

Children's Hospice South West Little Bridge House

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?	Outstanding ☆
Is the service responsive?	Good ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

This inspection was unannounced on 13 June 2016.

157 children, young people and their families use the services at Little Bridge House. The hospice can accommodate up to eight children or young people and there are additional facilities and suites to enable parents and siblings to stay at the hospice with the child.

The hospice supports babies, children, teenagers and young adults up to the age of 21 with life limiting or life threatening conditions and provides accommodation for respite (short breaks), and end of life care.

We last inspected Little Bridge House in December 2013 and the service met the regulations.

There was a registered manager at the service who had been in post since 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

The children we met during the inspection had complex needs and were not able to tell us their experiences because of their complex ways of communicating. We observed how the staff interacted with the children and their families.

Staff were caring and showed children and their families kindness and compassion. Staff were very motivated and demonstrated a commitment to providing the best quality care to children, young people and their families.

Children received care and support in a personalised way. Children and young people had good links and access to the healthcare support they needed during their stays at the hospice. All parents were happy with the care provided by Little Bridge House. Staff knew children well and understood their complex needs.

Parents told us their children were safe in the care of Little Bridge House. Children were relaxed and comfortable with staff. Staff knew how to recognise any signs of abuse and how they could report any allegations.

Any risks to children and young people's safety and health needs were assessed and managed in order to minimise the risk.

Children and young people and their families including siblings received a responsive service. Their needs were fully assessed, planned for and met. Children, young people and families were involved in developing care plans and keeping these under review.

Children and young people were supported to play, develop and take part in activities and new experiences

in the hospice.

Parents gave positive feedback about the qualities, skills and knowledge of the staff. Staff were recruited safely and received an induction, core training and specialist training so they had the skills and knowledge to meet children and young people's needs. It is recommended that the staff's competency for completing specific tasks is reassessed periodically. This is to make sure they are competent and have retained the right skills and knowledge.

Overall children's and young people's records were accurately maintained. However, we identified some minor shortfalls in records keeping and this was an area for improvement.

There were safe systems in place to manage and administer medicines. Children and young people were protected from the risks of infection by the systems and equipment in place.

We found the hospice building was well maintained. The hospice was designed and decorated to meet the specialist needs of the children and young people.

There was a children, young people and family focused culture at the service. Children, young people and families were involved and consulted about all aspects of the service. There was a clear management structure and staff, children and young people and their families felt comfortable talking to the managers. There were systems in place to monitor the safety and quality of the service provided. An improvement plan was being developed to drive continuous improvements across the service.

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.

Parents told us children and young people were safe.

Medicines were managed safely.

Staff knew how to recognise and report any allegations of abuse.

There were enough staff to keep children and young people safe. There were a small number of staff vacancies but this was not having an impact at the time of the inspection. Staff were safely recruited.

There were effective infection control systems in place and staff had access to protective equipment.

Is the service effective?

Good ●

The service was effective.

Staff had effective training and support to carry out their roles. Parents felt staff were skilled and knowledgeable in meeting children and young people's needs.

Children and young people were supported to eat and drink and had the specialist diets they needed.

The environment had been adapted and specialist equipment was provided to meet the individual needs of the children and young people.

Is the service caring?

Outstanding ☆

The service was caring.

Staff were kind and compassionate and treated children, young people and their families with dignity and respect.

Parents and professionals told us the hospices cared for the whole family not just the child receiving the service. The ongoing care and support provided was invaluable to families.

Staff had developed good relationships with children, young people and their family and there was a happy, relaxed atmosphere throughout the hospices.

Parents and their children were involved in planning their care which included what they would like at the end stages of life. Parents told us this was done sensitively and at a pace that was appropriate to them. Support was offered to bereaved families and contact maintained if this was what the family wanted.

Is the service responsive?

Good ●

The service was responsive to children, young people and their families.

Staff responded quickly and appropriately to children and young people's needs.

Staff understood children and young people's complex ways of communicating and responded to their verbal and non-verbal communication and gestures.

