learning and play opportunities for babies and infants during their stay. Play was seen as an important part of each child's stay and children were given plenty of opportunities to enjoy activities such as, arts and crafts, music, holistic therapy, for example, massage, DVDs and also supervised play time of their own choice. Children had a plan of care devised by a play leader and this was tailored to suit individual need. Children appeared to enjoy the play activities that were arranged during our inspection.

The service offered the services of a sibling group. This group enabled sisters and brothers of a child receiving care to enjoy social activities such as bowling, cinema trips and meals out, away from the family setting. Mothers could also enjoy spa pamper sessions provided by the hospice as a way of providing some relaxation time.

Arrangements were in place to seek the opinions of parents via satisfaction surveys and meetings, so they could share their views and provide feedback about the hospice.

## Is the service well-led?

### Our findings

At this inspection we looked at quality assurance systems, including audits (checks) to check on risks, monitor performance and to drive continuous improvement. The hospice held clinical three monthly clinical governance meetings to oversee the quality of care offered to children at Zoe's Place. The purpose of these meetings was to assure the compliance of systems and processes for the delivery of a safe and effective service and as a debrief for staff regarding matters arising. For example, untoward incidents. We were shown minutes of recent meetings to support this.

Although systems were in place there appeared to be a fragmented approach in respect of identifying and controlling risks and concerns, reporting on lessons learnt and actions taken. The concerns we identified at our inspection, for example, care planning, control of risks and medicines had also not been picked up by the current governance system and auditing arrangements. This meant the governance was not as robust as it could be to assure a safe and effective service.

When we reviewed the medicine management audit we saw there had been 11 medicine incidents from January 2016 to August 2016. The lessons learned from these instances were discussed at staff meetings, but the details of the lessons learned were not documented in detail within the team meetings' minutes. Not having accurate minutes from lessons learned prevents staff who could not attend the meeting to learn from medicine incidents.

Monthly performance reports provided an over view of how the service operated and the dependencies of the children receiving respite care. The report was inclusive of incidents, complaints, near misses, family support and staffing. We found however that the service did not operate a clinical risk register to manage/mitigate clinical risk. A number of incidents had also not been rated as to whether they were 'low', 'medium' or 'high' risk to help staff prioritise the actions needed. It was difficult to fully assess the governance arrangements and how clinical risks were being managed and actions prioritised in accordance with the level of risk identified.

This was a breach of Regulation 17(1) (2) (a) (b) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the registered manager was prompt to respond and provided an action plan to address the areas of concern we identified during our inspection. The registered manager has kept us informed of completed actions and how they intend to move the service forward. For example, the medicine action plan included verification of enteral feeds, care staff to check feed amount and rate with the nurses prior to commencement, amendments to the medicine policy and staff to receive training and development work around medicines and gastrostomy care. We were also informed of the actions taking place to assure care information was clear, concise and accurate and how governance training was to be provided for senior managers.

There was a clear management structure which helped to promote the management and ongoing

development of the service. The service had a manager who was registered with CQC and had relevant and up to date experience and expertise to lead the service. The registered manager was supported by a full team of experienced and skilled staff, along with a clinical executive lead for the organisation. During our visit we found the registered manager and staff very approachable and visible at all times. Parents and staff told us they were fully supported by the management team. Staff told us, "The manager is very good, you can always speak with (them)" and "Very good manager, well work as a team." An external health care professional told us the management and leadership of the hospice was very good.

Each nurse had a lead role in keeping up to date with different topics for example, infection control, clinical areas and safeguarding. They were responsible for updating their knowledge and sharing best practice with the staff.

Staff told us they understood the concept of whistleblowing and would feel supported if they needed to raise a concern. Staff advised us they attended meetings where information was shared about the service. They told us the meetings were informative and covered areas such as training, incidents and future development of the service. We saw minutes from staff and management meetings.

During the inspection we saw a number of completed audits. For example, infection control and cot mattress check. Recommendations from a recent infection control audit had been actioned to promote good standards of control of infection. We saw changes had been made to the cleaning schedule as a result of monitoring standards of cleanliness. Domestic staff now carried out cleaning duties in the afternoons rather than the morning as it had been acknowledged the mornings were a busier time for the children.

Parents were asked to provide feedback about the hospice. We saw findings from a parental questionnaire from April 2016. The overall analysis was very positive. The findings from the questionnaires are due to be published shortly.

We found that the hospice worked in partnership with other organisations at regional and national level which assisted in the monitoring and development of the hospice service. The hospice was a member of the Cheshire and Merseyside and Northwest Paediatric Palliative Care Network attending regular meetings and conferences to share good practice and update learning and skills.

The registered manager told us they were looking to provide end of life care in the near future. The PIR recorded this development which would include extending one of the bedrooms for end of life care and end of life care training for the staff.

This section is primarily information for the provider

## Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The registered provider had not always monitored potential risks to children's safety or ensured care was planned effectively to help ensure their care needs were being met. This was a breach of Regulation 12 (1) (2) (a) (b) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment</p> <p>The registered provider did not always safeguard people from abuse. This was a breach of Regulation 13 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The registered provider did not have a robust system in place to regularly assess and monitor the quality of the service. This was a breach of Regulation 17(1) (2) (a) (b) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>

This section is primarily information for the provider

## Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  The registered provider did not ensure the safe management of medicines. Current medicine practices put people at risk. This is a breach of Regulation 12 (1) (2) (g)

### **The enforcement action we took:**

We served a warning notice