Zoe's Place Trust

Zoe's Place Liverpool

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

At the previous announced comprehensive inspection of this service in August 2016 we found five breaches of legal requirements. We found a breach in regulation regarding the safe management of medicines and we took enforcement action in respect of this breach. We served the provider with a statutory Warning Notice regarding medicines not being managed safely. We found a breach of regulation as the service had not followed agreed protocols for reporting allegations of abuse to the local authority and to us, the CQC (Care Quality Commission); there was a lack of monitoring of potential risks to children's safety; care needs were not planned effectively to meet the needs of the children; and there was a lack of an effective system to assure the safe management of the hospice. We asked the provider to take action to address these concerns.

We undertook a focused inspection on 19 December 2016 to check that the service had now met legal requirements. This report only covered our findings in relation to the specific area / breach of regulation and we found improvements had been made and the breaches of regulation had been met. While improvements had been made we did not revise the rating at this inspection. To improve the rating to 'Good' would require a longer term track record of consistent good practice.

At this announced comprehensive inspection of 20 & 21 September 2017 we found the breaches met and there was evidence of continued improvement and development within the hospice. We were therefore able to change the rating to 'Good'.

Zoe's Place in Liverpool is part of the national organisation, Zoe's Place Trust. The hospice 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 network and sibling groups.

The organisation's website states, 'Zoe'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.

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 to 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.

A registered manager was 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.'

Safeguarding policies and procedures were in place and discussions with staff confirmed their knowledge around child protection.

Each child had a personalised plan of care; any risks associated with their care were recorded and observations/checks completed in respect of their care and wellbeing. Risk assessments reported on actions to keep each child safe.

Care records we looked at detailed individual needs, preferences, likes and dislikes and play. Care records had been reviewed and evaluated on a regular basis.

The children at the hospice were of very young age and therefore consent to care and treatment was obtained from the parents. During our inspection we observed staff gaining assent from the children before carrying out care and treatment. Staff talked with children about day to day activities such as, what they would like for lunch, arts and crafts and also about the care they were providing to ensure their inclusion.

Parents informed us they were involved in all decisions round their child's care and that the staff work closely with them.

Children received care and treatment from a multi-disciplinary staff team which included a registered manager, registered children's nurses, play leaders, local doctors, paediatric palliative care consultant, physiotherapist, health care assistants and ancillary staff. Advice from external health and social care professionals was sought at the appropriate time.

Medicines were administered safely to each child. The staff had implemented a clinical decision form for assessing medicines and feeds; this was completed if any risks were identified in respect of medicines prior to admission. Staff received medicine training and their competencies were checked to ensure they administered medicines safely.

Environmental risks assessments were in place and maintenance work of the building was completed. Safety checks of the premises and equipment were undertaken, including fire safety.

We found the premises to be clean and there was good adherence to infection control.

Recruitment was robust to ensure staff were suitable to work with children.

Sufficient numbers of skilled and experienced staff were employed. New staff received an induction and staff had access to a good training programme, including specific training to meet the clinical needs of the children they supported.

Play leaders oversaw a programme of social activities for the children staying at the hospice. The hospice offered good recreational facilities including a hydrotherapy pool, light sensory room and soft play area.

Staff told us they received supervision and good level of support from the management. Staff appraisals were also completed.

Mealtimes were family orientated with hospice staff and children eating together. Many of the children who

attend the hospice are unable to eat or drink and therefore receive enteral feeding which is the delivery of nutritionally complete food via a tube directly into the stomach, duodenum or jejunum.

The staff team knew the children they were supporting in respect of their health and social care needs. Each child was allocated specific member of staff to oversee their care and treatment. Staff were able to provide us with details of each child's care, treatment and tell us about the families. Staff approach with the children was warm, empathetic, respectful and sensitive.

Information was available regarding the hospice 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.

Parents were provided with accommodation on the first floor of the building should they wish to stay overnight. Parents and staff had access to a chapel on the first floor of the building.