Children and young people were supported to pursue activities and interests that were important to them.

Parents knew how to complain. Further work was planned on producing accessible complaint information for children, young people and their families.

Is the service well-led?

Good ●

The service was well-led. Observations and feedback parents and staff and a commissioner showed us the service listened to their views and acted on these.

The management team had arrangements in place to assess and monitor that there were enough staff, with the right skills, knowledge and experience to meet the needs of people.

There were systems in place to monitor the safety and quality of the service. There was learning from accidents, incidents and complaint investigations.

Little Bridge House

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 13 June 2016 and was unannounced. The inspection team consisted of an inspector, a pharmacy inspector and one specialist advisor. The specialist advisor had experience of children's and young people's palliative and hospice care.

We met and spoke with three children and with one parent during the inspection. The children we met had complex needs and were not able to tell us their experiences because of their complex ways of communicating. Following the inspection we telephoned three parents, two bereaved parents and one bereaved sibling. We spoke with the registered manager (head of care) and 26 staff. This included senior team leaders, the practice educator, medical and nursing staff, senior cook, care workers, the chaplain and a volunteer.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of children and young people who could not talk with us. We observed how the staff interacted with the children, and their families. We looked at how children and young people were supported during their stay. We reviewed a range of care records for six children and two young people. We also reviewed records about how the hospice was managed. This included, staffing records, audits, meeting minutes, training records and governance records.

Following the inspection we sought the views of five professionals by email and the Clinical Commissioning Group. We only received feedback from the Clinical Commissioning Group.

Is the service safe?

Our findings

We observed that children were relaxed with staff. They played, participated in activities, smiled, laughed and gave staff eye contact. One child who was distressed visibly relaxed when they were held and cuddled by staff. This showed they felt comfortable and safe with staff. Parents told us they felt their children were safe in the hospice. One parent said, "She is safe there, I have never had a concern but would definitely speak to staff if I felt she was not safe."

The registered manager was the safeguarding lead for the hospice. There were child and adult protection and safeguarding procedures in place. All of the staff had received children's and adult's safeguarding training as part of their induction and ongoing training. Staff were able to tell us about the types of abuse and how to report any allegations.

Risks to children and young people's safety were appropriately assessed, effectively managed and reviewed. These areas of risk included any potential hazards in the environment, pressure sores, nutrition, medicines, falls, access to the community, behaviours that challenged others and epilepsy management. Staff demonstrated they knew the details of these risk management plans and how to keep the children and young people safe. For example, the hospice had developed specific risk management plans about the use of blenderised diets. This is where meals are blended so they can be safely given to children and young people through their feeding tubes. Parents and staff told us the benefit of this was that the children and young people were able to have the same meals as the rest of the family rather than rely on other pre prepared nutritional feeds. We observed staff assisting one child to receive their blenderised meal through their feeding tube. Staff followed the detailed risk management plan. They were very knowledgeable about how to follow the procedure to make sure the child was safe.

There were emergency plans in place for each child and young person. These included emergency evacuation plans for all children, resuscitation plans and epilepsy protocols and management plans for those children and young people with epilepsy.

During our inspection we looked at the systems in place for managing medicines; spoke to staff involved in the administration of medicines, and examined two children's medicines charts.

Most medicines were brought into the hospice by children and young people's families for planned respite care, and were not prescribed at Little Bridge House. There were systems in place to make sure that these medicines were safe to use, and had full administration details printed onto the labels. These were transcribed onto medicines administration charts by nursing staff. There were clear transcribing processes for staff to follow, and risk assessments were used by staff if discrepancies were found. The risk assessments were reviewed and signed by a second nurse to ensure safe medicine transcribing and administration. Medicine Administration Records (MAR) were checked by the nurse transcribing and also checked and signed by the parent/carer or the young person. The charts and risk assessments were also checked and countersigned by a Children's Hospice Doctor within 24 hours. The charts we saw were accurately completed, correctly signed and risk assessment sheets had been completed where appropriate. Medicines

were signed when they had been given, showing that children and young people received their medicines in the way prescribed for them. Sometimes medicines were prescribed by hospice doctors, and small stocks of some medicines were held. Other medicines were supplied on individual prescriptions from a local pharmacy. These prescription forms were held securely and there were systems in place to monitor their use.

