

Hope House Children's Hospices

Hope House Children's Hospice

Inspection report

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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Requires Improvement ●

Summary of findings

Overall summary

This inspection took place on 29 September 2016 and was unannounced. Further phone contact was made with children and young people using the hospices services and their parents on 4 and 6 October 2016.

Hope House Children's Hospice provides specialist nursing care for children and young people with life limiting conditions within the hospice and in their own homes. The provider has a 10 bedded in-patient unit that accepts admissions for terminal care, symptom control and respite stays. At the time of our inspection six children and young people were on the unit. The hospice also supports the families of the children and young people who use the service. Specialist care and support in the community was also provided by an outreach service.

The manager was registered with us as is required by law. 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.

Staff were trained in how to protect children and young people from abuse and harm. There were sufficient staff on duty to meet children and young people's needs in a timely manner. Recruitment processes were robust and the provider was as sure, as possible, that staff employed were suitable and safe to work with children and young people. Staff were knowledgeable about the specific risks children and young people needed to be protected from. Accidents and incidents were recorded and monitored to identify how the risks of reoccurrences could be reduced. Medicines were prescribed, recorded and administered in safe and appropriate ways. Children and young people received their medicines in a timely manner and in line with their needs.

Children, young people and their families were supported by a highly qualified and experienced staff team. The provider equipped staff with a variety of training that met the specific needs of the children and young people being cared for. Staff were supported to acquire additional training to maintain and enhance their knowledge and skills. New staff were provided with a comprehensive induction. Regular supervision and annual appraisal was available to support staff. Management and staff understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA). Staff supported children and young people to access nutrition that met their dietary needs, restrictions and appetite. Children and young people were supported to access all the support they needed in order to maintain their health and wellbeing.

Children and young people's right to privacy was fully protected and they were treated with dignity and respect. Positive relationships were developed at the hospice and staff were kind and compassionate. Children, young people and their families were involved in all aspects of decision making, from symptom and pain management to end of life care. Communication within the service was effective and children, young people and their families were fully informed of their options for care and treatment. Children and young people were involved in the planning of activities that met their individual needs and preferences. A

broad range of activities were available that included creative ways to keep children and young people occupied, engaged and stimulated.

Regular multi-disciplinary meetings were undertaken to review and respond accordingly to children and young peoples' changing needs. The provider worked closely with other professionals and agencies to develop the hospice services to meet diverse needs and improve the health and wellbeing of children, young people and parents. Clear information about the service, the facilities, and how to complain was made available to children and young people and visitors. Complaints received were fully investigated and responded to, with evidence of the provider using them as a learning opportunity in order to make improvements to the service. Peoples' feedback was actively sought, encouraged and acted upon.

Quality assurance systems were overall effective but some elements of the care records had not been audited for some time. When the need for improvement was identified, remedial action was taken to improve the quality of the service. Staff knew the leadership structure within the hospice and were fully involved in its development. Emphasis was placed on continuous improvement of the service, including developing clinical guidelines in line with best practice. A variety of regular clinical, governance and senior management and trustee meetings took place to share, scrutinise and review the service. The hospice supported its staff lead on projects that would benefit children, young people, and their families to improve the quality of the service they provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Medicines were overall managed effectively.

The provider ensured sufficient staff were on duty at all times to meet children and young people's needs safely.

Safe recruitment procedures were employed by the provider.

Is the service effective?

Good ●

The service was effective.

Staff were well trained, provided with a comprehensive induction and were supervised frequently to ensure their learning and development needs were identified and met.

Children and young people had their human and civil rights upheld.

Children and young people were supported to access the health care and specialist support they required.

Is the service caring?

Good ●

The service was caring.

Staff communicated effectively with children and young people and treated them with the kindness, compassion and respect.

Children, young people and their families were consulted about and fully involved in care planning and decision making.

Support in relation to emotional and psychological well-being was accessible to all.

Is the service responsive?

Good ●

The service was responsive.

Children and young people had their needs assessed in

partnership with them and their family where appropriate.

Staff delivered children and young peoples' care in a person-centred way, treating them as individuals.

Children, young people and families knew how to make a complaint and felt confident that any issues they raised would be dealt with effectively.

Is the service well-led?

The service was well-led.

The management team provided strong and effective leadership.

Staff were well supported, valued and included in decisions about how the service was run.

Emphasis was placed on continuous improvement of the service, including developing guidelines in line with best practice.

Audits of care records was lacking and had not been a feature of the provider's quality assurance processes for some time.

Requires Improvement 

Hope House Children's Hospice

Detailed findings

Background to this inspection

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

This inspection took place on 29 September 2016 and was unannounced. Further phone contact was made with children and young people using the hospices services and their parents on 4 and 6 October 2016.