A complaints policy and procedure was in place and displayed for easy referral. Concerns and complaints were logged and investigated.

Feedback from parents regarding the care and treatment provided by the staff was sought. Satisfaction surveys sent out earlier this year were complimentary regarding the service provision.

Staff and parents told us the overall management of the hospice was good and the registered manager provided good leadership.

Quality assurance processes and systems were in place to monitor and improve the service. This included the completion of clinical and environmental audits. Where appropriate actions plans were drawn up and actioned completed in a timely manner. An external auditor undertook a review of the service as part of the governance arrangements for the hospice.

The hospice worked in partnership with other organisations at regional and national level and were keen to forge links with other hospice services to help monitor and develop the service provision.

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.

Medicines were managed safely by the hospice staff.

Staff knew how to keep children safe. Staff followed agreed protocols for reporting allegations of abuse to the local authority and received on-going training around the safeguarding of children (protecting children from abuse).

Risks to children's safety and well-being for their care and treatment were recorded and monitored by the staff.

Robust recruitment and selection procedures were in place and appropriate checks had been undertaken before staff commenced work at the hospice.

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

Environmental risks were monitored and checks were undertaken to ensure the premises and equipment were safe.

The hospice was clean and we observed good standards of infection control adhered to by the staff.

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.

Children received care and support from staff who were skilled and experienced. Staff told us they received a good training programme, supervision and appraisal of their job role.

Decisions were made with the consent of the parents and where possible staff gained assent from the children they supported in respect of their care, treatment and support.

Is the service caring?

Good

The service was caring.

Parents told us the staff were very kind, polite, compassionate and supportive of them and the needs of their children. This we observed during the inspection.

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.

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?

Good

The service was responsive.

Children's care needs had been assessed prior to admission and their care documents provided a good over view of their care needs, preferences, choices and likes and dislikes. Care reviews took place to report on any changes and to evaluate care.

Staff had a good understanding and knowledge 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. Any complaints/concerns 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. This included the use of feedback cards and surveys.

Is the service well-led?

Good

The service was well led.

Quality assurance processes and systems were in place to monitor and improve the service. Where appropriate actions plans were drawn up and completed in a timely manner. An external auditor undertook a review of the service as part of the governance arrangements for the hospice.

The hospice had a registered manager in post. The registered manager had relevant and up to date experience and expertise

to lead the service.

We received positive feedback from parents regarding the management and leadership of the hospice.

There was a clear management structure and staff told use service had an open, inclusive and positive culture.

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 checked 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 announced inspection took place on 20 & 21 September 2017. 'The provider was given 48 hours' notice because of the nature of the service.

The inspection team consisted of an adult social care inspector, a specialist advisor (SPA) pharmacist and an SPA with experience in palliative 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 spoke with the registered manager, deputy manager, two members of the care staff, four children's nurses, a student nurse, two play leaders, ancillary staff, two children and three parents whose children were currently receiving respite care. We also spoke with a commissioner of services and a health professional who had regular input into the children's care. By telephone we contacted a general practitioner (GP) who provides a service at the hospice and three parents.

During the inspection we observed how the staff interacted and supported the children and their families. For the children this included elements of care and support, where appropriate, and play.

We looked at two care files, four medicine administration records (MARs), four recruitment staff files and training and supervision (dates only) for staff. We viewed and checked records, policies, procedures and other records relevant to the quality monitoring and management of the hospice.

Good

Is the service safe?

Our findings

We asked parents if they though the hospice provided a safe service. Parents told us, "Absolutely, fabulous, I trust everyone", "They are brilliant, feel very happy to leave (child) here, I am not at all worried" and "I don't worry, completely content leaving (child) at the hospice." Parents also told us there were always lots of staff looking after the children which meant there were enough staff to 'check on' the care and make sure the children were safe. In respect of arranging respite care a parent told us they had increased the number of visits to the hospice, as they had confidence in the staff's ability to care for their child.

