

# The Bradbury Children's Respite Hospice Hope House Children's Hospice

## Inspection Report

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# Summary of findings

## Overall summary

Hope House Children's Hospice provides specialist nursing care for up to 10 children and young people with life limiting conditions from Shropshire, Cheshire and north and mid Wales. The hospice also supports the families of the children and young people who use the service. There was a registered manager in post at the home. This meant that there was an allocated person who was responsible for the day to day running and management of the service.

Specialist nursing care was provided at the hospice and within children and young people's homes. During this inspection we looked at the care provided to the children, young people and their families in the hospice environment only.

The staff understood the children and young people's needs and we saw that care was provided with kindness and compassion. Children, young people and their families told us they were happy with the care.

Care was provided in a safe environment by staff who were appropriately trained and skilled. We saw a robust induction and training system to ensure this.

Throughout our inspection we saw examples of innovative care that promoted an inclusive culture. Children, young adults and their families were involved in care planning and were treated with dignity, privacy and respect.

The provider had employed staff to ensure care was based upon best practice and individual staff had taken on champion or link roles to ensure that best practice guidance was implemented and followed by all staff.

The registered manager consistently assessed and monitored the quality of care. We saw that action was taken to make improvements to the care children, young people and their families received.

# Summary of findings

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

We always ask the following five questions of services.

### **Are services safe?**

Children and young people were protected from abuse because the staff had received training in how to identify and report possible abuse.

The hospice's diversity group met regularly to ensure that procedures were in place to enable the staff to meet the diverse needs of the children and young people who used the service.

Effective systems were in place to identify and manage individual risks. This meant that children and young people were protected from harm.

We saw evidence of positive risk taking which enabled children and young people to participate in activities that were important and meaningful to them.

Effective procedures were in place to ensure that medicines were managed safely. We saw that medicines were stored and administered in a safe manner.

### **Are services effective?**

We saw that children and young people's care preferences and choices were sought and met because staff communicated effectively with the children and young people who used the service.

Involvement from advocates could be requested if a child or young person was unable to express their wishes and views.

Children and young people had access to specialist care and treatment from staff who had appropriate knowledge and skills. Arrangements were in place to enable medical support to be requested outside of standard working hours.

The hospice environment and facilities enabled children and young people to receive safe, personalised and equitable care.

New and innovative roles were being developed at the hospice to improve the outcomes for the children and young people who used the service.

### **Are services caring?**

Children, young people and their families told us they were happy with the care they received and we saw that care was provided with kindness and compassion.

# Summary of findings

Children and young people were treated with privacy and dignity and individuals and their families could access private areas within the hospice environment as required.

Children and young people told us their pain was managed well. Systems were in place to ensure that children and young people's end of life care needs were met in a manner that promoted a dignified, comfortable and pain free death.

## **Are services responsive to people's needs?**

Staff understood how each child and young person communicated and systems were in place to promote the involvement of the children and young people in their care.

Children and young people received personalised care and support. Support was also offered to the families of children and young people during their treatment and following their death.

Staff worked with other organisations and the local community to meet the individual requests of the children and young people.

The provider consistently listened to and acted upon feedback received from children, young people and their families. This resulted in improvements in care.

## **Are services well-led?**

Children, young people and their families confirmed that the hospice's philosophy and values were applied during day to day care. Staff told us they felt well supported.

The management team monitored and incidents and risks to ensure that the care provided was safe and effective.

Systems were in place to ensure that the numbers and skills of the staff enabled children and young people's care needs to be met.

The management team effectively assessed and monitored quality so that improvements could be made.

We saw that care and treatment was based upon best practice evidence and a staff member had been employed to specifically look at ensuring this. Examples of innovative practice were evident throughout our inspection and have been referred to throughout our report.

# Summary of findings

## What people who use the service and those that matter to them say

On the day of our inspection seven children or young people were staying at the hospice. Some of the children and young people were unable to express their views about their care with us due to their medical condition. Two young people chose to speak with us. They told us they were happy with the care they received. One young person said, "I wish I could live here". The other young person said, "I have made a few friends here and it's good to be able to meet at Hope House".

We spoke with the relative of one child who used the service. They also told us they were happy with the care provided. They said, "This is an exclusive place" and, "You can tell that the staff want to be here and are interested in X (the child)".

We looked at the results of the last satisfaction survey that had been completed between March and June of 2013 by the families of 24 children and young people who used the service. This showed that 79% of respondents rated the care as excellent. Comments from this survey included, 'Everything was exactly as expected from Hope House. Excellent doesn't come near the care provided, its beyond excellent' and, 'You all do an amazing job and I'm incredibly grateful to all the staff for your level of care and being wonderful'.