The inspection was carried out by one inspector, a member of the CQC medicines team and a specialist advisor. The specialist advisor had the experience of working as a nurse within the field of palliative care.

Before our inspection we asked the provider to complete a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. The registered manager had submitted the information as we requested.

We reviewed the information we held about the service including notifications of incidents that the provider had sent us. Notifications are reports that the provider is required to send to us to inform us about incidents that have happened at the service, such as accidents or a serious injury.

We contacted commissioners from three local Clinical Commissioning Groups (CCG) who had commissioned the service to provide care to children and young people to ask for their views on the service. The CCG is responsible for buying local health services and checking that services are delivering the best possible care to meet the needs of people.

We spoke with three young people who used the services provided by the hospice, two parents, the chef, the

estates manager, a clinical practice facilitator, two coordinators, two lead nurses, a clinical nurse specialist, the registered manager, the chief executive, two social workers, the head of community services, the hospice team leader and seven other staff members.

We reviewed four young people's care records, to see how their support was planned and delivered. We spent time observing staff interacting with children and young people and their parents. We looked at other records related to children and young people's care and how the service operated. These included four medicine records, three staff recruitment records, a range of meeting minutes, quality assurance documents, clinical and environmental audits and records of complaints.

Is the service safe?

Our findings

Children and young people who used the hospice inpatient unit and in the community were complimentary about the support they received telling us they felt safe and well looked after. They said, "I have support from staff in a way that makes me feel safe", "I used to come here with my mother and brother but now I am older I come in on my own as they [staff] make me feel safe" and "I feel very safe here".

We found that the provider was committed to protecting children and young people from any potential risk of abuse or harm. Staff had received the necessary training and demonstrated a good understanding of the provider's safeguarding procedures. They were also aware of their responsibilities for protecting children and young people and the process they needed to follow if they suspected or witnessed abuse. This included liaising with the social work team to discuss and share any concerns they had. A member of the social work team told us, "We attend the weekly rapid review meetings and share safeguarding information there. We act as a lead and when an issue is identified to us we will run with it and work closely with the local authority where necessary". Staff told us that they were given feedback about abuse issues and updates either individually and/or in meetings.

Staff understood their right to share any concerns about the care at the hospice. The provider had a whistle blowing policy and staff were aware of this; they told us they would be confident enough to inform senior staff or management of any concerns they had.

We reviewed the provider's arrangements for managing accidents and incidents and minimising any risks of reoccurrence. Staff interviewed could describe the appropriate incident reporting procedures; they told us they received feedback about incidents including any resulting changes to practice. We found that all clinical incidents were investigated and the findings were shared with all levels of staff, to aid their learning and improve practice. The hospice coordinator told us they helped to review incidents that occurred and that they 'looked for patterns' and 'any learning was then applied'. For example there had been an increase in reported incidents in relation to behaviours displayed by children and young people who had an autistic spectrum disorder. This was a challenge for staff; so the provider organised autism training for staff to help them understand how best to manage and support children with this condition. We also saw that following a number of similar incidents relating to one child's behavioural needs during care provision. with autism, their needs had been reviewed and risk assessed when being supported by staff with moving and handling; a behaviour management care plan had been implemented and staffing increased to manage their care more effectively. This meant the provider fully investigated incidents and shared their findings and implemented any learning accordingly.

Regular checks of the safety of the environment were undertaken. There was a fire safety risk assessment in place with clear procedures in the event of an emergency evacuation. Staff we spoke with understood what the evacuation procedures were in the event of an emergency. Tests of the fire safety equipment were carried out regularly to make sure this was in good working order and fire exits were clearly sign posted. We saw that scheduled planned maintenance took place in a timely manner which included all servicing of equipment used on the hospice premises to ensure it was safe to use.

The provider had effective recruitment processes in place. Recruitment records we reviewed contained the appropriate identification documents, a full employment history, two references and a Disclosure and Barring Service (DBS) check. A DBS check helps employers make safer recruiting decisions and minimises the risk of unsuitable people being employed.

Children and young people had individual risk assessments undertaken in relation to the support they received. A parent told us, "They [staff] have such specialist knowledge and know how to manage all the risks to [young person's name]". Staff were knowledgeable about potential risks from children's and young peoples' health conditions. For example, they were able to describe how they used the equipment necessary to ensure children and young people received an adequate nutritional intake. Our observations demonstrated that staff were effective in assessing, managing and reducing any risks that children and young people may be exposed to.

Children and young people told us they were attended to quickly by staff and arrived on time to support them when in community. We observed that there were sufficient numbers of nursing and care staff on duty. We saw staff were available to attend to children and young peoples' needs in a timely manner. Staff spoken with said that staffing levels were 'good'. The needs of children and young people were considered in relation to levels of staff required or available on a daily basis by management to ensure their needs would be effectively met.

