Children's Hospice South West

Little Harbour

Inspection report

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Date of inspection visit:
12 December 2016

Date of publication:
31 March 2017

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

Little Harbour is a children's hospice. 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. The service is registered to accommodate up to a maximum of six children and their families. On the day of the inspection two families were staying at the service and one family was visiting the service for the day.

We carried out this unannounced inspection on 12 December 2016. 95 families were actively being supported with 20 bereaved families receiving support from Little Harbour. The hospice can accommodate up to six children or young people and there are additional facilities and suites to enable parents and siblings to stay at the hospice with the child.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The 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.

We identified two areas that needed further development at the service. The registered manager told us following a recent staffing restructure and staff leaving there were a number of posts that were to be recruited to. Some practice specific posts were particularly difficult to recruit to. Due to this it had impacted on the number of families the service could support at any one time. For example on the day of our inspection only two families were able to be supported on a 24 hour basis due to staffing levels. This was to ensure that the staff ratio would meet the child and family's needs safely. We found that due to the strategies the management team had put in place they were able to provide a safe service to the families they supported, however, they were not able to use their resource to its full potential.

We found that the fridge temperature was not monitored consistently. This could mean that medicines were not stored at their correct temperature and could affect the medicine. We recommend staff should monitor and record the temperature of the medicines refrigerators daily.

Our findings were that children, young people and their families were being cared for by competent and experienced staff. 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 Harbour. Staff knew children well and understood their complex needs.

Parents told us their children were safe in the care of Little Harbour. One parent told us "The staff are fantastic. When I come here I can rest, I know that my son is in safe hands and so I can sit and have a cup of tea and not worry."

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. The hospice had not yet implemented the Care Certificate but was aiming to do this.

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 was a positive culture in the service, the management team provided strong leadership and led by example. All of the staff were highly motivated and keen to ensure the care needs of the families they were supporting were met. Every member of staff we spoke with was very open and proud of the service they provided.

There was a management structure in the service which provided clear lines of responsibility and accountability. 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 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?

Good

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

Parents told us the hospice cared for the whole family not just the child receiving the service. The on-going 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 hospice.

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.

Care plans were personalised and informed and guided staff in how to provide consistent care to the people they supported.

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

Parents knew how to complain.

Is the service well-led?

Good

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

The registered manager provided staff with appropriate leadership and support and staff were well motivated.

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 Harbour

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 12 December 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 peoples palliative and hospice care.

Before the inspection we reviewed any information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law. We received the Provider Information Record (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make.

We met and spoke with five children and with five parents 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 or age.

We spoke with the registered manager (head of care) and 12 staff. This included senior team leaders, the practice educator, medical and nursing staff, senior cook, care workers 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. We also reviewed records about how the hospice was managed. This included, staffing records, audits, meeting minutes, training records and governance records.

Good

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 wanted to show us around the hospice with a staff member and so left their parents to do this. This demonstrated how comfortable the child felt in staff's company.

Parents told us they felt their children were safe in the hospice. One parent said, "I trust the staff here, they know my son and me very well. I know that they will look after him so I can rest. I trust them completely."

Staff had a good understanding of what may constitute abuse and how to report it. All were confident that any allegations would be fully investigated and action would be taken to make sure people were safe. The management of the service recognised when to report any suspected abuse. The registered manager told us when needed, they had reported concerns to the local authority in line with local reporting arrangements. This showed that the service worked openly with other professionals to ensure that safeguarding concerns were recognised, addressed and actions taken to improve future safety and care of children and young people living at the service.

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 on-going training. The registered manager had arranged for additional safeguarding training, Multi-Agency Public Protection (MAPPA) Arrangements to take place in January 2017. This training is also used by education services and would ensure that staff had updated knowledge and additional skills in this specialist area of care and were using the same behavioural model as other local professionals. The registered manager told us this would enable them to provide consistency in supporting children and young people between the various agencies.

Staff had worked with other professionals to develop different ways of working so appropriate measures could be put in place to minimise risks to children and young people. We found that 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, moving and handling, nutrition, medicines, access to the community and behaviours that needed a positive response .

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 blended diets. This is where meals are blended so they can be safely given to children and young people through their feeding tubes.

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.

Patients, or their families, brought their current medicines into the hospice for their stays. There is a doctor available for seven days per week and the Out of Hours services was utilised after 6pm/ evening. For end of life care a twenty four hour, seven day a week roster was arranged on a case specific basis.

