Derian House Childrens Hospice

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Inspection report

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Date of inspection visit:
29 July 2016
02 August 2016

Date of publication:
16 November 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Outstanding ☆
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection was announced and took place on 29 July and 2 August 2016. The service was last inspected in May 2014 and was rated overall as 'Good' using the pilot wave inspection methodology in place at the time.

Derian House Children's Hospice provides palliative and end of life care for children and young people who have life limiting or life threatening conditions. The manager has been registered with the Care Quality Commission since September 2013. The hospice is set in its own ground and provides accommodation for nine children in the main house and four young people in the lodge. There are four self-contained flats which are used by families. The hospice also provides a service for children and young adults in their own home. This is known as Derian at home. Bereavement support for parents and siblings is provided before, during and after end of life care and this support is not time limited. We were given an example of one family who had recently come to the hospice for support ten years after their child died. Support has been given to this family.

The hospice covers a wide geographical area including; Chorley, Preston, South Ribble, South Lakes, Fylde Coast, Wigan, Bolton, Rochdale, Blackburn, Burnley and Salford. This incorporates working with ten different Local Authorities to provide 24/7 End of Life support. Support consists of approximately 80% respite and 20% end of life care. During the 12 month period prior to our inspection the hospice had supported 40 children and young people through to the end of their life.

The hospice employed 75 staff within the care team at the time of our inspection, in addition to this there were over 200 volunteers working within the hospice and externally, for example within Derian House shops or as fundraisers.

The one young person we were able to speak with told us they felt safe at the hospice. Families we spoke with also told us they felt safe leaving their children in the care of staff at the hospice. This included families whose children had very complex needs. Some of the families we spoke with became very emotional when speaking about the care and support given by Derian House as it was the only service they entrusted to look care for their children outside of their immediate family.

The hospice had a safeguarding and whistleblowing policy in place which was being followed in practice. This meant that staff had clear guidance to enable them to recognise different types of abuse and who to report it to if it was suspected. Staff were appropriately trained to recognise and respond to potential safeguarding incidents.

We looked at the systems in place at the hospice for medicines management. There was good evidence to show that medicines were audited effectively and that staff were trained and competency checked for administering medicines. However we found some issues including the current service level agreement for the provision of a pharmacy service not being an agreement between two separate legal entities, that an

authorised witness to oversee the disposal of controlled drugs should be appointed and disposal records should include the two signatures of the staff involved in the disposal process. We have made a recommendation regarding these issues.

We looked at arrangements at the hospice in relation to Infection Prevention Control (IPC). An audit by an external company had taken place shortly before our inspection which had identified some minor issues. The issues had already been placed into an action plan and the hospice was working towards addressing them. The issues were mainly with reference to recording and administration. We found no issues with IPC during our inspection.

We found the service to be appropriately staffed with the correct skill mix of nursing, care and domestic staff to cater for the complex needs of the children and young people using the service. We also looked at recruitment processes and found the service had recruitment policies and procedures in place to help ensure safety in the recruitment of staff, including volunteers.

The service was working within the principles of the Mental Capacity Act and followed the Department of Health guidance for hospices in relation to Deprivation of Liberty safeguards.

Staff we spoke with told us, and training records confirmed, staff had undertaken a wide range of training to ensure they could meet people's needs effectively. There were two dedicated clinical educators at the hospice who had worked at the hospice for 16 years in various nursing roles. We could see from reviewing staff files, training records and from discussions with staff, volunteers and management that training was in place to meet the complex needs of the children and younger people using the hospice. We found that mechanisms were in place to be reactive to people's needs and staff requests for ad hoc training as needs presented.

Staff we spoke with told us they felt supported. They confirmed they received regular one to one supervision and appraisals. This provided an opportunity for staff and management to discuss performance, training and any issues or concerns. Staff spoke highly of the management at the service and felt they had input into their own career development.

The hospice environment was appropriate for the children and young people using the service. There was a definite distinction between the two separate children and young people's areas within the hospice in terms of décor and facilities available. Families we spoke with were very complimentary about the hospice and its facilities which included a hydrotherapy pool that catered for the very complex needs of the children and young people at the hospice.

Relatives we spoke with found it difficult at times to express how much the service meant to them, their child or young person being cared for and their immediate and sometimes wider family network. We had several emotional conversations with families who told us how the service cared for their child and also siblings and their entire family. This was mirrored via other methods of feedback such as written compliments and emails received.

It was evident from our observations and discussions with staff and relatives that staff had a very good knowledge of the children and young people they cared for. Staff that we spoke with were passionate about their roles and were clearly dedicated to making sure children and young people received the best person centred care possible.

Children and young people's dignity was taken into consideration at all times. Children and young people

have their own bedroom with en-suite facilities during their stay at Derian House. This enabled their privacy and dignity to be maintained.

We saw evidence that end of life care was provided with compassion, dignity and professionalism. Staff spoke with knowledge and passion about end of life care and how important this aspect of their work was.

There was an extensive range of information for people and families regarding the care and support Derian House could offer.

We saw that evidence based care was embedded within the care plans which were person centred, reviewed regularly and contained the information needed to provide the care and support needed.

A robust system was in place for listening to and responding to concerns and complaints. Staff we spoke with were aware of the hospice's complaints policy and how to deal with and refer people appropriately if concerns were raised.

There was a Registered Manager in place at Derian House who had worked at the service for three years. They were also the Head of Care at the hospice. We received very positive comments from people and staff about the registered manager. Staff described her as being supportive, committed and passionate about the service and the children and young people they cared for.

There was a comprehensive audit programme in place. There were also many other management mechanisms in place to monitor, measure and compare the performance of the service.

We saw a wide range of meetings and forums were in place. Meeting notes showed that all meetings were well attended and notes were of good quality and reflected what was discussed. Action plans were attached when necessary to show what progress had been made since the previous meeting.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The Service was safe.

Families we spoke with told us that they thought the hospice was a safe environment for their children.

Arrangements were in place for the secure storage, administration and recording of medicines, including controlled drugs.