There were separate prescription forms for doctors to prescribe medicines to be given by injection in syringe drivers or pumps. Records showed that staff regularly checked these pumps were working correctly. There was also a mechanism to allow nurses to give a range of discretionary non-prescription medicines, for up to 24 hours. This allowed nurses to respond in a timely way to treat children and young people's minor symptoms.

It was clear when 'as required' medicines were to be administered and records showed that children and young people received these medicines when they needed them.

Some young people could take their own medicines, if it had been assessed as safe for them to do this, and clear risk assessment processes and policies were in place.

Medicines were stored safely. Medicines that require additional controls because of their potential for abuse (controlled drugs) were stored securely and handled correctly. There were daily checks of these controlled drugs, and staff followed up and reported any incidents where necessary. Medicines requiring cold storage were kept within a monitored refrigerator in the medicines room. Medicines received into the hospice, and those returned or disposed of after a stay, were clearly recorded. This helped to show how medicines were handled during children and young people's stay at the hospice. There was a supply of medicines and oxygen for emergency use, and records showed these were checked regularly to make sure they were suitable for use if needed.

Staff were able to access up to date information on the safe use of medicines. Comprehensive policies and procedures were available for staff and these were kept under regular review. Staff received training on giving medicines and the use of syringe drivers and pumps, and they were checked to make sure they could give these medicines safely.

Staff carried out regular medicine audits to check medicines were being managed safely. Recent examples, included a controlled drugs audit, and prescription chart audit. The audits identified any recommended actions and these were followed up. Medicines incidents, including any risks identified, were reported and reviewed at regular meetings. Actions were fed back to staff and recorded to help reduce the risks of similar incidents happening again.

A new service level agreement had been drawn up with the local hospital pharmacy department, which will enable a hospital paediatric pharmacist to visit regularly. This will help to provide further medicines advice and support to the hospice.

Children and young people were protected from the spread of infection. Staff washed their hands prior to undertaking any procedures with children and young people. Parents told us the hospice was always clean and that staff followed any infection control procedures. One parent said, "They are always wearing gloves and washing their hands to make sure she doesn't get any kind of infection when she is there." There were supplies of protective equipment such as gloves and aprons. The hospice building was well maintained and clean throughout the inspection.

Environmental risk management systems were in place for the hospice. The maintenance manager told us there were maintenance records for servicing of equipment, fire systems, boilers and the building. Audits were undertaken to make sure all equipment and the building were checked and serviced as required. Robust systems were in place for the maintenance of equipment such as hoists, specialist beds and equipment.

The registered manager said staffing levels for each shift were determined following the assessments of each individual child or young person. Where a child or young person had specific nursing needs they were supported by a nurse. Staff told us each child or young person was supported on a one to one basis. However, following risk assessments some children or young people were supported by two staff. Parents and staff had no concerns about staffing levels at the hospice.

The registered manager told us following a recent staffing restructure and staff leaving there were a small number of posts that were to be recruited to. The registered manager told us some practice specific posts such as a physiotherapist were particularly difficult to recruit to. The clinical commission group also identified the recruitment of some specialist staff could be problematic. They told us this did not currently have an impact on the quality care and support children, young people and their families received from the hospice.

Recruitment practices for staff and volunteers were safe and relevant checks had been completed before staff worked unsupervised at the service. These checks included the use of application forms, Nursing and Midwifery Council (NMC) checks, an interview, reference checks and criminal record checks. This made sure that children and young people were protected as far as possible from staff and volunteers who were known to be unsuitable.

Is the service effective?