Each of the staff that we spoke with was clear about what action they would safeguard a child and were aware of the procedures to follow in respect of reporting an allegation of abuse. Staff told us they received child protection training. Staff comments included, "Yes I am aware of how to make a referral", "We receive training around protecting children" and "I know the agencies involved and would not hesitate to speak up." A student nurse on placement at the hospice confirmed they understood the escalation procedure if they had concerns and would have no problem with speaking to any member of staff if worried.

Safeguarding policies were available and contact details for reporting an allegation of abuse were clearly displayed for staff to follow. We discussed with the registered manager a review of the safeguarding policy to meet the specific needs of the children which the registered manager said they would consider when reviewing the organisation's policies. In respect of an incident that was considered a safeguarding concern, this was reported through to the local authority by the registered manager and we, CQC, were also notified in accordance with our regulations. The hospice acted in a timely manner and in accordance with local safeguarding procedures and those of the organisation.

We looked at the management of medicines and found them to be safe. We reviewed two medicine administration records (MARs) for the children staying at the hospice and two MARs of children who had been discharged. MARs were signed by two staff following administration and all MARs had a photograph of the child, allergy status was recorded and there was evidence of individualisation of treatments, such as special instructions as to how to give the medicine and route.

The drug room where medicines were stored had a key lock and medicines were stored in cabinets and the medication fridge. Temperature monitoring of the medication fridge was undertaken however there was no record of temperature of the treatment room. This was brought to the staff's attention and acted on during the inspection. This helped to ensure this room was kept at safe temperature for storage of medicines. Controlled medicines were inspected and no anomalies were found. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation.

A local service level agreement was in place to undertake medicine reviews and provide the hospice staff with support. Staff received medicine training and competency checks were undertaken to ensure they had the skills and knowledge to administer medicines safely.

The PIR stated, 'medicine reconciliation begins 48hrs before admission when each parent is contacted and a

pre-admission form is completed highlighting any changes to medication and feeds which need to be verified. If a child comes into the hospice with a medicine which has a discrepancy on it, we now have a clinical decision tool which allows us to risk assess if we are safely able to accept the child, it also ensures all the action is documented.' At the inspection we observed and found clear evidence of implementation of clinical decision forms for assessing medicines and feed for a child who was due to be admitted. Any changes to medicines were identified and highlighted and agreement / confirmation sought with family and clinicians to ensure the safe administration of medicines.

We looked at the management of incidents within the hospice and saw any incident that affected a child's safety or wellbeing had been recorded. Risks to children's safety were appropriately assessed and reviewed prior to admission and during the child's stay. Care files contained risk assessments which were specific to each child; they recorded the risk and how to ensure the child's safety. Examples of risk assessments included, use of the hoist, hydrotherapy pool, safety, nutrition, bathing, cross infection and ligatures. Safety checks were undertaken for the remotes used to reposition the cots; this was to prevent the risk of entanglement, along with detailed checks on each child's safety and health throughout the day and night. Talking with staff confirmed their knowledge around these safety checks and the safety records seen were up to date.

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.

Qualified nursing staff accompanied children on trips out from the hospice or for external medical appointments. The nurses provided one to one support for these trips. Risks associated when leaving the hospice were assessed along with the provision of medical equipment if required.

The PIR stated, 'staffing is maintained at a level where we can provide 1-1 care throughout the day and overnight if required. Last year we revised our staffing establishment to allow for the shift leader to be out of the numbers. This allows them the time to co-ordinate the shift'. We looked at the staffing arrangements for the service and these were determined by the number of children and the level of care, support and treatment they needed during their stay at the hospice. At the time of our inspection two children were staying at the hospice and this included a child who was admitted and discharged. Staff were providing one to one care for the children. Staff told us the staffing levels were maintained at all times and this helped to ensure a good standard of care.

Parents were provided with a minimum of two nights respite care each month for their child and the registered manager told us they were able to plan the staffing levels in advance as admission to the hospice were normally planned. Staffing numbers were increased to support children with more complex needs and bank staff were used to fill any 'gaps' on the staffing rota. 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. Staff told us there was an 'on call' system should they need managerial support.