Sufficient staff were employed to meet the complex needs of the children and young people at the hospice and receiving service within the community.

Recruitment process were robust to ensure that staff and volunteers were recruited safely.

Is the service effective?

Good

The service was Effective.

Children and young people were supported by staff who were trained to provide the specialist care they needed.

The service was working within the principles of the Mental Capacity Act and followed the Department of Health guidance for hospices in relation to Deprivation of Liberty safeguards.

The hospice was designed and decorated appropriately for children and young people across the age range of 0 - 26 that met their physical needs and choices.

Is the service caring?

Outstanding

The service was extremely Caring.

The young people who used the service told us that the approach of staff was very caring. This sentiment was replicated via discussion with families who praised highly the entire staff

team at Derian House.

The service worked in partnership with the children, young people and families who accessed its services and we saw many examples of how people's views were listened to and incorporated into how care and support was delivered.

Staff knew the people they were caring for well and had a person centred approach when doing so.

We saw evidence that end of life care was provided with compassion, dignity and professionalism.

Is the service responsive?

Good

The service was Responsive.

A robust system was in place for listening to and responding to concerns and complaints and staff we spoke with were aware of the hospice's complaints policy.

Person centred care was delivered via a partnership approach with children, young people and families.

There were a number of activities taking place within the hospice and externally that were well organised and appropriately risk assessed.

Is the service well-led?

Good

The service was Well-led.

The quality of the service was continually reviewed to help identify and plan further improvements to the care and support people received. This was done in conjunction with people accessing the service when possible.

There was a committed, experienced and passionate management and staff team in place that were continually looking to identify areas to improve the service offered.

Everyone we spoke with told us that the culture of the hospice was positive, caring, professional and fun.

Derian House Children's Hospice

Detailed findings

Background to this inspection

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

This inspection took place on 29 July and 2 August 2016, we announced the inspection 48 hours prior to the first day of the inspection. We announced this inspection to ensure that key personnel in the service were available to speak with us and so people who used the service, and their relatives, could be given notice of our visit and asked if they would be happy to talk with us.

The inspection team consisted of the lead adult social care inspector for the service and two specialist advisors. One of the specialist advisors was a pharmacist and the other was a paediatric nurse.

Before our inspection we reviewed the information we held about the service including notifications the provider had made to us. This helped to inform us what areas we would focus on as part of our inspection. We had requested the service completed a provider information return (PIR); this is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. The provider had submitted the PIR prior to our inspection. We used the information to help plan this inspection.

We spoke with a range of people about the service which included; ten members of staff, including the Registered Manager, Chief Executive Officer, Resource Manager, Human Resources Manager, nurses, team leaders and support workers, three volunteers, one young person who used the service and four relatives. We were unable to speak with the children at the service who were receiving care and support due to the fact they were unable to verbalise their opinions. There were no young people staying within the separate annex during the two days of the inspection due to the first day being a changeover day prior to the

weekend and people coming later on the second day. The young person we spoke with, and some of the family members, were spoke with via a telephone conversation. We observed interactions between staff, children and relatives throughout the inspection.

We looked at the care records for eight people who used the service and the personnel files of four members of permanent staff and four volunteer staff. We looked at a range of records relating to how the service was managed including training records, quality assurance systems, policies and procedures and the services website.

Good

Is the service safe?

Our findings

We asked the one young person who was able to speak with us if they felt safe when they used the service for respite care. They told us, "Yes, I know the staff are always there for me if I need them." They told us that staff were easy to speak to and that they felt comfortable during their stays at the hospice and they never felt worried or anxious due to the level of care and support provided.

Relatives we spoke with also had no concerns for the safety of their loved ones whilst staying at the hospice. One relative we spoke with told us, "[Name] is only a baby but I know she is happy when she visits. The difference in her when she goes into a hospital setting, by that I mean her stress levels, are amazing. I don't know where we would be without them other than in a total mess. The whole (Derian House) team is amazing. I can't stress enough the complete change in [name] and myself." Another relative told us, "I feel totally at ease when [name] is at Derian. I know when I go home she is in the best place possible. If I have any worries or concerns I just pick up the phone. The support you get from every single person here is unbelievable. It is a godsend." Some of the relatives we spoke with became very emotional when speaking to us about the hospice, the staff at Derian House and the feeling of security it gave them and their family. It was obvious that without the support, guidance, empathy and compassion shown to them that they would struggle to cope with the demands placed on them, as each person told us they had been prior to being referred to the service.

We looked at the systems in place at the hospice for medicines management. A service level agreement was in in place with Lancashire Teaching Hospitals NHS Trust for the provision of both medicines and support. This included two weekly visits from both a dispensing assistant and a Pharmacist. However, this document became out of date in March 2016. It was phrased as if the agreement was between two parts of the same legal entity rather than two separate legal entities. This was discussed with the hospice's Pharmacist and they agreed to follow this up as a matter of urgency.

Policies and procedures were in place covering medicines management within the Hospice, however these were also out of date and did not accurately reflect the procedures within the hospice (for example they included the name of the previous supplying pharmacy). New ones had been developed including one covering the role of the accountable officer. The accountable officer is the person who has a legal responsibility to ensure that controlled drugs are properly managed. The policy was awaiting approval by the governance committee.

Medicines were stored in dedicated treatment rooms within appropriate cabinets and fridges. Access to the treatment rooms was via a secure fob system. Nurses carried the medicines cabinet keys. Medical gases were stored appropriately. Emergency medicines were provided and monitored by the NHS Trust. They were securely stored but easily accessible if required. Fridge and room temperatures were appropriately monitored and recorded. Peoples own medicines (except controlled drugs) were stored securely within a medicines trolley. Each child had their own named baskets.

The Registered Manager for the Hospice was the accountable officer for controlled drugs. Storage was in

appropriate cabinets. Registers were kept to record the receipt, administration and disposal. Regular stock checks were in place. However, the disposal of out of date stock was not being overseen by an authorised witness. The ordering of Controlled Drugs was also being carried out as if the hospice was part of the NHS Trust rather than a separate legal entity. These issues were discussed with the Registered Manager and the Pharmacist and it was agreed that an authorised witness would be appointed and that the ordering process would be reviewed.