Our findings

We observed children and young people being supported by staff. Staff had the skills and knowledge to be able to meet each child's complex needs. Staff were confident of their abilities to be able to support each child. Staff were described by parents as being skilled and knowledgeable and they followed care plans about meeting children and young people's needs. Parents all commented positively about the staff. One said, "I have the confidence to step back when I'm at Little Bridge, it means I can just have cuddles and not worry about the care or the next job that needs doing".

Each child and young person had a 'key contact' who co-ordinated their care and got to know them well. Staff told us that during a child or young person's stay their 'key contact' was allocated to be on duty for their arrival and during their stay wherever possible. Parents told us they valued the 'key contact' role. One parent said, "When we go and stay they always make sure the contact staff work a few shifts so that they keep in contact with xxx and get to know if anything has changed. They will sometimes just ring us at home to hear how things are going, always before a visit to hear if anything has changed so they can prepare for our stay. They know xxx well and make an effort to stay up to date with their needs or any changes in their health or medicines."

Staff were trained so they could provide specialist care for the children and young people. There was a practice educator who provided training to staff. The practice educator also regularly observed staff working with children and young people. The staff we spoke with had completed an induction programme and had annual update training week in January each year. Each month at the team meeting an area of learning was identified and a session delivered. A member of staff was undertaking their induction during the inspection. They spoke highly of the support and training they had received. A member of care staff told us. "The education and training here is excellent, I have never felt out of my depth and training is tailored to specific children's needs".

The competency of staff to undertake specific nursing and care tasks was assessed on induction and on completion of training to make sure they were able to put the training into practice. All staff also undertook an annual care skills assessment in addition to the annual mandatory training. This assessment was in key skills and areas of practice such as medicine management, intravenous (IV) therapy or ventilation. The practice educator and team leaders worked alongside staff on shift to be able to assess and monitor skill levels of all staff. The registered manager planned to introduce further competency assessments for staff and this was included in their improvement plan.

Staff told us they had one to one support and annual development meetings and felt well supported by managers to fulfil their roles.

Little Bridge House had links with a local university and offered placements to student nurses. We spoke with one student nurse during the inspection who spoke highly of their placement at the hospice.

Consent was sought from children's parents and this was reviewed at each stay. One parent said, "They are always polite, kind and always ask our permission and consent for her care at each visit."

Staff verbally sought children and young people's consent before supporting them or providing any care. Records showed young people gave their own consent where they were able to and this was included in their care records.

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.

Young people over the age of 18 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 hospices is called the Deprivation of Liberty Safeguards (DoLS). The hospice had made appropriate referrals to the supervisory bodies under DoLS for young people prior to their stays. The senior team leader had liaised with young people's supervisory bodies to check whether they needed to apply prior to each stay or whether an authorisation would cover a fixed period of time.

Some young people and adults had been assessed as not having capacity to make decisions about some aspects of their care and treatment. We saw best interest decisions were recorded where needed.

Children and young people's health needs were assessed and planned for to make sure they received the care they needed. All of the children we met had complex health needs.

Children and young people were supported by specialist children's nurses, two newly appointed adult learning disability nurses, practice specific professional care roles such as occupational therapists, teachers and social workers, the care team and a team of GPs. GP's provided daily medical cover for the hospice and provided children and young people and other professionals involved with a discharge summary at the end of their stay. The GP's participated in the daily care team handovers. Parents spoke highly of the access to GPs and the cover they provided. One parent said, "The medical cover here is above and beyond and I can always talk to the GP here. They then communicate with all the other professionals involved in (child's) care by writing a discharge letter."

Staff were assessing one child's discomfort and pain who was not able to verbalise this. The child had a clear pain management plan and we saw staff were following this and took action to ensure the child received the pain relief they needed. A parent told us, "If xxx (child) becomes unwell or is in pain they will let the doctor know and they will give her something. They can tell when she does not feel well."

Children and young people's nutritional needs were assessed and care plans were in place. Records were kept of children and young people's food and fluids.