There were systems in place to make sure that medicines brought into the hospice were safe to use and had full administration details printed onto the labels. Nurses copied these details onto medicines administration charts. There were clear processes for staff to follow, and risk assessments were in place. A second staff member checked these charts, and a doctor checked and signed them 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.

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 (a system which allows medicine to be administered by slow release over a period of 24 hours) 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.

Information was available to staff to show when 'as required' medicines were to be administered. Records showed that children and young people received these medicines when they needed them. Personalised pain assessments were completed and provided detailed information to staff about how to recognise non-verbal indicators of pain, for example body position, heart rate or facial expression. Pain was scored on a 1-10 scale and different interventions were suggested, including non-medical intervention and different painkillers.

Some young people could take their own medicines or families could administer medicines, if it had been assessed as safe for them to do this. Clear risk assessment processes and policies were in place. Young people or their families could store their medicines safely in their rooms if they wanted.

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 controlled drugs, and staff followed up and reported any incidents where necessary.

Medicines requiring cold storage were kept within a refrigerator in the medicines room. The minimum, maximum and actual temperature of the medicines refrigerator was recorded and was in range, but staff were not checking this every day. This meant that staff may not quickly identify if medicines were not stored at the correct temperature. This could affect the safety or effectiveness medicine. We recommend staff should record the monitor and record the temperature of the medicines refrigerators daily.

We saw that staff clearly recorded medicines received into the hospice, and those returned or disposed of after a stay. This helps 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 that staff checked these regularly to make sure they were suitable for use if needed.

Staff had access to 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 they were checked to make sure they could give these medicines safely. Nurses delegated some medicines related tasks to health care assistants. These carers were trained to handle medicines safely and were assessed annually to make sure they were competent to perform the tasks asked of them.

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. There were supplies of protective equipment such as gloves and aprons. The hospice building was well maintained and clean throughout the inspection.

The registered manager told us following a recent staffing restructure and staff leaving there were a number of posts that were to be recruited to. The registered manager told us some practice specific posts such as registered Children's Nurses were particularly difficult to recruit to. They had recruited an occupational therapist who was due to start in January 2017.

The registered manager acknowledged that due to current staffing vacancies at the hospice this had affected the service they could provide to families. This meant that as staffing levels were reduced that the provision offered to families was also reduced at this time. The hospice reviewed their model of work and offered instead of the traditional overnight stays they piloted opening for a day visit . This was aimed at all families particularly those who had found it difficult to use the service. We met one person who was visiting for the day and welcomed this opportunity.

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. On the day of our visit there were three registered nurses. By the afternoon as new children were planned to begin stays the staffing increased to three registered nurses plus a Senior Team Leader and a Carer. In addition to this there was a Sibling Worker, housekeeping, cook, and admin staff on shift . Staff who were part of the wider team, but were not present on the day of our visit, included Learning Disability Nurses, Music Therapists, Social Worker, Physiotherapist, School Teacher, Psychologist, Chaplin, Doctors and a Treasure Seeker. The team are supported by the Senior Management Team which specifically for the Care Team includes the Director of Care, Deputy Director of Care and the Head of Quality & Compliance. Parents and staff had no concerns about staffing levels at the hospice.

There were suitable arrangements in place to cover any staff absence. Staff told us that all members of the staff team would cover additional care shifts especially if there were staff absences at short notice due to staff sickness. Staff told us they would cover any shift absences where possible as they believed having a dedicated team of staff to support families was in their best interests. The service operated an on call system. Staff told us managers would "Always respond promptly" to any queries they might have.

We found that due to the strategies the management team had put in place they identified how many staff were available to provide support to families and this was then provided. For example, during the inspection a family delayed coming to the service. Due to this the service was able to offer an emergency respite service for an additional night for a family as they had the staffing levels to be able to provide this.

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.

Environmental risk management systems were in place for the hospice. Maintenance records for servicing of equipment, fire systems, boilers and the building were in place. 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.

Good

Is the service effective?

Our findings

We observed babies, and children being supported by staff. 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, "The staff are fantastic. When I come here I can rest, I know that my son is in safe hands and so I can sit and have a cup of tea and not worry."

Families received care and support from staff that were well trained and supported and knew their needs and preferences well. Staff had the skills and knowledge to be able to meet each child's complex needs. The registered manager and service manager, shared the view that Little Harbour staff were committed to their work, and were motivated to provide high quality care. Comments from staff included; "I love my job" and "This work is new to me and I have received so much training and support, it's wonderful. It is so rewarding."