Prior to admission parents were provided with a guidance leaflet which explained about the information that was needed in order to administer the child's own medicines during their stay. This was evidenced to be in place. A risk assessment was in place which identified possible issues with the transcribing process on admission. There was also a process in place to help ensure that the risks identified were avoided. This included a flow diagram and dedicated recording templates. Medicines were assessed upon admission to determine suitability to use and transcribing was witnessed.

Despite these processes being in place issues were identified. Labels on one child's medicines did not match the documentation brought in with the medicines and the instructions on the medicines administration record. The Hospices' procedure of seeking evidence to support a change to dosage instructions had not been followed. One medicine was also found to be in the wrong child's basket within the medicines trolley. These issues were discussed with the staff responsible for administration of medicines, the Registered Manager and the Pharmacist. It was agreed this would be discussed with the members of staff who had transcribed the medicine upon admission and the Pharmacist who had visited the ward (this was not the regular Pharmacist as she had been on annual leave).

The medicines administration records had been completed correctly. A new design was being developed so that all the forms used at the moment were incorporated into one document. A draft of this was seen.

Processes were in place to ensure the timely ordering of medicines. Receipts were kept in a file. Ordering of medicines was via a top up system for stock items and a prescription for non -stock and named patient items. This was discussed with the Pharmacist as discussions with the staff on the day of the inspection gave the impression that named patient medicines may be ordered using the top up system. It was agreed that this would be reviewed to ensure that staff were aware of the correct procedure. Disposal of expired medicines was recorded in a dedicated log but this did not include the two signatures of the staff involved in the disposal process which is recommended within NICE guidelines.

We would recommend that the service level agreement for the provision of a pharmacy service should be reviewed to ensure that the procedures were correct for an agreement between two separate legal entities, that an authorised witness to oversee the disposal of Controlled Drugs should be appointed and disposal records should include the two signatures of the staff involved in the disposal process.

The hospice had a safeguarding and whistleblowing policy in place. This meant that staff had clear guidance to enable them to recognise different types of abuse and who to report it to if suspected. We spoke with staff about the hospices safeguarding procedures. All the staff we spoke with clearly understood the policy and their responsibilities in reporting potential safeguarding issues. Training in this area was up to date and included volunteers who worked across the different areas of the service.

The service had reported only one safeguarding incident for the 12 month period prior to our inspection. The registered manager had contacted the lead inspector for the hospice at the various stages regarding this incident keeping them informed of developments and had also notified the relevant statutory agencies of the incident. No other safeguarding referrals had been made against the service other than the one

incident stated above. An in-depth investigation had taken place which had resulted in internal disciplinary measures being followed by the hospice. There had been no whistle blowing issues during the 12 month period prior to our inspection.

Two social workers were based at the hospice who acted as the services safeguarding leads. The hospice also had a designated Local Authority Designated Officer or LADO. The role of the LADO is set out in Working Together to Safeguard Children (2015) and is governed by the Authorities duties under section 11 of the Children Act 2004. This guidance outlines procedures for managing allegations against people who work with children who are paid, unpaid, volunteers, casual, agency or anyone self-employed.

We saw several posters, leaflets and references to safeguarding procedures on notice boards throughout the hospice that were visible to staff, visitors and people accessing the service. There was a specific safeguarding information leaflet for volunteers which explained the hospice's safeguarding responsibilities and how to recognise and report suspected abuse. This was in the process of being updated at the time of our inspection and we were shown a draft version. The existing version had been given to volunteers as part of their induction and when the new version was completed this was to be distributed to all volunteers working for the hospice.

We looked at arrangements at the hospice in relation to Infection Prevention Control (IPC). An IPC audit had been carried out by an external company two weeks prior to the inspection. The company who carried out the audit were a recognised and established company who carry out audits within hospices, care and nursing homes. The outcome of the audit was that 10 out of the 20 sections were 100% compliant, for example; linen management, enteral feeding, decontamination of the environment and urinary catheter management. The remaining sections were between 54 to 96% compliant. This included areas such as hand hygiene which was 85% compliant and kitchen servery which was 96%. The lowest scoring area was for governance and documentary evidence which rated at 54%.

The management team, including the Head of Care, had met two days prior to our inspection to complete an action plan in response to the audit. This included actions that were to be completed within two weeks of the management meeting. There were a number of changes being implemented as a result of the audit and following the meeting including the appointment of a lead housekeeper which had been identified as an issue. A post of Head Housekeeper was being developed and the job description was in the process of being drafted at the time of our inspection. The Head of Care had arranged for the external company who carried out the audit to provide bespoke training to the housekeeping team once the Head Housekeeper was in post. The hospice had an IPC lead who was part of the team responding to the IPC audit.

All the bedrooms had hand gel stations and hand gel stations were situated at the entry to the bedroom areas and at other relevant points in the hospice. We checked five hand gel stations, they were functional, clean and adequately stocked with hand gel. All the clinical staff had hand gel bottles attached to their uniform. Staff were observed to carry out satisfactory hand washing techniques prior to contact with children and young people and at other relevant times.

We reviewed the hospices cleaning schedules and cleaning records. They were consistent with the recent audit report that stated the cleaning schedules required more detail and clarity. A small proportion of signatures were missing from cleaning records For example, there were three signatures missing from the records in May, two in June and one from July for the current year. The current IPC policy was being reviewed as part of the response to the recent IPC audit but the current policy was in date with a review date of 2017. The hand hygiene policy was comprehensive, included detailed information and was due for review in August 2017.

We looked at recruitment processes and found the service had recruitment policies and procedures in place to help ensure safety in the recruitment of staff. Prospective employees were asked to undertake checks prior to employment to help ensure they were not a risk to vulnerable people. We reviewed recruitment records of four permanent staff members and four volunteers and found that robust recruitment procedures had been followed including Disclosure and Barring Services (DBS) checks, suitable references being sought and thorough background checks being carried out. We found personnel records for staff to be very organised and information easy to find.