We looked at staff recruitment and found the necessary recruitment checks in place to ensure staff were fit, suitable and had the experience and skills to work with children. We reviewed four staff files and saw evidence of references (including references from past employers), a completed application form, a record of staff interview and confirmation that appropriate Disclosure and Barring Service checks (DBS) had been carried out before staff started work.

The hospice presented with a very clean environment and staff had access to personal protective equipment (PPE) and hand gel was available at designated 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. Visitors to the hospice were encouraged to use the hand gel on entering and leaving. Infection control policies and procedures were available and a staff member was appointed the lead role for overseeing the control of infection.

The hospice was subject to on-going maintenance and service contracts were in place to ensure the building and equipment were safe. We saw contracts for areas such as, Legionella and water treatment, fire prevention, gas and electric service and moving and handling equipment. A fire risk assessment was in place and children had a personal emergency evacuation plan (PEEP) in the event of an emergency such as fire.

With regards to night time security at the hospice the main gates were locked at night. There was an intercom for entry and CCTV cameras monitored the grounds and hospice entrances. Visitors were asked to sign in and out of the building to meet fire regulations.

Good

Is the service effective?

Our findings

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 to 6pm during the week and a sibling support group. The registered manager told us there was no set catchment area though referrals for the service were received mainly from the North West area.

We discussed the provision of care with the parents we spoke with. They told us how pleased they were the standard of care their child received. Parents' comments included, "Fabulous care", "The care is so good it's like home from home", "I trust them completely with (child), they know all about (child's) care" and "I never have to worry they get the doctor out when at the hospice if they are worried and contact me to tell me." With regards to the admission process, a parent explained to us how their child's needs were assessed at each visit and the medication 'gone over' so that the staff had all the information. They went on to say staff talked over the plan of care with them and any changes in care or treatment were recorded and discussed.

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. There was also contact with 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 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 by required. An out of hours GP service was available through UC (urgent care) 24 and also by attending Alder Hey Children's Hospital with access to a palliative care consultant. Three health care professionals we spoke with were very positive regarding the standards of care and treatment provided by the hospice staff team.

Children's care files contained information about their care and medical needs with involvement of external health and social care professionals. It was evident that children's medical needs were monitored during their stay to ensure their health and wellbeing. During the inspection the staff were concerned regarding a child's health and a visit to the GP was immediately arranged. Staff subsequently commenced the medicine prescribed by the GP and monitored the child's health closely for any further change in their condition.

Care monitoring (observation) charts were in place to help evidence and evaluate the care. In respect of moving or turning a child to provide pressure relief, this was not recorded. This is of particular importance for a child who is immobile. The registered manager said the chart would be amended to record this. We saw a fluid balance chart which provided an accurate record of the child's intake and output to help monitor their condition.

The PIR stated, 'we review each member of staff's competencies and training needs at annual appraisals and regular 1-1. All staff had online mandatory training to complete and this is backed up with practical training sessions in the appropriate areas throughout the year'.

Staff told us they received a good standard of training and also received supervision and appraisal of their job role. A staff member said, "(Registered manager) is very supportive in terms of learning opportunities." Likewise a staff member told us they had undertaken recent bereavement training and all mandatory training. We looked at records which showed staff supervision meetings (clinical supervision from an external provider) and an annual appraisal. Staff told us they received a very good level of 'all round' support and that everyone worked as a highly motivated team.

We saw that staff had access to an induction and training in subjects considered to be 'mandatory' and those more specific to the needs of the children. Staff received training in areas such as, infection control, first aid, fire awareness, child protection, food hygiene, equality and diversity, resuscitation and safe medical gases. In respect of more specific training this included, 'being open', communication, conflict resolution, dysphagia, duty of care, palliative care, 'mixed messages', medicines management, information governance and privacy and dignity. Staff received training 'in house' and external training in partnership with Alder Hey Hospital. Training was up to date for all staff and a clinical educator was overseeing staff training/education days. 69% care staff had completed a National Vocational Qualification in Care (NVQ) or equivalent. A health care professional told us the staff were very competent and skilled.