The results and actions from the satisfaction survey were published on the locations website.

# Hope House Children's Hospice

## Hope House Children's Hospice

### Detailed findings

## Background to this inspection

We inspected Hope House Children's Hospice on 2 April 2014. This was an unannounced inspection which meant the staff and provider did not know we would be visiting.

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 of the Health and Social Care Act 2008. It was also part of the first testing phase of the new inspection process CQC is introducing for adult social care services.

The inspection was led by an inspector for Adult Social Care. We were accompanied by a specialist advisor who had experience of the provision of children and young people's hospice care.

Before we inspected the service we checked the information we held about the service and the provider. We saw that no concerns had been raised and the service met the Regulations we inspected against at their last inspection on 5 November 2013.

During our inspection we informally observed how the staff interacted with the children, young people and families who used the service. We also observed how children and young people were supported during their lunch and during individual and group play and therapeutic activities.

We spoke with two young people and the relative of one child who used the service. We also spoke with the hospice's registered manager, the director of care and 12 other members of staff. This included a social worker, a student nurse and care staff.

# Are services safe?

## Our findings

Effective procedures were in place to ensure any concerns about a child or young person's safety were appropriately reported. All the staff we spoke with told us how they would recognise and report abuse. Staff told us and training records confirmed that staff received regular training to ensure they were up to date with the systems in place to report safety concerns. During our inspection we observed staff sharing information during a staff handover. Information was shared about a recent safety concern and the staff demonstrated that they had reported the concern to the appropriate professionals.

Children and young people's risks were appropriately assessed, managed and reviewed. We looked at the care records of four children and young people who used the service. Up to date risk assessments were present in each care record. These assessments were different for each individual as they reflected each individual's specific risks. Where risks had been identified, management plans were in place and staff demonstrated they knew how to keep the children and young people safe.

We saw that the risks to each child or young person's safety and welfare had been considered for their care at the hospice and within the local community. For example, we saw that staff had considered the risks associated with facilitating trips away from the hospice. Systems were in place to ensure that the risks associated with the use of the hospice transport had been assessed and plans were in place to ensure that qualified nursing staff were present during these trips, so that emergency situations could be managed by suitably qualified staff.

We saw that children and young people could participate in their preferred activities through positive risk management. For example, we were told that some children and young people enjoyed being in or around water, but they could not use the hospice's hydrotherapy pool because of their medical condition. In these circumstances they were able to access a shallow bath where they could experience the sensation of being in water in a safe and controlled manner.

The staff involved the children, young people and their families and other professionals in the risk assessment process. Staff told us they communicated with other professionals, such as GP's to ensure that children and

young people's current risks were shared on admission. One relative told us how they were involved in the assessment and management of the risks associated with their child's medical condition. They said, "The staff are keen to learn from me about X's (the child) needs and presentation when they become unwell."

Children and young people were protected against the risks associated with medicines. We saw that medicines were stored securely and safely. A review of the medication administration records of two children and young people and a small audit of their medicines showed that effective procedures were in place for the recording and administration of medicines. Staff described the strategies they would use to manage situations where children or young people declined to accept their medicines. None of these strategies involved forcing a child or young person to take a medicine against their wishes. Some children and young people who used the service took medicines that were not prescribed by a medical professional, for example; complementary therapy medicines. There was a system in place to enable the children and young people to continue to take these types of medicines safely whilst they stayed at the hospice.

Children and young people were cared for in a safe environment. The hospice was spacious and accommodated specialist equipment that was required to keep the children and young people safe. Children and young people were not restricted to the confines of the indoor hospice environment. The entrances and exits to the hospice were locked to ensure that staff could monitor who entered and exited the building, but the children and young people could access safe spaces within the hospice's grounds and could request to leave the hospice grounds with the appropriate supervision if they wished to do so.

Children and young people were protected against the risks of discrimination. The hospice's diversity group met regularly to discuss how children and young people's cultural, spiritual, emotional and physical needs could be met. We saw that this group was used to make improvements to the service. An example of an improvement made through this group included changing the format of the hospice's referral form. This enabled more information about people's diverse needs to be gathered

## Are services safe?

so that staff were aware of children and young people's individual needs. The hospice had also purchased resources to equip the staff with the knowledge required about cultural and spiritual needs.

We saw that when incidents occurred they were reported and investigated appropriately. Staff told us they were made aware of actions taken to reduce further incidents through 'daily notices' during staff handover's.