Individual risk assessments were included within people's care records such as the pool area and tracheostomy equipment. Risk assessments within four care records were reviewed and they were all detailed, completed, legible and with review dates being met. We found both individual and care plans for specific activities to be very detailed, up to date and fit for purpose. Care plans and individual documentation showed evidence that medical intervention had been accessed in a timely manner if there was concern about a child or young person.

We observed staffing levels to be sufficient on both days of our inspection and reviewed staffing rotas for the previous two-week period to our inspection. There was a good mixture of qualified nursing staff and support workers as well as a variety of other roles such as domestic, kitchen, specialist play workers, youth workers, sibling support worker, bereavement counsellor and a range of volunteers. The hospice also had 24/7 access to local GP's who worked a four week rota and had a specialist interest in palliative care. No one we spoke with expressed concerns about the levels of staffing in the service. This was despite five members of the nursing staff being on maternity leave at the time of our inspection. Three nurses had been appointed but they had been offered more money to remain within the NHS. For the first time at the service newly qualified nurses were being considered and the induction programme was being adapted for this. No agency staff were used as an internal bank of staff was available. Enhancements to pay were offered to bank staff covering shifts and to night staff to ensure cover was available.

Good

Is the service effective?

Our findings

People were being supported by staff who had sufficient skills and knowledge to provide effective care and support for the children and young people who accessed the hospice. The young person we spoke with told us; "Staff are really good, they are easy to get on with. You can have a laugh with them as well. They make you feel relaxed; I would say they are brilliant at their job." Relatives also spoke very highly of the staff at the hospice. One relative told us, "The staff are awesome. They are extremely knowledgeable. The Derian Nurses are so calm, nothing is made a bid deal of despite [Name's] complex needs. All the staff are great though, not just the nurses." Another relative said, "All the staff from the cleaners, nurses, volunteers, they are amazing."

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The hospice had a MCA policy and a DoLS policy, both of which referred to current legislation and both had review dates of August 2018. However despite an up to date policy being in place the hospice has not fully embedded the MCA or DoLs within their practice. We spoke with the Deputy Head of Care for The Lodge who had been appointed nine months prior to our inspection because of their expertise in MCA, DoLs, and safeguarding. They explained that over the last few months the service had identified that 54 out of the 76 young people who have access to the hospice had communication problems and would benefit from further information regarding support and advice, for example advocacy, benefits, transition, MCA and DoLS. They had written to all 54 of the young people and their families to explain their role and ask for feedback about the best means to explain further subjects such as MCA and DoLS. The outcome was that parents had asked for information sessions at the hospice at lunchtime as this was the time of day that suited them best. The first session was to be held in August with a subsequent session in October for those that could not attend the first session.

At the time of the inspection the hospice did not have any DoLS in place but had made one DoLS application five weeks prior to the inspection to Lancashire County Council. We were told that as parents and younger people were given more information about MCA and DoLS over the next 2 months that the hospice planned to make further DoLS applications.

The service had facilitated a charter for young people and adults accessing Derian House. The charter was in

draft form and awaiting further feedback from staff and trustees. The charter included relevant information about the MCA and DoLS in a format that was accessible to young people and adults.

However the hospice did not have a consent policy and care plans did not make reference to the Gillick competency for children and young people therefore did not meet current guidance from the General Medical Council (GMC) and Royal College of Nursing (RCN) Guidelines. The Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. For example one young person had consented to their picture being used for media purposes but a nurse had signed the consent form for activities instead of the young person. We recommend that the hospice has a consent policy in place that meets the guidance of the GMC and RCN and that the policy and care plans comply with the Gillick competency.

We spoke with two members of staff who had started working at the Hospice in the last year and they both praised the induction programmes that they had followed. The Deputy Head of Care for the Lodge had been in post nine months and said, ''I had a fantastic induction with a very clear induction schedule from day one''. A Clinical Nurse Specialist had also been in post nine months and told us that, ''The induction was great. I worked a month on shift in a supernumerary capacity to get to know the team''. Both nurses also described that they were given opportunities during the induction period to visit other local hospices such as the nearby St Catherine's Hospice, to establish links with them.

We reviewed completed induction programmes and found them to be well structured and appropriate for each role they were assigned to. They included information about the hospice, children's palliative care and the philosophy of the organisation as a general introduction to the service. There were orientation checklists in place alongside the induction checklist and any outstanding items were highlighted. Induction review forms were in place as well as one, three and six month probationary reviews to monitor staff progress and to ensure they were competent for the role. Alongside the probationary period staff had to complete 'Progression through competencies' booklets which were monitored via supervision and probationary reviews. These were role and task specific to ensure that people had the relevant competencies in place for their designation.

Staff we spoke with told us, and training records confirmed, staff had undertaken a wide range of training to ensure they could meet people's needs effectively. With regards to the training offered at the hospice one nurse we spoke with told us, "I've never worked in a place where it is so thorough. There are two clinical educators in the team so I can approach my supervisor if there is an area I want to learn more about." Another member of staff told us, "There is a wide range of knowledge within the team to back up formal training. We also have workshops and speakers in for issues we have not dealt with before."

We spoke with one of the clinical educators at the hospice who had worked at the hospice for 16 years in various nursing roles prior to their current role. They told us how they reacted to the teams needs and that alongside the services mandatory training programme they delivered training to address the needs of the people in the service and for staff who expressed an interest in an area that was within the remit of the hospice. The clinical educator we spoke with was happy with the current skills mix within the team and the competency levels of clinical staff.

We saw that staff were continually assessed with regards to their competency. For example, staff involved in the administration of medicines had to complete a medicines competency assessment within the first three months of employment. This included completion of a workbook and an observational assessment. There was also an annual assessment of competency. We saw this arrangement was in place for a range of other

areas such as Infection Prevention Control.