We observed one child being supported to have their blenderised meal through their feeding tube. Staff chatted with the child, comforted them and responded to their discomfort when they had reflux. The child had their blenderised meal in the dining room sat by the dining table with staff where they could smell the food being cooked before it was blenderised. During the mealtime staff provided extra visual and tactile stimulation for the child by giving them toys to touch and hold. This meant their mealtime experience was as enjoyable and stimulating as possible.

Parents told us and we saw from care plans that their children's and families meals preferences were recorded. Parents told us they appreciated being cooked for and that the food was good quality.

Little Bridge House was very homely and there was a relaxed atmosphere. Children looked relaxed in both the communal areas and their bedrooms. Parents told us that it was like a home from home and the whole family enjoyed coming to stay at the hospice. One parent said, "It feels so normal at Little Bridge, I just walk in and go Ahhh and feel relaxed immediately we get there."

There were eight individual bedrooms for children and young people. In addition to this there was family accommodation on the first floor. Some of the family rooms were suitable for large families with interconnecting bedrooms and one of these family rooms was fully accessible for wheelchair users.

The hospice was well equipped with specialist equipment and fully accessible bath and shower rooms. There was a post bereavement suite where families can stay with their child following their death. All of the facilities were child and young person friendly and there was a large sensory garden, games room, Jacuzzi/spa, messy play, soft play and sensory rooms. Each child had a room plan in place so their bedroom could be set up with the décor, equipment and bedding of their choice.

Is the service caring?

Our findings

Positive caring relationships were developed with children and their families. We observed that staff were very caring and compassionate towards children and their families. They made sure children were content, comfortable and having fun wherever possible. Staff showed concern and responded quickly and calmly when children were unsettled or upset. Staff were highly motivated and developed caring and supportive relationships with children and their families.

Parents told us staff were caring and kind and all staff were very committed to providing a high quality service for the whole family. They said if they did not live near the hospice staff would phone them on a regular basis to check if they were ok and needed any support. They also told us staff understood their emotional needs and focused on their wellbeing as well as the wellbeing of their child.

The hospice had produced an online video with one family about their experiences of using Little Bridge House. These two information films included the experiences of the child's siblings and of their parents. The family involved described how the service catered for and cared for the whole family and how important the hospice was to them. They said, "They are always thinking of ways of making better for you. We feel very privileged that we can come here". This video story was available on the hospices' website. This showed that family support was seen as key to children's and young people's wellbeing and the needs of families were also supported.

We observed staff treating children and their families with dignity and respect. We saw staff spent time listening and talking with parents and siblings when they brought their child to the hospice.

The staff promoted the privacy of children, young people and their families. Personal care was provided discretely and in private. The service kept any private and confidential information relating to the care and treatment of children and young people secure. Children, young people and their families had access to private spaces in the hospice.

In addition to the nursing, medical, and care staff, the family support team provided ongoing care and support for children, young people and their families. This included bereavement support and sibling workers. The 'key contacts' for families provided bereavement support to the families they had built up relationships with during children and young people's time at the service. The support continued for as long as a family needed it. There was a bereavement coordinator who was also part of the care team. The bereavement coordinator was allocated two days per week to support the care team in their bereavement work. In addition they supported families whose 'key contacts' no longer worked at the service. They had developed a bereavement planner that included 'A child's understanding of death' and 'offering support to siblings'. They had also developed a 'bereavement competency' that formed part of staff training. This was a comprehensive document that looked at all aspects of care and communication with families' pre and post death of their child. They also ran the de-briefs for staff following the death of a child or young person and organised bereavement events and support groups. The sibling workers were highly valued by both parents and siblings themselves.

At the time of our inspection no children or young people were receiving end of life care at the hospice. However, staff showed us the bedroom suite, processes and resources available to individuals who required this specialist care in the hospice. We saw that the families of children and young people could be close to their relative during this time. The bedroom suite in the hospice was also available for families to stay close to their child after they had died and before their funeral. Staff told us they were led by each parent as to when and if they were comfortable and ready to have any discussions about their child's end of life care. Where these discussions had taken place their wishes were recorded in the care records. One parent told us, "After (child) was ill we needed for the first time to have conversations about end of life. It was much easier having these with the staff because they have known us and could do it sensitively. They gave us a lot of information and answered our questions; I felt I could ask anything that I might not have been comfortable discussing with other professionals."