The registered manager advised us of the updates being arranged for staff this included tracheostomy care, infant loss, medicines management and assessment of clinical skills. In respect of formal end of life care/palliative care, eight staff had completed a formal course and two senior health care assistants were registered for the course. The hospice provided placement for student nurses and mentorship for the students was current and updates provided by Edge Hill University.

Qualified nurses working at the hospice undertook continuous professional development to maintain their registration with the Nursing Midwifery Council (NMC).

Light snacks and drinks were prepared by the staff in accordance with children's dietary preferences and needs and oven ready meals were provided by an external caterer.

Staff told us how they promoted healthy eating and assessed children's dietary requirements on admission and throughout their stay. We saw records which confirmed nutritional risks. We did not see any children having lunch however staff told us that for children who were eating then they had their meals with them to promote a 'family feel'. Many of the children who attend the hospice are unable to eat or drink and therefore receive enteral feeding which is the delivery of nutritionally complete food via a tube directly into the stomach, duodenum or jejunum.

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. Parents told us their consent was always sought regarding their child's care. Staff where possible did obtain assent and inclusion from the children in respect of their care and support. Staff asked children if they could give them their medicines, or would they like a change of position in their chair or a cuddle before undertaking this.

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 were aware of this.

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. A parent told us how much their child loved the light room and we saw this in use during the inspection. There were well-tended gardens including a sensory garden and paths for wheelchairs. The hospice had a minibus for outings.

Good

Is the service caring?

Our findings

Parents told us how much their children enjoyed their stay at the hospice and this was mainly due to the caring, kind and supportive nature of the staff. Parents said, "The staff are just great and always keep in touch", "Just wonderful", "Can't praise the staff enough" and "They are so helpful and kind." For a parent who recently started using the hospice they told us how reassuring the staff had been when they first left their child and how the staff had kept in regular contact to allay any fears.

The children we met were not able to speak due to their age and/or due to their medical and care needs which made communication difficult for them. We however spent time with the children and they appeared relaxed and happy in the presence of the staff. The children enjoyed taking part in the various therapeutic sessions and were at ease when receiving care from the staff.

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. A staff member said this was a very important part of getting to know each child and the family. It was evident the staff knew the children well and had built up close relationships with them. Families could come and go during their child stay if they so wished with no restrictions on visiting. We saw staff welcoming parents warmly and when one child arrived the staff were ready for their approval and rushed to meet them. One staff member went on bended knee to give the child a hug and this was warmly reciprocated by the child. In respect of communication, care files detailed calls to parents whilst their child was staying at the hospice.

It was evident the staff team knew the children they were supporting in respect of their health and social care needs. Staff were able to provide us with details of each child's care, treatment and tell us about the families. Their approach with the children was warm, empathetic, respectful and sensitive. The care interactions we observed were of this nature age appropriate. Attention was paid by the staff to ensuring children's dignity was maintained when receiving personal care and for example. When medicines were given via a feeding tube we saw a child's clothing being rearranged so as not to expose their body.

The PIR stated, 'we mirror the child's routine to make their stay a real home from home experience'. 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 for them. This was discussed around bed time for example and television shows children liked to watch. We saw evidence of this recorded in the care documents we looked at. A staff member said, "It is so important to provide a homely and caring place for the children and this reassures the parents."

There was plenty of literature available for families and visitors to read and the hospice has its own website. Information regarding the hospice 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.

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.

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. Staff told us they received training on how to support families when dealing with complex emotions and adjusting to loss. An external counselling service was also available for parents and siblings.

There were no children receiving end of life care at the time of our inspection. The provision of end of life care is an area that the hospice wishes to develop. Plans for this include some changes to the premises and the provision of further staff training.

Good

Is the service responsive?