Staff we spoke with told us they felt supported. They confirmed they received regular one to one supervision and appraisals. This provided an opportunity for staff and management to discuss performance, training and any issues or concerns. Supervisions took place every six to nine weeks and fed into the appraisal and personal development systems in place. We saw examples of staff supervisions and appraisals and saw that staff had the opportunity to raise issues and development opportunities were discussed alongside performance and well-being issues. Staff told us that alongside formal support mechanisms informal support was also in place. One member of the nursing team told us, "The support you get is amazing. There is always someone to ask for support. You never get a negative response or the feeling that someone hasn't got the time for you." This was typical of the responses we received from all the staff we spoke with.

One of the volunteers we spoke with said, "Volunteering here is one of the best decisions I have ever made. I feel like I am really helping here and making a difference for families who don't have much of an opportunity to sit back and unwind." Another volunteer told us, "We constantly get feedback from families which makes you feel great about what you are doing. I couldn't think of a more worthwhile way to spend my time."

Communication within the service was found to be effective. There were numerous notice boards for people using the service, visitors, other professionals and staff. Notice boards were kept up to date and had a range of information on them from safeguarding details to events that were happening on that day or in the future. There was a new television display within the kitchen area that showed a rolling display of videos and pictures of past events that had taken place at the hospice. There were also specific areas of display for siblings, the family support team and volunteer information.

As well as visual displays within the service there were newsletters that went out to families and young people, suggestion boxes and surveys. Relatives we spoke with told us that the communication via telephone conversations prior to accessing the hospice and whilst their children were at the service was excellent.

From a staffing perspective, in relation to communication, we sat in on a staff handover. We found this to be very detailed, each child and young person who was staying within the hospice or was due in that day was discussed. The handover dealt with all medical needs, medicines management, pain management, eating and drinking, care planning and any other relevant information. Lessons learnt were also discussed as there had been a shortage of medication for one child the previous night which was discussed and logged as an error. The GP had been contacted and the issue had been resolved however staff were made aware of how the error could have been prevented and how to ensure the chance of a reoccurrence would not happen again. Each member of staff had an individual tray for internal communication purposes, staff below team leader level did not have a work email account at the time of our inspection however this was being brought in at the end of the year for all staff. All the staff we spoke with told us that communication was excellent and they had no issues within this area.

We were taken on a tour of the building by the registered manager at the beginning of our inspection. Derian House has a comprehensive range of rooms that enable care to be offered in creative and therapeutic ways. These included a sensory room and soft play room which had been recently refitted to a high standard and included new hoisting tracks. The hospice also offered music and music therapy in a variety of ways and with different instruments. Access to music was available across the hospice including the Lodge. The Lodge was set up appropriately for younger people in terms of the décor and facilities available to them. The lounge area had internet facilities with PC's, gaming consoles and laptops available for people to use. The registered manager informed us that the kitchen area was being developed to give it a more homely feel and

to make it easier for young people to become involved with food preparation.

Outstanding ☆

Is the service caring?

Our findings

The one young person we were able to speak with told us they thought the service was caring as was the approach of staff. They said, "It really is (caring). I love it here. I really look forward to coming." Relatives we spoke with found it difficult at times to express how much the service meant to them, their child or young person being cared for, and their immediate and sometimes wider family network. One relative of a child with very complex needs told us, "As a family we have to keep adjusting our normal. Derian House is the only environment that get this. [Name] is complex even for Derian but this is not an issue for them. I have been with paramedics who panic because of [name]'s needs but not here. I can leave [name] here and feel she is safe. I can't even do that in a hospital. To be able to come somewhere with as safe an environment as this is amazing." Another relative told us, "It gives you a light at the end of the tunnel knowing that your child is in such safe hands. [Name] has very complex medical needs, we can only leave them with people we are 100% confident with. I've never come across anyone here who isn't fantastic, the staff make the place. It is a pleasure to come and visit."

We received positive comments from all the relatives we spoke with regards to the approach, empathy, compassion and professionalism of the staff team at Derian House. Relatives described staff with such words as, 'Wonderful', 'Amazing', 'Brilliant', 'Professional' and 'Like Family'. We also saw a large amount of messages in the way of thank you cards, emails and letters from families who had accessed the service that praised the expertise, energy and compassion of staff.

There were a number of stories we were told by families, staff and volunteers we spoke with that showed not only the caring approach of the service but how much planning and effort went into making things possible for the children and young people who used the hospice. We were told by one member of staff how one mother had not been able to hold her child due to the complexities of their child's health needs. The hospice had been able to safely organise for this family, with the assistance of the care team, to use the hydrotherapy pool so the child could use this facility. This meant due to the buoyancy of the water the child could be held by her mother for the first time in a number of years. Al the families we spoke with whose children had very complex needs not only told us that they felt at ease whilst their children were at Derain House but that they could see their children felt safe, at ease themselves and enjoyed their time at the service. As already stated the amount of praise for the service, and in particular the staff team, was constant to all members of the inspection team throughout our visit.

It was evident from our observations and discussions with staff and relatives that staff had a very good knowledge of the children and young people they cared for. Staff we spoke with were passionate about their roles and were clearly dedicated to making sure children and young people received the best patient centred care possible. One member of staff told us, "This is more than a job; it's a privilege to work here and care for the children and families." Another member of staff said, "I've come from a job which consisted of spending a lot of time on the computer. Here it is very much child and family focused. That is what any nurse enjoys doing. We provide one to one care and devote our time and attention to the children. I get a lot of satisfaction from being with the children and young people here."

We saw evidence that children and young people were encouraged to express their wishes and feelings and we saw this was documented in care plans. One example was a teenager who had recently been referred to the hospice. They had given clear directions about the amount of time they would want to stay at the hospice and that they primarily would like to stay at home. Another example included in a care plan stated, 'I will tell you what I am feeling when I am ready as I am a very private person'. This showed that those people that were able to, and wanted to, were involved in the planning of their care and support.

Children and younger people who have died could remain and rest in the hospice, if the family wished, until the day of the funeral. The families can stay with their child in a specialist temperature controlled room which is called the Sunflower Suite. The registered manager told us that the suite could be personalised according to the family's wishes. There were two of these rooms available at Derian House. A young person was resting at the time of the inspection but we were able to view the second room. Pictures of sunflowers were placed in the corridors around the hospice which was the hospices policy to alert staff and visitors that a child or young person was resting in the Sunflower Suite.