There were examples of 'parallel planning' for four children and infants who had been referred to the hospice for end of life care and or ongoing bereavement support. This is where a child or young person has two plans in place for different circumstances around their condition. This shows good preparation for the family for if and when the circumstances change. The hospice staff met with the infants and children and their families in the hospital or their homes to discuss and make plans for their end of life care. There were examples of where the hospice had responded at very short notice to be able to provide this support. They had developed a tool so they could gather all of the information they needed to be able to respond quickly in these unique situations. In addition they had worked with three families and midwives when a child with a life limiting condition was identified during antenatal checks. This work allowed the families to make realistic plans and gave them choices in relation to their child's care and future including making the decisions as to where their child died and to the level of support they wanted from the hospice. The use of parallel care planning is an example of outstanding practice.

Staff from the hospice participated in local palliative care networking groups to maintain links and to promote early parallel planning for children and young people where possible. There were plans to further develop the relationships with antenatal and neonatal services to develop pre-emptive end of life parallel planning in other settings. This was so family's wishes could be better achieved whenever possible. For example, the hospice cared for a baby with an anticipated short life span, who survived beyond expectations. By working with community teams the hospice was able to prioritise the family to ensure they came for a stay as soon as possible. By planning several short stays relatively close together meant the family got to know the hospice team and gained confidence to feel able to let the hospice care for their child whilst they were away for a short break. The hospice provided support in terms of reviewing and managing the baby's symptoms with the community teams. The community team supported family directly at home at the child's end of life at home and the hospice assisted with ongoing family bereavement support.

The care team also participated in child death review meetings and worked with colleagues from other services who also attended the reviews. This was to learn about how care could have been improved at the end of life for the child or young person, and to look at how services could work better together in the future. Following one child death review for a child who had received an end of life respite stay, it was identified how beneficial this had been to the child and their family in supporting the family's overall wish for their child to die at home. In response to this the hospice now proactively offers and provides end of life respite stays for children, young people and their families.

Feedback from bereaved parents and siblings was positive about the support the staff at the hospice had provided them with. One bereaved parent said, "They still call me regularly to hear how I am doing. There is a support group for bereaved parents and siblings. You can access and use it at your pace they really respect that and do not push you but just let you know it is there if you want it. My other children have decided for

now they do not want to attend but know it is there if they want to. They are amazing, it is the most amazing place with everything we needed under one roof."

One bereaved sibling told us, "I liked going there it gave me a break from everything. They had incredible sibling workers and they just gave me space to not be responsible with helping with my sister but just to focus on my school work and they helped me with projects. I feel what they gave me was life changing; I could focus on getting into college and studying music which was my dream, if they did not help me I do not think I would have been able to do it. They were always there for me, taking me on day trips, I was always asked what I wanted to do and part of planning my stay. If I felt upset or frustrated I could talk to them and they helped me work through it. I know they are still there if I needed them".

Is the service responsive?

Our findings

Our observations showed us staff were responsive to children's needs. Staff responded to children's verbal and non-verbal gestures and communication. All of the staff we met and spoke with understood children and young people's complex ways of communicating. This reflected what was in their care plans. The plans included how they communicated and what they liked and did not like. This meant these children's choices and needs were responded to quickly. They did not experience any delays in doing what they wanted to do and subsequently did not experience any frustration at their communication not being understood by staff. We did not see any children showing any frustrations or negative behaviours because they were not understood by staff.

Parents fed back that staff understood their children's different ways of communicating. One parent said, "Both boys purely communicate with their bodies and faces, staff know them and they can see when they are unhappy, in pain or discomfort and will pick up on this and make sure they are OK. If they are unsure they are confident to ask us to help them understand what they boys are saying."