Each child and young person had a named 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 contact was allocated to be on duty for their arrival and during their stay wherever possible. Parents told us they valued the contact role. One parent told us that whilst they had chosen not to use the service for some time that staff kept in touch to provide support and advice. The parent appreciated this continued support and contact and felt it helped them to access the service when they needed too.

New employees were required to go through an induction which included training identified as necessary for the service and familiarisation with the service and the organisation's policies and procedures. We found that new staff had completed an induction. A new member of staff was in the process of working through their induction and told us it was helpful and comprehensive. The new employee would shadow more experienced care staff. This enabled them to get to know families and to see how best to support them prior to working with them alone. This helped ensure that staff met the child/ young person's needs in a consistent manner and delivered good quality care.

The registered manger was aware of the Care Certificate framework which replaced the Common Induction Standards with effect from 1 April 2015. However, this had not yet been implemented at the service.

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 hospice was part of the 'Children's Palliative Care Network across the South West' and received updated training and guidance from this network.

Staff had annual update training week in January each year. The Hospice is closed for one week of the year to routine planned stays but one bed remains open for End of Life care. During this week essential maintenance and upgrading of the facilities occur which cannot happen with children and families on site. For the Care Team this week is utilised for mandatory and specialist training, and quality work streams including service improvement. It was also a chance for the staff team to work together and to look at their practise over the year and to consider how they could improve their service further.

Monthly team meetings were held. At the team meeting if an area of learning was identified by the team a session would be arranged and delivered. Staff spoke positively about the training they received and the support they had if they wanted to expand their training. Little Harbour had links with a local university and offered placements to student nurses.

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 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.

Staff told us they felt well supported by managers. Staff attended regular meetings (called supervision) with their line managers. Staff discussed how they provided support to families to ensure they met their needs. It also provided an opportunity to review their aims, objectives and any professional development plans. These meetings were held at the commencement of employment, then approximately at monthly intervals. Staff had an annual appraisal to review their work performance over the year.

Staff also had access to a psychologist who visited the service fortnightly. The psychologist met with any staff member if they wished to discuss any issues. In addition the psychologist attended bi-monthly staff meetings to offer support and advice to the staff team.

Bank staff had a supervision session once a year by the practise educator. However, due to the staffing vacancies, bank staff were being used more regularly. We discussed the need for bank staff to have access to more individual supervision. The registered manager and practise educator agreed to address this immediately.

From reviewing care records it was evident that consent was sought from children's parents and this was reviewed at each stay. Consent was gained in areas for example of medical treatment and in the sharing of records and the use of Closed Circuit Television (CCTV). We also found that care plans had been developed with the young person or their family which demonstrated that they were in agreement with how staff would provide their support.

Consent had also been gained in the area of resuscitation or a sudden emergency situation such as cardiac arrest, respiratory arrest or other immediate life threatening condition. During the inspection one of these plans was updated by the nursing staff but the nurse was unclear who it should be forwarded to outside of the hospice setting. The plan clearly identified the wishes of the child/ young person and family.

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 are called the Deprivation of Liberty Safeguards (DoLS). The hospice had discussed if applications needed to be submitted with the appropriate supervisory bodies under DoLS for young people prior to their stays. Currently no DoLS applications were identified by the hospice or supervisory body. All staff had

received Mental Capacity Act and DoLS training and had a good knowledge in this area.

Children and young people's health needs were assessed and planned for to make sure they received the care they needed. The hospice accepts any child meeting the criteria which includes oncology patients, on the day of our visit all the children had complex health needs. Children and young people are supported by the specialist multi-disciplinary team roles include children's nurses, adult nurses, learning disability nurses, carers, doctors, social workers, teachers, psychologist, allied health professionals, music therapist, sibling workers, activity co-ordinator in the direct care team. Volunteers including complementary therapists and beauticians for example are also available to enhance the child and family stay.

The service worked closely with other health professionals to help ensure children and young people had access to the services they required to maintain their health. Parents were satisfied with the access and support they received from the Little Harbour team and also from other health teams. For example, a family met the midwifery team who would be supporting them in the community at the hospice. This allowed the midwifery team to get to know the family and understand how they would like to be supported. They had also arranged that when they returned to the family home the midwifery team would be there to support them as soon as they arrived home. This demonstrated good communication between different services to support the family.