We spoke with the young person's mother who was very complimentary about the care that had been given to her child and the support she and her family were getting. Immediate family were staying in the hospice so they could remain with their child until the funeral. The young person that had died had two siblings who were being supported by the sibling support worker and wider team. The young person's mother told us, "There have been key members of staff who have helped us through it but all the staff have been very supportive to us. My two daughters have been looked after brilliantly. I'm aware of who to go to for support going forward. I know when I go home that I can just pick up the phone and ring whenever I want."

We saw advance care plans in two of the care pans we reviewed. The advance care plans were detailed and concise and showed evidence that the family had been involved in all aspects of care planning. The outside of the notes folder was clearly marked with a sticker that this particular child had an advance care plan; We were told by the staff that this had been recently introduced so that staff caring for that child were immediately alerted that they had an advance care plan in place.

One set of notes that were reviewed included a do not attempt cardio pulmonary resuscitation (DNACPR) form that was fully completed and legally viable. It was also cross referenced to relevant documentation in the care plan notes e.g. consultant's letter. The DNACPR form was also clearly displayed at the front of the notes so staff and other professionals were immediately alerted to the fact.

The hospice provided 24 hour medical support from a team of four local GPs with a special interest in palliative care. The GP on call at the time of the inspection told us that the GP's work a 1:4 rolling rota and covered the equivalent of one week in four. They also said that the GP's, ''work seamlessly" to provide cover 24 hours a day and 7 days a week and there are not any problems with providing cover. They said that they were always able to cover for each other if they attend training courses, were on annual leave or off sick. The GP we spoke with also described that when one GP recently retired that the newly recruited GP worked alongside the medical team for a few weeks so that there was a seamless transition.

Derian House held memorial events and an example of this was the 'Forget me not service' held in May 2016 .This annual service was open to anyone whose child has died. We looked at some of the feedback from this years' service, which included comments such as; 'Very moving as always. Just the right time in length. Brings back so many memories' and 'I found the service very uplifting and moving'. There was a chapel in the hospice that contained photographs of many of the children and young people who had died within the hospice. There was also a memorial garden and relatives could place engraved stones within the garden. Some relatives had buried ashes within the garden. They were not marked but a map was kept at the

hospice for people to refer to if needed.

Children and young people's dignity was taken into consideration at all times. Children and young people have their own bedroom with en-suite facilities during their stay at Derian House which enabled their privacy and dignity to be maintained. En-suite facilities were shared between two bedrooms in the main house but the door to the bathroom could be locked on the bathroom side to ensure privacy when it was occupied. Each bedroom had large amounts of storage for personal possessions which ensured enough storage space even if parents also wished to be resident with their child. Every room in the hospice had a track hoist and television facilities. Any specialist equipment that was needed was brought into the hospice prior to any child being admitted to the hospice. We saw several examples of specialist equipment across a range of ages and needs in children and young people's rooms and in storage.

We saw some excellent examples of how the hospice worked in partnership with the children and young people using the service. The young person we spoke with told us how they had raised an issue over the no alcohol policy that was in place for external trips. As a young person over the legal age for consuming alcohol they had raised the policy with the registered manager after discussing the issue with other people within the young person's forum they attended. This had resulted in a member of the hospice's board attending one of the young people's forums and listening to what people who used the service had to say on the subject. This had resulted in a limited amount of alcohol being allowed on trips out dependent on people's age and a number of other factors such as their health and medication. The young person we spoke with told us, "It was definitely useful attending the forum and I am happy with the result. I feel comfortable raising any issues as I know I will be listened to."

There were also a range of information booklets and leaflets available for people and their families. There was a comprehensive booklet entitled 'An introduction to Derian House' which explained the different types of services and support available for families. It also went into good detail about the history of the hospice, how funds were raised, the care team and the philosophy of care. There was also a shorter version of the booklet in leaflet form. We saw a simple Admission Guidance leaflet that gave people information about medication, equipment, specialist feeding techniques, siblings and other pertinent information for people. There were a wide range of 'Family Factsheets' available for families including; emotional support and wellbeing, spiritual, religious and cultural wishes, transport, talking with your child about their life limiting condition and understanding siblings needs. There was also a detailed parent's guide which went through a number of key issues such as critical care choices, end of life care planning, dealing with professional and family and friends. All the leaflets, booklets and information we reviewed were up to date, professionally produced and gave links to the hospices website and contacts details for further information if people needed clarification or further help.

Good

Is the service responsive?

Our findings

We asked relatives and the one young person we spoke with if they knew how to, and felt confident, raising issues or complaints. No one we spoke with had made a formal complaint or raised any recent issues. One family we spoke with had experienced some issues with the service under a previous management structure a few years previously. This had led to the current registered manager contacting the family, discussing their issues and re-engaging with them. We spoke with one member from this family who told us, "I had previously had issues with the service and was reluctant to re-engage but I'm so happy I have done. The care is over and above and staff are extremely knowledgeable." No other families we spoke with had experienced any issues with Derian House but did tell us they would feel confident raising concerns if they had them. They told us that they would approach any member of the team or the registered manager.

The hospice had a complaints policy in place which was on display. The policy contained details of external organisations as well as the hospice's own internal procedures in the event that someone did not feel confident approaching the hospice directly. A complaints file was kept securely in the main office and hard copy complaints were available from 2013 onwards. When speaking with staff they were all able to tell us what they would do if someone raised a formal complaint or concerns people had. Staff we spoke with told us there was an openness and transparency within the hospice. One member of staff described a recent event when a parent made a verbal complaint to them. We were told that it was resolved at the time and was talked through with the parent concerned'. The complaint concerned a parent who arrived with their son much later than had been planned in the evening and they were unhappy about the way the room had been set up. Discussion with the parent resulted in the outcome that the parent has included in the care plan how they would prefer the room to be set up in the future. The complaint did not progress to a written complaint.