The care plans were child and young person centred and focused on children's and young people's strengths, abilities and development and not on their life limiting conditions. Children and young people and their families had been involved in developing these plans. Health and social care professionals had also contributed to the plans. The care plans detailed the personal and health care support children and young people needed as well as focusing on their social and emotional wellbeing, play and learning, their end of life care and communication needs. Parents told us they were contacted prior to each stay to update care plans. One parent said, "We are very much involved in the planning of (child's) stay and care. They ask us at each visit to look through their care plans and make sure it is up to date and then sign that we agree it is correct and they can provide the care written in it."

There was a daily handover report between staff shifts and we observed this during the inspection. This also included anything that needed to be considered in relation to the whole families support. At the handover staff were allocated to work with each child or young person. The staff allocated then had a further handover from the care team member on the previous shift. This meant important information about the children's medical, personal care and well-being were handed over to the staff coming on duty and those specific staff responsible for their care that shift.

Children's and young people's care plans were updated as their needs changed and before each stay. There was an annual multi-disciplinary review held that children, young people and their parents contributed to. Information was gathered from the families and the child or young person plus key professionals that were identified by the families. These reviews were coordinated by the child and young person's key contact.

Staff completed records of the care, treatment and support they provided to children and young people. Where parents did not stay with the child at the hospice a photographic diary was kept so staff could show families what the child or young person had done during their stay. Children contributed to these diaries where they were able to by adding their own art works or comments.

Children and young people's spiritual care needs were identified in their care plans. There was a chaplain who worked at the hospice four hours a week who was able to provide spiritual support. However, some staff identified that spiritual support was limited because of the small number of hours provided.

Children and young people's interests, activities and play needs were recorded and planned for. Children participated in messy play and different sensory activities during the inspection. Children laughed, smiled and actively engaged with staff and the activity. Siblings played in the games room as soon as they arrived. Parents told us there was always plenty for their child to do and that activities were tailored to each individual child or young person. One parent said their children, "Like to do the sensory activities, they do something different every time we go and different staff come up with new ideas the whole time. We as a family can choose to take part as much or as little as we want, sometimes we will all join in the sensory activity, spend time together in the garden, go for a walk, to the park or use the jacuzzi."

In response to children and young people's changing needs as they grow older teenage weekends were held four times a year and a teenage sibling weekend once a year. These weekends have different themes to meet the changing needs of the groups. During one of these weekends the young people decided to have a sleepover. In response staff arranged to put four beds in one of the bedrooms so this could happen. An outdoor activity weekend was arranged for teenage siblings. This meant teenage siblings had the opportunity to spend time with others of their own age and in a similar situation to themselves. In addition 'sensory' weekends were held for those children and young people who had sensory needs.

Parents also told us the service was responsive. One parent told us that one of their children was not well and needed to go to hospital. The hospice contacted them and offered to come and pick up their other child and arranged for them to stay at Little Bridge House so they could focus in supporting the child who was unwell in hospital. The parent said, "They always go that extra mile... It helped us to just focus on getting (child) better".

Parents who stayed at the hospice were offered a 'child minding service' for their child's siblings (who also stay at the hospice) so the parents can go out if they wished to. The hospice also made arrangements to collect those families who do not have access to transport.

A commissioner told us that following a recent contract review parents had found the service very responsive.

We spoke with staff and looked at records about the way Little Bridge House supported children and young people when they moved between services. We saw records of involvement in meetings between health, education and social care professionals so there was a co-ordinated approach for children and young people. The GP discharge letter at the end of each child and young person's stay also updated professionals about any important changes that had happened during their stay.

An audit of young people's experiences of transition to adult services had been completed. This identified some areas for improvement in relation to all involved agencies and professionals working together. The hospice was part of a Regional Action Group looking at how transition for young people can be improved in the North Devon area. This included consultation events with young people, professional study days, working with the transition lead nurse from the local hospital and engaging with a local adult hospices in the region.

We looked at two young people's care records and saw the hospice had been involved in the young person's transition planning. A transition pathway had been developed and we saw these in young people's care

records.