Parents were complimentary about the variety and quality of the food and told us they had discussed with the catering staff their likes and dislikes so that they were given meals that they and their children liked. We saw from care plans that children and young people's nutritional needs were assessed. Records were kept of children and young people's food and fluids.

The catering staff had a good knowledge of people's dietary needs and catered for them appropriately, for example, awareness of allergies or diabetic diets. If food needed to be blended this was undertaken by nursing staff. There was a three weekly rolling menu but the cook said this could be altered at the parent's request. Parents prepared their own breakfast and could access the kitchen for snacks and drinks throughout the day. The cook prepared all lunches and tea and baked homemade cakes. There was an appropriate budget to buy all foods needed. The last Environmental Health Inspection awarded the service an excellent five star food safety rating.

Little Harbour 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.

There are six children's bedrooms downstairs and five of these child rooms have an additional bed for a sibling or parent carer if this is what the family wish. Every room is personalised (bedding, toys etc.) for each child with themes and preferences being noted in care plan and wish list as part of preparing for their stay. The sixth bedroom has been designed so it could be a parent or child's bedroom and is frequently used at end of life for example, parents who wish to be in bed with their baby or child. Some of the children's bedrooms have interconnecting rooms to facilitate children who need more space and those that arrange breaks at the same time to replicate sleepover's. The parent / family accommodation upstairs offers four rooms and three sibling rooms, one of these sibling rooms adjoins one of the parent's rooms, two are separate. The service model welcomes whole families when possible including grandparents to stay promoting the ethos of family life rather than the child being separated as part of the short stay. The child can come with a relative or carer of their choice, it is not restricted to parents.

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. The outside grounds were on one level so were accessible for children, young people and parents with different mobility needs. There was a play area, bird watching centre and sensory garden.

Good

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 where 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 service had received many comments about the service. Some examples were "(Child's name) really enjoyed the most relaxing few days with you all last week. The main reason for the stay was rest and recuperation for mum following major surgery… Little Harbour is an incredible place and a happy place," and "A very big thank you for looking after us and making our stay great fun and relaxing."

We found the staff team were creative and responsive in how they met children's interests and preferences. For example, a child had a huge interest in the 1940's era. Staff arranged a 1940's themed birthday party for the child and dressed up in 1940's clothes. The catering staff prepared spam sandwiches and ration books. Staff organised a plane fly over and an army tank turned up during the party. The volunteers performed a swing dance. Feedback from the family was "I can't thank you enough for the care, effort and love that went into creating a fabulous party for my child and our family it was fantastic"

A family had arrived at the hospice for their child's end of life care. The family spoke to us in how staff supported them as initially the emotions of forming a relationship with their baby was very difficult. The family had stayed at the hospice for some time and their child's health had improved and was now at the stage that they could go home. Parents told us they were now more confident in how to care for, hold and feed their child. The parents praised the staff for the support they gave them, their child and also to the child's sibling. It was clear from listening to parents how comfortable they felt staff at Little Harbour had worked with them to be able to talk in such a positive way about their child dying and undertaking memory work they had done with the family. One of the parents told us they had initially not wanted to come to the hospice, but were now so pleased that they had. The way the parents were taking on the physical care of their child was also a tribute to the work of the staff at Little Harbour. It was clear the staff were very skilled and caring.

Work with the sibling around understanding death was undertaken, and they also tried to keep a routine going for them. For example, the sibling team liaised with the child's school to ensure that work was undertaken so that when they returned to school they would "not need so much catching up to do". The sibling team also looked after the sibling so that the parents could do the work they needed to do in preparing for their child's death or for going home This demonstrated the level of care, compassion and

support that staff provided to this family.

Staff told us that it was important that they supported parents too. They gave examples of arranging a wedding anniversary meal in the 'crow's nest' which is a quiet area of the service. Staff provided a waiter service to make it feel for the parents that they were in a restaurant, whilst staff cared for their child. Staff commented to us "Families always look refreshed when they leave."'

Staff teams were identified to be the named contact with particular families so that they could build relationships with them. The named contact staff team would then remain in contact with the families when they were not staying at Little Harbour so they could support them in the community. A parent told us this was a valuable resource to them.

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.