# Are services effective?

(for example, treatment is effective)

## Our findings

The staff used an admission and discharge checklist to ensure that admissions and discharges were effective. We saw that staff communicated with other professionals during the admission and discharge process to ensure that important information was shared. Systems were also in place for emergency admissions and discharges. We saw an example of an effective emergency admission during our inspection.

Children, young people and their families confirmed they were involved in the assessment and care planning process. This enabled the staff to identify children and young people's care preferences. The relative of one child told us, "I am involved in care planning and this is reviewed every time X stays at Hope House". Another relative said, "They (the staff) even ask what television programmes X likes and these are then recorded in the care plan". Some children and young people who used the service required support to express their views and preferences. There was a system in place to request the support of an advocate who could represent the views and wishes of a child or young person.

Children, young people and their families told us that their individual care needs and preferences were met. One young person told us, "I don't like onions, so I can have different food to what's on the menu board if I want to". Care records contained up to date plans that were personal to each child and young person. These plans outlined the likes, dislikes and preferences of each child and young person and the staff we spoke with were aware of each individual's preferences.

The staff were trained to provide the specialist care that the children and young people required. All the staff completed an annual two week mandatory training period. Examples of subjects covered during this training included; care planning, consent, therapeutic play and sensory integration. Staff also completed competency based assessments to ensure that they could demonstrate the required knowledge and skills. Examples of these assessments included; medication, enteral feeding (feeding through a tube into the stomach) and airway suctioning (clearing breathing airways). One new staff member told us, "The competency assessments are good. You can do them when you're ready and it's good to look at the skills you can work towards and acquire".

There was a robust review process in place. Assessment and monitoring tools were used to enable the staff to identify changes in the children and young people's health and wellbeing. There was access to appropriate health, social and medical support. Social workers and physiotherapists were employed by the hospice and doctors visited the hospice on a daily basis. There was a system in place to gain out of hour's medical support if it was required. Doctors that visited the service were suitably trained in children and young people's palliative care and they had access to support from a level four children's palliative care consultant.

The hospice environment provided facilities that were appropriate to the children, young people and their families. Easy read signage was visible throughout the hospice, and we saw that children and young people were able to navigate their way around the hospice. Resources were available to enable staff to meet the needs of all children and young people, from neonates to young people up to the age of 25. Resources included; sensory equipment, play areas and a room for teenagers and young people. Family suites were available so that families could stay at the hospice with their relative if they wished to do so.

Some children and young people who used the service attended schools or colleges. The registered manager had recognised that improvements were needed to ensure that children and young people's educational needs were met during their stay. They said, "Most children and young people treat their stay here like a holiday, so they enjoy a break from school. We are aware that the schools are not always sending work, but we are working towards making special links with the schools so that this can happen". This meant that the registered manager had identified that some children and young people's educational needs were not being met effectively during their stay at the hospice, and work was being undertaken to improve this.

The staff at the hospice had identified that there was limited support for young people as they moved to adult services. A transition nurse had been recently appointed to address this service gap. We saw that the implementation and development of this role had resulted in improved outcomes for young people as they moved to adult

# Are services effective?

(for example, treatment is effective)

services. We saw positive examples of how the transition nurse had worked with adult service providers to ensure the needs of the young people were handed over efficiently.

# Are services caring?

## Our findings

The children, young people and their families who we spoke with told us they were happy with the care and support they received at the hospice. One young person said, "I wish I could live here" and, "I just like it so much". The relative of one child said, "This is an exclusive place". We saw evidence that the provider regularly sought feedback from children, young people and their families about the care. Feedback from the hospices last satisfaction survey in 2013 showed that 79 percent of respondents rated the care as excellent. Comments from this survey included, 'Everything was exactly as expected from Hope House. Excellent doesn't come near the care provided, its beyond excellent' and, 'You all do an amazing job and I'm incredibly grateful to all the staff for your level of care and being wonderful'.

We saw that children and young people chose the activities they wanted to participate in and their choices were respected. One young person told us, "I like going to the play room, I choose to go there". A member of staff who was responsible for activities and play told us, "I am guided by what the children want. The play here is child led". We observed one child choose not to participate in a music group. The member of staff supporting the child respected their choice and supported them to participate in an activity of their choice.

We saw that children, young people and their families were supported with care and compassion. For example we observed one young person wake from a sleep in a distressed state. We saw the staff immediately respond to the young person in a calming and soothing manner which the young person responded positively to.