There had been five complaints received in 2016. All had been investigated in line with the hospice's policies and procedures, including taking formal witness statements from any staff involved. Action plans were in place and were appropriate to help ensure the risk of the issues causing the complaint did not reoccur. All complaints were discussed as part of the hospices quality report that was submitted to the Chief Executive Officer and Clinical Auditor every month at their senior management team meeting. Staff we spoke with told us that any learning points were fedback to them regardless of their involvement in any issues raised at the service to ensure mistakes were learnt from.

We saw that feedback forms were located in many places within the hospice and therefore children, young people and visitors could access them easily. We looked at the last three months of compliments and found there to be a wide range of comments from families and visitors that complimented the service and staff.

We looked in detail at eight people's care plans and other associated documents. People's care plans and nursing and medical notes were stored securely as they were locked in offices and rooms that could only be accessed via a swipe card which were held by the nursing team. When children and young people were resident in the hospice their care plans were accessible to the nursing and care staff within the bedroom area but the registered manager told us that the nurses on duty always ensured that the notes were within

the line of vision of the nurse or were stored in a room that could be locked. This was witnessed by the inspection team whilst on site at Derian House.

Documentation relating to the children and young people was maintained in two folders, one containing notes and the other the care plan itself. The registered manager told us that the notes and care plans were always reviewed prior to the admission date of a child or young person and that when they arrived in the hospice the named nurse on that day would review the documentation again with the family or advocate. We saw evidence of this in the care plans we reviewed, e.g. new vocabulary that a child had developed since the last visit.

Written entries into the notes and care plans were legible and written in black ink. All written entries were signed but a small number of entries did not include the printed name and the designation of the member of staff. The date of the entry was always included but a small number of entries did not include the time of writing. The entries that included both date and time showed that most entries were contemporaneous but a small number were written in retrospect. The notes we reviewed showed evidence of multi-disciplinary working as entries included different members of staff, for example GP's, physiotherapist's and other professionals.

Care plans that the hospice used were adapted from the person centred care plan. The registered manager also told the inspection team that the hospice was in the process of reviewing the care plan documentation that was currently in place. Care plans inspected showed that they were personalised, for example; 'I like a bath in the morning' and 'Encourage me to drink- I really like coke'. The care plans did though have some gaps in them and when we enquired about this we were told that if an entry was not made that was because this section was not relevant to that child or young person. This meant that care plans were a little bulky as there were sections not relevant to all children. However, staff we spoke with told us that they found care plans easy to navigate and contained all the necessary information they needed to care for people.

We saw that evidence based care was embedded within the care plans to a large extent, for example the Bristol Stool Chart was used to effectively monitor bowel movements. The clinical nurse specialist explained to us that staff were motivated into researching what was best practice and had recently reviewed the best practice for mouth care. They also told us that there was corroboration between the local hospital and Derian House regarding guidelines and that a hospital consultant had recently led a review of total parenteral nutrition (TPN) guidance. This guidance had been implemented and was currently part of some of the care plans of children and young people in the hospice. They told us that this is also helped to provide continuity of care between the hospital and the hospice.

Generally we found care plans to be person centred. Aside from some minor issues with regard to adding further detail to some of the information in some of the care plans we reviewed, some missing signatures/names and dates they contained the necessary detail and information needed to provide the medical care and personal care for the children and young people who accessed the hospice. The young person we spoke with and families were aware of their or their loved ones care plan and told us they could access or have input to the content of it as they desired.

We found there was an extensive range of activities available to children and young people that catered for all ages and abilities. There was a weekly programme of activities that was displayed on the walls in the main hospice and in the Lodge which catered for older children and young adults. This included cooking, art activities and pet therapy. Wall displays included extensive varieties and types of artwork and craft work that the children and young people had carried out. The dining room had a large screen that displayed photos and video clips of the children engaged in different activities and outings on a continuous loop.

During the inspection we observed a child in the hydrotherapy pool. The registered manager explained that this was the child's fourth visit to the pool and that on their first visit they had been frightened and had needed gentle coaxing and encouragement into the pool. They told us that over the last few visits they had come to really enjoy the sessions in the pool. We witnessed that the child was happy and smiling and maintained eye contact with the staff who were supporting them in the pool. The staff also displayed that they took great pleasure in being part of the child's obvious delight in their session in the pool. Many of the families we spoke with told us that this was the only place they could access pool facilities and without it they would not be able to take part in such an activity.

A wall display in the main hospice was aimed at siblings and showed the support offered to siblings. The photographs in the display showed that siblings were involved in activities within the hospice. There was also a sibling ambassador who acted as an interface between siblings and hospice staff. A family support group that specifically supported families who had children with Duchene Muscular Dystrophy had developed extensively over recent years and this summer the group was going on a trip to Portugal. We saw many other examples of external trips including visits to football clubs, outdoor activities and even a trip to Downing Street Christmas party following an invitation from the Prime Minister.

The hospice held community open days to raise the profile of the service and also to inform people of what the hospice offered the children and young people who accessed it. The registered manager told us that this was a valuable way of not only raising the hospice's profile but also dispelled a number of myths about hospice care. As building work was taking place at the hospice at the time of our inspection there had not been an open day in 2016 but we were told that they had been well attended previously and saw evidence of this via newsletters and their website. We could see from pictures on the wall, by the number of donations received, letters and emails received and high number of volunteers and partnerships the hospice had in place that the service was highly regarded within the local and wider community. There were even pictures of high profile celebrities on display who had given their time to promote the hospice and spend time with children at Derain House.

The Hospice offered facilities for young people aged from 16 to 26 years in the Lodge. The upper age limit had recently been raised from 24 to 26 in order to further assist young people in transition who had life limiting conditions. The Deputy Head of Care, who had been recently recruited, was reviewing policies relating to transition. Information and guidance was included in the draft of the hospices charter for young people and adults. The charter included the following pledge; 'To make sure you have a positive experience of transition and receive the right support, we here at the Lodge make sure that you have the right information and are well prepared for the process where possible.' We were given examples of young people who the hospice had assisted into supported living so they could live independently, some of whom were near to end of life. When speaking to the Chief Executive Officer they told us that they were looking at new ways they could improve younger people's transition into adult care services and the charter and increase in age limit was part of this work.