Our findings

We asked parents to tell us how the staff responded to their children's needs. Parents told us that prior to admission the staff details about their child's care, medicines and treatment and at each visit the information was assessed and any changes recorded in their child's care file. This meant the staff had accurate and up to date information to ensure each child's care needs were met. Parents said that the staff arranged emergency respite if needed and if a child's stay was cancelled, for example, due to ill health, and then the staff would arrange another admission date as soon as possible. A parent told us the staff were flexible around admission dates. Another parent said, "(The registered manager) and the team know exactly how to look after (child), it's like a big family here."

The PIR stated, '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. We contact families prior to admission to confirm any changes to the child's care and if required contact the appropriate person to obtain evidence to support this. We are always able to offer emergency respite if a family is in crisis.'

The hospice offered respite care 24 hours a day, seven days a week. The staff conducted 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. 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. For transition between the hospice and other services staff member was appointed the role of link nurse to ensure this ran smoothly.

Each child had a plan of care. The nursing care plan provided direction on the type of care a child needed following their care needs assessment. Care planning is important to ensure children get the professional care they need when they are at the hospice. Care plans covered areas such as, mobility, personal hygiene, skin integrity, communication, nutrition and social care. The care files we looked at recorded detailed information about each child's care needs, preferences, likes and dislikes and how they liked to communicate. For example, time of going to bed, time of waking, when a child liked a 'nap', enjoying a bubble bath and facial expressions if distressed or happy. Parents told us staff made sure they had all these details so they could provide the same kind of care given in their own home. We saw evidence of care plans to support specific care needs such as enteral feeding or care of a tracheostomy. Specific observations were recorded to ensure this clinical care was delivered safely. Staff told us they received a handover at each shift change and this this provided detailed information in respect of each child.

The PIR stated, 'all children have play plans devised by our play leader which identify suitable activities. All children are given tactile stimulation that is child specific.'

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. We saw children had a plan of care devised by a play leader to

reflect their interests and abilities.

The hospice offered 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.

We met with two play leaders; one play leader was an artist and decorations were being made for Halloween. A child who was going home took the decorations they had made. Musical instruments were played and age appropriate television programmes were watched in the afternoon. There was very relaxed atmosphere and the children appeared to enjoy the various recreational activities.

Feedback was sought from parents regarding the hospice. Earlier this year parents were asked to complete a satisfactions survey. Seven surveys were returned and in the majority of areas the service scored 100%. Feedback was positive and parent comments included, 'staff are very friendly and lovely without little girl', 'especially loves art therapy, (child) is always happy staying at Zoe's Place', 'all the nurses are lovely', 'very approachable and thorough' and 'they go through every medicine making sure it's correct'. Feedback cards have recently been introduced for families; these were available at the entrance to the main unit along with a post box.

We asked parents if they felt happy to speak with the staff if they had a concern. They told us they did. A parent said, "No problem at all, would just go and talk to (registered manager)." A staff member said, "I would have no problems escalating any concerns I might have to (registered manager). A complaints procedure was displayed for easy referral and we were shown a complaints leaflet for parents. A concern was being investigated by the registered manager and they were providing a response in accordance with the timescale stated in their complaints policy and procedure. The PIR informed us of one other complaint which had been responded to.

Good

Is the service well-led?

Our findings

Parents told us the hospice was well managed and the benefited from good leadership. Parents' comments included, "Really runs well (registered manager) always has time to meet with me" and I would be lost without them (staff), they are really good." In respect of the service a staff member said, "The staff are all approachable, keen to learn, it's great to have the flexibility with hours and maintain links with patients that are already in my care." Another staff member said, "We have worked hard over the year to make lots of changes to ensure safer practices."

Our discussion with staff helped to evidence how passionate staff were about their role and how much they enjoyed working at the hospice. Staff comments included, "I am blessed to work here", A fulfilling job", "This is an amazing place work, it's a privilege to be here and "The children are our priority and we do everything we can to make their stay special." Staff spoke positively regarding the management of the hospice and all confirmed the management team were supportive with everyone worked as cohesive team. Staff told us they attended staff meetings and they advised us the registered manager consulted with them and listened to their views. This was a view shared by parents.