We observed staff treating children, young people and their families with dignity and respect. For example we saw that the staff dined alongside the children, young people and families. The relative of one young person who used the service told us, "I feel like an equal here".

Children, young people and their families' privacy was promoted. We saw that private and confidential

information relating to the care and treatment of children and young people was kept secure. Children, young people and their families had access to private spaces within the hospice environment. Notices on doors were used to show staff and other people that privacy was required. Children and young people we spoke with confirmed that their privacy and need for time alone was respected. One young person who used the service said, "I tend to go to the teenagers lounge after dinner because it's calmer in there, but I can go wherever I want".

Independence was promoted at the hospice. Where appropriate, children and young people were encouraged to participate in everyday activities such as getting dressed. There was a system in place to enable children and young people to administer their own medicines if they wished to do so and had been assessed as being able to do this safely.

We saw that children and young people's pain was controlled and managed well. One young person told us, "I can always get a tablet if I am in pain". Care records contained up to date plans that described each individual's pain presented and how their pain could be managed. This included information to guide the staff on how to identify when children and young people who could not verbally communicate were experiencing pain.

At the time of our inspection no children or young people were receiving end of life care, but the staff showed us the processes and resources that were available to individuals who required this specialist care. We saw that the families of children and young people could be close to their relative during this time and a dedicated area within the hospice was available for families to stay close to their relative after they had died and before their funeral. Systems were in place to ensure children and young people experienced a comfortable and pain free death. This included regular assessment and reviews by nursing and medical staff and individual care plans which would outline the end of life preferences of the child, young person and family.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

On admission information about the hospice was presented to children, young people and their families in a manner that reflected their communication needs and their ability to understand. A welcome pack was given to families which provided information about the hospice and the facilities and support offered, and easy read information was available to children, young people and their siblings that included pictorial prompts.

Staff worked with children, young people and their parents to establish effective methods of communication so that individuals could be involved in their care and treatment. Personalised plans were developed for each child or young person to guide staff on how to involve them in their care. For example if a child or young person could not verbally communicate, other communication methods were used as appropriate, such as; communication cards and pictorial pain scales. These communication aids were based upon best practice and professional guidance.

We saw that staff gave children and young people time to express their views. One staff member told us, "One child can only communicate they are okay with us helping by moving their foot. Sometimes it takes them some time to respond to us, but if you wait they will let us know it's okay to help".

Children and young people's rights were protected. Where appropriate the staff sought consent from the children and young people. Care records contained information detailing who had parental responsibility for children and who should be included in best interest decisions for children and young people. Children and young people told us their consent was sought for their care and treatment at the hospice. We saw examples where young people over the age of 16 had signed to confirm they had consented to have their medicines administered by the staff but the care records for children and young people under the age of 16 did not always demonstrate that they had been involved in the consent process. The provider could consider how they record the discussions they have with children and young people under the age of 16 that relate to gaining consent.

Children, young people and their families told us that staff spent time with them on admission to identify or review their care preferences and future wishes. Care records

contained information about the children, young people and family's future wishes. This included; where individuals wanted to receive their end of life care and how they wanted to be cared for after they had died.

We observed staff meeting children and young people's physical and emotional needs in a timely manner. We saw that staff endeavoured to meet the individual requests of the children and young people. Staff worked with charities and other organisations to do this. For example, one young person who used the service expressed an interest in aviation, so the staff worked with the young person and a local organisation to facilitate a trip to a local airbase.

The hospice had good links with the local community to enable the children and young people to engage in community life. One member of staff told us they planned to start working with a local equestrian centre to provide children and young people with the opportunity to be around horses. On the day of our inspection one child who used the service was enabled to officially open one of the hospices newly refurbished charity shop that was located in a nearby town.

Staff at the hospice promoted the involvement of the children and young people's families and friends. Families and friends could visit at any time and services were offered to support the families of the children and young people. This included counselling services and sibling support. One young person told us, "My mum and brother have visited me here".

We saw that staff had considered the needs of children and young people who were restricted to receiving their care in a reclined position. Sensory items were located on the ceilings and walls to provide these individual's with sensory stimulation. For example the ceiling of an outdoor gazebo was decorated. Some children and young people who used the service were at times restricted to their beds due to their medical condition. Communal areas were able to accommodate hospice beds so these individuals were not socially isolated.

Children, young people and their families submitted their preferences for respite stays in advance. The staff had a system in place to negotiate respite stays in a fair and equitable manner. Where possible admission was planned to enable children and young people to stay at the same time as their friends they had met during previous admissions. One young person told us, "I have made a few

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

friends here and it's good to be able to meet at Hope House". The hospice also had a system in place to accommodate emergency admissions alongside planned respite stays.