There was an extensive range of information for people and families regarding the care and support Derian House could offer. The website for Derian House was being updated at the time of our inspection however the website that was in use at the time of our inspection was found to be informative and easy to navigate. The website included information about the types of services offered by the hospice, the hospice's philosophy of care, contact details and information about the team and board members. We were sent a prototype of the new website during our inspection which had been updated with links to social networking sites and looked to be even easier to navigate.

Good

Is the service well-led?

Our findings

There was a registered manager in place at Derian House who had worked at the service for three years. They were also the Head of Care at the hospice. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

We received very positive comments from people and staff about the registered manager. Staff described her as being supportive, committed and passionate about the service and the children and young people they cared for. One member of staff told us, "[Registered Manager] has been incredibly supportive and I feel very supported in my role". Another member of staff said, "[Registered Manager) could not be more supportive to staff, children and families. They are very visible in the service and get involved in everything that is going on. She has made a big difference here."

We spoke at length with the chief executive officer (CEO) for the hospice who was a successful local businesswoman. She had been involved with the hospice from the beginning and had been on the board of trustees and vice chair. She had been the CEO for just over two years at the time of our inspection. She told us that during the previous two years she had worked alongside the board of trustees and management at the hospice to make several key changes from an operational and business perspective. There had been a complete evaluation of personnel and realignment of salaries for staff and an evaluation of the membership for the board of trustees. This had resulted in three new trustees being appointed.

There had been a number of other changes implemented including the setting up of a bespoke human resources function as this had previously been provided externally. She told us that the hospice now invested more money and time into staff as the key resource within the service. A senior management team had been created for better oversight and a six month training course had been implemented for middle management in conjunction with the Lancashire Teaching Hospital's (LTH). We were told that due to the success of these changes that the hospice was now in a position to go out and assist other hospices by sharing good practice and knowledge.

One of the major pieces of work going forward was to improve the IT infrastructure within the hospice. This had resulted in a piece of work being commissioned which was joint funded with another local hospice to introduce a 'Datix' monitoring system which would eventually mean that care plan documentation could be shared in real time with other professionals such as GP's and that incident reporting, and other relevant information could be stored and analysed more effectively. We were told that there had been a lot of collaborative working with this local hospice including the sharing of facilities and expertise to improve the standards and knowledge across both sites.

There were very good links with other local businesses who would send people in to carry out work and maintenance at the hospice, in many cases free of charge. When the building works that were being carried out at the time of our inspection were finished there was a plan in place to bring community groups into the

hospice including a toddler group. This would in turn raise the already high profile of the hospice and engage people two would not ordinarily have contact with the service.

We saw evidence that Derian house engaged with, and listened to the children, young people and families who accessed the hospices services. There were young people's, family and staff forums I place which had been introduced over the past couple of years. There were new 'keeping in touch meeting' which feedback the discussions held at board level to staff. This was led by the CEO. A parent representative had been co-opted onto the board, an initiative that had been in place for just under 12 months. There were plans for a member of the younger people's forum to be invited to do the same. We were told that any confidential information was redacted and saw evidence of this when reviewing notes from these meetings.

The hospice carried out annual surveys to parents and staff, the results of which were analysed and a report compiled and shared with all families and staff. The family survey for 2015 was sent out to 190 families and 19% were returned. The results were very positive. As well as statistical information being produced quotes were given from families, a few examples are as follows; 'It's an extension to our family home and somewhere we can all have fun', 'I don't know how we would have coped without Derian', 'It's a place of fun for our child who loves the hydro pool and messy play, we can also meet with other parents in similar positions' and 'Derian makes me a better parent as it gives me time to recharge'. The staff survey had a response rate of 68%. Again the result and comments were very positive and showed that staff were supported by an effective management team. 91 % of staff said they were proud to work at Derian House.

We saw notes from meeting with professional such as the hospice GP quarterly meeting, clinical governance meetings that were split into operational and strategic functions and various team meetings internally. Meeting notes showed that all meetings were well attended and notes were of good quality and reflected what was discussed. Action plans were attached when necessary to show what progress had been made since the previous meeting.

There were detailed monthly newsletters produced that were available within the hospice and on-line. They were professional, informative and included photographs of recent events. Families we spoke with were aware of them and found them a useful way to keep informed of forthcoming events and developments at the hospice.

There was a comprehensive audit programme in place. One example was to monitor the management of medicines. This included monthly audits of the storage of the medicines, significant events and errors. A summary of issues that were identified from this process are discussions at team meetings including a lessons learned presentation. There was a detailed investigation of any errors that occurred. Other examples of audits included infection prevention control, care planning and environmental.

Members of staff that we spoke with during the inspection were passionate about developing the services within the hospice and told us they were encouraged to do so. Some of the examples we were given where the introduction of a Charter for young people and adults, action plans in response to the recent infection control audit, training staff to have the competency to verify deaths and bringing the public into the service more frequently to create better links and to promote the hospice. The new building work, that was happening at the time of our inspection to create more capacity and increase the facilities, was another example of how the hospice was looking to future proof the service and constantly improve.

As well as formal audits there was a range of management information and analysis produced. We saw a range of staff performance and human resources information. One good example of this was the analysis if sickness absences. This was converted into costs as well as hours and compare dot previous year's

performances. We could see that over the past 12 months sickness absences had dramatically reduced by nearly 20%. This was due to a greater investment in staff in terms of training and support which was evidenced via our conversations with staff throughout the inspection process.

There was a three year strategy in place for the period 2015-18 entitled, 'the house – Our strategy'. This laid out the aims of the organisation, how the service would make a difference to the people using it and what the priorities were over the three year period. Priorities included the workforce at the hospice, partnership working and looking at how to constantly improve how effective the measurement of success. There were also appendices attached to further explain key issues such as children's palliative care and life threatening conditions.