Staff also provided post-bereavement care. A dedicated space in the hospice was available where parents could stay for five nights following the death of their child. 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. Wherever possible children were included in these discussions. Where these discussions had taken place their wishes were recorded in the care records. Staff told us they decorated the room in keeping with the child's preferred interests. For example they ensured the décor reflected the child's favourite football club kit. Children who had also died in the community or a local hospital could also use the suite

In addition to the nursing, medical, and care staff, the family support team provided on-going care and support for children, young people and their families. This included bereavement support from the Senior team leader, Family Support and sibling workers. The named 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.

Staff also provided support groups, for example, a dads group meets three times a year, where fathers in similar circumstances could meet and support each other. Likewise a mums group had been created. An annual remembrance day is held due to feedback from parents who told the service that they needed the opportunity to talk to staff who knew their child. At the last remembrance day the parents released a bubble and took home a butterfly as a keepsake.

There were examples of 'parallel planning' for children and infants who had been referred to the hospice for end of life care and or on-going 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.

Good

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.

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. Children and young people's spiritual care needs were identified in their care plans. There was a chaplain who worked at the hospice who was able to provide spiritual support

Parents told us they were contacted prior to each stay to update care plans. One parent said, "Staff always ask if anything has changed with (child's name). If it has they write it down in the care plan and share it with all the staff. I know (child's name) is well cared for here." There was an Multi- disciplinary Family 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 contact. Staff completed records of the care, treatment and support they provided to children and young people.

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. We concluded that staff were knowledgeable about the families they supported and how to ensure that good quality care was being provided at all times.

Children and young people's interests, activities and play needs were recorded and planned for. We saw children playing with staff from the sibling team. They were role playing and were encouraged to choose the activity that they wished to play. The child was joining in the activity with the sibling worker and was clearly enjoying this play. We saw another child access the large toy cupboard with staff support and chose what games they wanted to play.

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 told us their child enjoyed the jacuzzi and even though they were on a ventilator, with staff they had worked out how their child could access the jacuzzi safely. The parent told us staff listened to how they felt it could be managed and between them their child could now access the jacuzzi safely.

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. 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. A games room for older children/teenagers was available in the service. In addition 'sensory' weekends were held for those children and young people who had sensory needs.

Parents told us the service was responsive. One parent told us that her usual family support at home was not available for a specified time. She contacted the hospice and informed them of this. They then contacted her to say that they could provide additional support during this time which she accepted and was appreciative of their support The parent said "That's what they do, they help when they can."

Little Harbour works well with other professionals. For example, a parent told us their child is under the care of a London hospital pain team. Little Harbour were involved in making plans to return their care to a more local Consultant, so they did not have to travel.

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.

We spoke with staff and looked at records about the way Little Harbour 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. Staff told us how they had worked with schools to ensure that a sibling, who was staying at the service, did not miss out on the school curriculum. They also liaised with the school in how the child would be reintroduced to the school as there had been a gap in their attendance.

The service's complaints procedure provided children, young people and parents with information on how to make a complaint. The policy outlined the timescales within which complaints would be acknowledged, investigated and responded to. It also included contact details for the Care Quality Commission, the local social services department, the police and the ombudsman so children, young people and parents were able to take their grievance further if they wished.

We asked parents, if they would be comfortable making a complaint. They told us they would have no hesitation in raising issues with the registered manager or staff. One parent said "[the registered manager] would listen, respond and sort it out." No-one we spoke with had made a complaint and everyone said they would feel confident to approach the service's management or staff if they had any concerns.

Staff felt able to raise any concerns. They told us the management team were approachable and they would be able to express any concerns or views to them. Staff told us they had plenty of opportunity to raise any issues or make suggestions to improve the service further.

Good

Is the service well-led?

Our findings

The registered manager promoted a culture that was well led and was centred on meeting the needs of children, young people and their parents. Parents told us how they were involved in decisions about the care of their child and how the service was run. The management and running of the service was 'person centred' with parents, children and young people being consulted and involved at all levels of decision making.

Parents, children and young people made decisions about their activities and meal choices as well as having regular meetings with their named staff member. The provider actively supported staff to ensure care was 'person centred,' which meant care reflected the child and their parents preferences as well as their needs.

The registered manager commenced her post in June 2016 and was aware that changes were needed to the service. Some changes included promoting the service to people and professionals. For example, the registered manager attended health colleagues team meetings to inform them what services Little Harbour provided. Open days were held so that health and social care professionals could visit the service, and attend their team meetings, to gain insight into their work. The registered manager said "Networking is important, it's been a lot of hard work getting them (professionals) to understand what we are about. Paediatricians came to visit which has never happened before." Due to the promotion of the service the numbers of referrals to the service increased and the service is now better known in the health and social care and local community.