The provider was responsive to the feedback from children, young people and families. Examples of this included the

provision of a daily menu board in response to feedback from children, young people and their families and plans to redecorate the young person's lounge. This was after receiving feedback from the young people who used the service.

# Are services well-led?

## Our findings

There was a positive and inclusive culture at the hospice. We saw that staff were made aware of the hospice's values and philosophy through their induction programme and training. The relative of one young person told us, "You can tell that the staff want to be here and are interested in X (the child)".

Staff understood their right to share any concerns about the care at the hospice. All the staff we spoke with were aware of the provider's whistleblowing policy and they told us they would confidently report any concerns in accordance with the policy.

The provider sought feedback from the staff through a staff survey. The registered manager told us that changes had been made in response to feedback gained from the staff. An example of this was the introduction of regular nurses and support worker meetings to share information and improve communication between the provider and employees.

All the staff we spoke with told us they felt supported and enjoyed their work. One staff member said, "I love working here". Another staff member said, "I feel very supported. There is always someone around to check I am okay and up to date with everything". We saw that staff received regular supervision and appraisals. Staff could also access a counselling service to seek professional emotional support if this was required.

There was a clear management structure at the hospice. The staff we spoke with were aware of the roles of the management team and they told us that the managers were approachable and had a regular presence within the hospice. During our inspection we spoke with the registered manager and the hospice's director of care. Both demonstrated that they had an understanding of the care provided to the children and young people which showed they had regular contact with the staff and the children and young people who used the service.

We saw that systems were in place to monitor the quality of the care provided. Audits of medicines management, care records and educational resources were completed. These audits were evaluated and where required action plans were in place to drive improvements. We saw that one audit had demonstrated improvements were required in

the recording of epileptic seizures. As a result of the audit changes had been made to the way seizures were recorded and an epilepsy champion was appointed and trained to help to implement the required improvements.

The management team involved children, young people and their families in the assessment and monitoring of the quality of care. We saw that a parent participation forum event had been held in 2013 where parents had been asked to share their experiences so that themes for improvement could be identified. Parents were also asked to prioritise the importance of the identified themes so that the management team could address the areas of greatest concern first.

We saw that incidents were recorded, monitored and investigated appropriately and action was taken to reduce the risk of further incidents. Staff told us they were always made aware of any changes that had been implemented in response to incidents. The provider had received no complaints since our last inspection, but we saw there was a system in place to monitor and investigate complaints.

We saw that a risk register was maintained by the management team. The register contained information about potential risks and the actions taken to manage the risks. For example the hospice managed the potential risk of poor medicines management by; regularly reviewing the medicines management policy, analysing incidents involving medicines, providing appropriate training, auditing the quality of medicines management, working with their local NHS trust pharmacy team and attending local meetings where medicines were discussed.

We saw that effective systems were in place to ensure the staffing numbers and skill mix were sufficient to keep the children and young people safe. Staff told us that staffing numbers enabled them to provide one to one care during the majority of shifts. One staff member said, "There is always enough staff to allow us to provide individualised care. Most of the time this is on a one to one basis". The relative of one child who used the service told us, "I always know X is safe when they stay at Hope House".

We saw that the care provided was based upon best practice evidence. A clinical standards coordinator was employed by the hospice. They told us, "I look at practice and make sure it's current and up to date". Some children and young people who used the service received their hydration and nutritional requirements through a tube into

## Are services well-led?

their stomach. This is called enteral feeding. The clinical standards coordinator told us, "There is no national guidance on enteral feeding, so we follow local guidance. I worked with staff from local children's hospitals, liaised with the feeding companies and spoke with nurse trainers to devise enteral feeding procedures here. I am also becoming part of a large steering group to look at enteral feeding practice. We saw that an enteral competency based training system had been put in place to ensure that staff followed the correct evidence based procedures. The clinical standards coordinator had developed an information board that contained all of the different types

of feeding tubes used at the hospice for staff to refer to. We saw the staff referring to this board during our inspection and the staff told us that it helped them understand how to meet the needs of individual children and young people.

Staff at the hospice worked with other organisations to ensure that local and national best practice standards were met. The hospice had infection control link nurses who attended local and national meetings and a social worker from the hospice was a member of a local safeguarding group and committee. A neonatal nurse was also employed by the hospice. Part of their role was to train and support staff from local hospital's in the care of neonates who had palliative or end of life care needs.