Parents knew how to raise any concerns and complaints and told us they were confident that if they did have any concerns they would be addressed. Parents did not raise any concerns with us. There were robust systems for investigating complaints and ensuring that any actions and learning were implemented. However, complaints information was not displayed or was easily accessible to children and young people in formats they could understand. Following the inspection the registered manager told us they planned to develop accessible complaints information.

Is the service well-led?

Our findings

Overall records for children and young people were accurate. However, some records were not always consistently maintained. For example, one child had some sore areas on their skin from a pre-existing condition. Whilst these were documented in their care records a body map was not completed. Staff told us a body map should be completed to show any injuries or marks on children and young people so these could be monitored and to check any healing or deterioration. Immediately following the inspection the registered manager confirmed that they had reviewed this and had implemented new monitoring body map records. These were to be implemented across the organisation. Other records included some duplicate information and some included out of date contact details. Consistent record keeping was an area for improvement.

There was an electronic feedback system in place and paper surveys were also sent to families who used the hospice service. Children, young people and their relatives could leave anonymous feedback by the use of a touch screen computer tablet. Any feedback received was acted on. For example, some parents feedback they did not understand the booking system in place. In response following each child or young person's annual review information was sent about their allocation of nights and the booking system. In addition to this the senior team leader responsible for quality and compliance, supported by the head of quality and compliance was planning to arrange focus groups to follow up and check that the information had improved.

During the inspection we saw parents were relaxed and comfortable talking with staff and managers. There was a friendly atmosphere with staff and families being visibly pleased to see each other. All of the parents we spoke with felt they were involved, consulted and their views and opinions were listened to. None of the parents we spoke with had anything negative to say about the service they received they only had praise.

Children, young people and their families have been involved in developing a film for professionals and new families about the work the hospice does. It was planned for this to be put on their website.

Little Bridge House staff participated in both local and national children's hospice forums. In addition the nurse who had championed blenderised diets had spoken at several conferences, and had written articles in national paediatric journals.

Every member of staff we spoke with was motivated, very open and proud of the service they provided. Staff told us that the management team were very accessible and visible and they all felt able to approach them. They had regular opportunities to give feedback and felt involved. There is a staff council with its own constitution that contributes to the governance systems. Staff knew how to whistleblow and the registered manager was able to give us an example of how they had responded to a whistle-blower.

Staff told us they felt well supported and were listened to. There were bereavement sessions held for staff following the death of a child. They said they felt valued and they had a commitment to the children, young people, their families and the team at Little Bridge House. They told us about the staff choir which works as

a team building and de-stressor.

There was an open culture about reporting and investigation incidents. Staff told us there was not any blame culture about incidents and that learning was shared with them so they could change any practices they needed to.

There were monthly care team meetings and the management team meetings on a weekly basis.

There was an effective system in place to regularly check and monitor the quality of the service. There was a comprehensive program of in-house regular audits such as medicines, infection control, care plans, departure letters, accidents/incidents, record keeping, complaints and compliments that fed into governance systems. There was clinical governance group that fed into the board meetings. Actions were taken in response to any shortfalls or areas of concern noted. For example, following a review of incidents of behaviours from children and young people that required positive support, a learning disability nurse was appointed. The positive behaviour support plans that were in place for children and young people at schools and in the community were sought and then followed whilst they were staying at the hospice.

The registered manager told us they had also started to develop an improvement plan for Little Bridge House with measurable outcomes that could be reviewed on an ongoing basis. The improvement plan was based on the results of feedback received and any shortfalls identified in the audits. For example, there were plans to introduce further competency assessments for staff to be able to demonstrate that staff had the right skills to meet children and young people's needs. The registered manager told us as part of the improvement plan young people's transition experiences were to be audited again to assess any improvements. Likewise there was plan to audit the incidents of behaviours that needed positive support following the implementation of the joint working programme.

A commissioner told us they were assured in respect of the safety and quality of the service provided by Little Bridge House. They said the provider was open, willing to work with the commissioners and with other providers, and they demonstrated learning and improvement.