The service had staff vacancies and some staff were due to leave the service. The registered manager explained the challenges of recruiting staff to certain posts. The Children's Hospice South West policy on recruitment of staff was being reviewed as it had potential of limiting the staff that would apply for the posts at the service. For example the contracts specified staff members needed to work a minimum of 24 hours per week, the registered manager was liaising to change this to 18 hours. The registered manger was aware that a work, life balance was needed for staff and believed that offering fewer hours may increase the number of applications.

The registered manager was looking at innovative ways to recruit staff at the service. For example, with one staff member they had set up a partnership with the local hospital so that the person could do their post registration preceptorship nurse training at the hospice. The member of staff then divided their working week between the hospice and hospital. This demonstrated that the service was looking at innovative ways to recruit staff to the service.

The registered manager wanted to ensure that staff felt supported in all of their roles. A drive on training and ensuring that staff had support via supervision, team meetings and staff team building days had occurred.

Staff told us there had been lots of positive changes to the service. Comments included "I can feel it's changing, we've had some difficult times and it's a lovely place to work," and "Little Harbour is a wonderful

place to work because of the strength and solidarity of the management and team. The ethos of the organisation is exemplified by the fact that everyone from the housekeepers to the Head of Care, care passionately about the wellbeing of the children, their families and each other. But this isn't just blind wishful thinking, as with any organisation there are problems but it is the way these problems are dealt with at Little Harbour that matters, Little Harbour is responsive, not reactive and as such solutions are readily found to problems and an organisation can only be responsive if there is strong, knowledgeable management coupled with a diligent and hardworking team and that is what Little Harbour possesses."

There was a positive culture in the service, the management team provided strong leadership and led by example. All of the staff were highly motivated and keen to ensure the care needs of the families they were supporting were met. Every member of staff we spoke with was very open and proud of the service they provided. A student nurse told us, "Everyone has been so welcoming and supportive whilst also giving me so many learning opportunities. Little Harbour is truly a special place that I feel lucky to have spent time at Little Harbour."

Staff said they were supported by the managers and were aware of their responsibility to share any concerns about the families who used the service. Staff told us they were encouraged to make suggestions regarding how improvements could be made to the quality of care and support offered by the service. They did this through informal conversations with managers, regular formal supervision and staff team meetings. Staff told us the managers were "very supportive" and "I enjoy my job". Staff said they felt valued by the managers and they knew their personal circumstances and supported them in this aspect to.

There was a management structure in the service which provided clear lines of responsibility and accountability. The registered manager had overall responsibility for the service, supported by the provider. A nurse worked on each shift to provide support to the care staff. The Head of Quality and Compliance supported the registered manager and monitored the service. The service also received support from many departments such as finance, administration, Human Resources (HR), training and quality auditing to help with the running of the organisation and where they could access any advice or guidance. Staff attended conferences and seminars on a variety of health care topics so they were able to keep up to date on developments in the field.

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. Frequent discussions took place between the registered manager and staff about any issues that affected the running of the service.

The organisation sought the views of parents, children and young people and health and social care professionals in a questionnaire. Parents were invited to complete a questionnaire as were children and young people. The children's questionnaire was presented in a child friendly manner in that children could tick or draw a picture. No concerns were identified from children in the 16 questionnaires we reviewed. Likewise parent's questionnaires were positive about the service they received. The results of these were compiled in a report which identified what the service was doing well as well as areas for potential improvement.

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.

Staff told us they felt well supported and were listened to. There were debriefing 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 Harbour.

There was an open culture about reporting and investigating 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. Independent reviews from external professionals also fed into reviewing the quality of the service. For example, a contract was in place with the local hospital pharmacy department to provide a medicines audit service twice a year as part of a drive for quality improvement.

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, exit interviews for staff leaving the service, were being completed. Their findings could then be analysed and action taken to address any issues arisen from the feedback.

The registered manager and staff were committed to continuous improvement of the service by the use of its quality assurance processes and its support to staff in the provision of training. The registered manager told us they had started to develop an improvement plan for Little Harbour with measurable outcomes that could be reviewed on an on-going basis. The improvement plan was based on the results of feedback received and any shortfalls identified in the audits. For example, addressing staff retention and recruitment.