The service had a manager who was registered with CQC and had relevant and up to date experience and expertise to lead the service. During our inspection we observed the registered manager being involved with the children, parents and staff. The registered manager was very visible throughout the hospice, parents and staff knew who the registered manager was and all commented on their approachability.

The PIR stated, 'we carry out clinical audits, infection control, medication, cleaning, health and safety and documentation. External pharmacy, infection control, health and safety and fire audits'.

At this inspection we looked at quality assurance systems, including audits (checks) to check on risks, monitor performance and to drive continuous improvement. Audit seen such as medicines, infection control and health and safety were current and any recommendations had been actioned promptly and shared with staff. We saw actions from the medicine audits were followed up by the clinical educator.

The registered manager and staff were able to tell us about actions taken following incidents. We noted that in respect of a medicine incident involving transcribing there was however a lack of information around actions taken. We discussed with the registered manager the actions that had been taken and the need for more specific action plans with lessons learnt, with time limits for review to see if actions put in place had resolved the issue.

The registered manager informed us audit review meetings were now taking place to help monitor standards and drive forward improvements. These meetings were also being used as a platform to review changes made to existing audits to ensure they were effective. The registered manager had prepared some case studies for us to view. The case studies evidenced their commitment to working alongside parents and multi-disciplinary teams to provide the best outcomes possible for the children they supported.

The hospice held clinical three monthly clinical governance meetings. The purpose of these meetings was to assure the compliance of systems and processes for the delivery of a safe and effective service, as a debrief for staff regarding matters arising and oversee the quality of care offered to children at Zoe's Place. The clinical governance committee consisted of executive trustees, an executive clinical lead and heads of care for each hospice within the organisation. Team. They in turn fed their findings to the Board of Trustees to provide assurance as to how the service was operating. Findings from audits were discussed at the governance meetings and lessons learnt shared with staff to improve practice. We were shown an example of the frequency of the oxygen audit being increased to improve safety. When reviewing medicines we saw that changes made to improve medicine practice over the last year had resulted in improved verification of medicines and medicine labelling.

September 2017 an external auditor had carried out an in depth audit of the hospice. An action plan had been drawn up to meet recommendations and these had been completed in a timely manner to ensure compliance with the report. This included window restrictors being fitted, more robust cot safety checks and work to fire doors. These measures help to ensure the health and safety of those using and visiting the hospice. The registered manager told us about their attendance at external palliative care meetings and palliative care networks to help monitor and improve governance.

Staff had access to a whistle blowing policy. Staff and the student nurse were aware of procedure and told us they would not hesitate to use it if needed.

The PIR told us about a number of developments within the service. This included the provision of end of life care, training in customer service, a closed social media group for parents and the introduction of 'block respite for a group of children who would benefit from all interacting together.' These proposed actions were discussed with the registered manager who was able to confirm these plans. There was no current recorded benchmarking within the organisation or with other children's hospices to define and implement best practice; the registered manager agreed that is was an area for development.

The registered manager told us that staff were given polices to read each month. We found not all policies had been signed by the staff to confirm they had read and understood them. A number of staff had not signed a plan of care to confirm their understanding of the child's care needs. We raised this with the registered manager who said they would look at more robust monitoring of records within the service to ensure these actions were undertaken. We also asked the registered manager to review/remove information recorded on the staff handover sheet as this recorded some detail about each child's care, or in some instances, 'no problem' was recorded. There was a risk therefore that this document would solely be used for discussing each child. The information shared should be from the plan of care and daily evaluation. The registered manager provided us with assurance that the plan of care was the main source of documentation used for the staff hand overs and we saw children's case notes being used for staff handovers.

From April 2015 it is a legal requirement for providers to display their CQC (Care Quality Commission) rating. 'The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided'. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for Zoe's Place Liverpool was displayed for people to see.