Children and young people told us that the support they received in relation to their medicines was effective. A GP visited the hospice daily to manage each individual child's healthcare and medicine requirements. A specialist pharmacist from the local hospital trust came in to check the prescriptions each week. A clear system for managing the ordering and supply of medicines including controlled drugs [CD] was in place. Controlled drugs are a group of medicines which are subject to strict legislative controls due to their potential for abuse and harm. Medicines that children and young people brought in to the service were used in addition to medicines prescribed by the GP. Medicines were checked when a child or young person was admitted to the service by a nurse and another member of care staff to ensure the medicines were accurate, current and suitable to use. There were no formal arrangements for obtaining medicines out of hours for a child or young person. A nurse told us that they have always had the medicine in stock or have been able to wait until the morning. The provider's policy in managing any urgent need for medicines out of hours was that the child or young person would be taken to the local hospital.

We checked the medicines prescribed on four prescription charts. There was clear recording of the children and young people's prescribed medicines including additional instructions for their safe administration. For example, where a child had to have the medicine administered through a tube in their stomach, the necessary information and safeguards were in place that told staff exactly how to prepare and administer each medicine safely. Prescribed medicines were kept in children and young people's rooms, in a locked cabinet. Only nurses and care staff had access to these medicine cupboards. Nurses gave children and young people their medicine when they needed it and not at set administration times. This meant the provider had a child or young person centred approach.

Daily temperature records were available which detailed the temperatures for the medicine refrigerator. However, we found that records for the last few months documented that the refrigerator temperatures were not within the recommended safe storage range for medicines. Staff said there were no records available to show any action taken to ensure refrigerated medicines were stored safely. This issue was raised with the registered manager and they took immediate remedial action to ensure all medicines were stored at their optimum. Medicines that were kept in stock were stored securely in locked cupboards in a locked treatment room. Only authorised staff had access to the treatment room. Medicines that require additional

controls because of their potential for abuse [controlled drugs] were stored securely and monitored according to safe practice. Staff had access to emergency medicines in the event of a severe allergic reaction.

Medicine incidents were reported and arrangements were in place to ensure they were investigated and an action plan was completed. This meant that lessons were learnt and the risk of incidents re-occurring was reduced. The hospice had recently implemented a competency checking system for all staff involved in medicines administration. This meant that they were able to see if staff were competent to give medicine safely and if there were any training requirements. We saw evidence that the training package around medicines management was being updated and improved.

Is the service effective?

Our findings

Children and young people were positive about the level of skills and knowledge that staff demonstrated when supporting them. They told us, "They [staff] are really skilled" and "I get really great care provided to me". Parents told us, "They [staff] are very well trained and look after [young person's name] really well" and "Their [staff] specialist knowledge is so good".

We saw the hospice closed except for end of life care for two weeks in January every year and for a further two days in the summer to ensure all staff received comprehensive annual mandatory and other clinical skills training. Clinical skills training included a variety of identified areas where staff felt they needed additional training or that met the specific needs of children or young people. For example, specific training in autism had been provided to staff due to an increased number of children or young people with autism who had been referred to the hospice service. A hospice coordinator we spoke with also described recent training staff had received in female genital mutilation, grooming, communication and sexual health. Staff told us, "You do get lots of opportunity for professional development", "We are lucky here as there are good training opportunities" and "We are always striving to improve our practice and get the support we need through training to do this". We saw the provider had developed 'in house' specialist clinical roles. These roles were in place to advise the wider team and lead on training in specialist areas of clinical practice for example pain management, epilepsy, tracheostomy, respiratory/ventilation, mouth care and nutrition.

The provider supported newly recruited staff by ensuring they undertook a comprehensive induction before they commenced fully in their role. We spoke with three care assistants who were currently on their induction programme. They told us they had been working at the hospice for six weeks and they had been on a detailed and comprehensive induction programme. This had involved shadowing and being supported by experienced members of the team on the shifts they had worked. They went on to tell us they had been on a number of study days, which had provided them with the training they needed to prepare them for their role. On the day of our inspection they were attending study sessions on the dying process, care of the body after death, communication with families and memory making which were provided by the clinical practice facilitator, who was in post to train and develop care assistants. The care assistants described the session as, "Brilliant", "Excellent" and "Very interesting".

Staff received regular support and supervision from a variety of sources. Staff described the ways in which they received support, telling us, "I get regular clinical, caseload and peer supervision", "I have never worked anywhere else where you get supported like you do here" and "We have clinical supervision, one to one every six to eight weeks where we reflect on different situations". One member of nursing staff told us they had received an annual appraisal and these meetings enabled them to identify the help and support they may need in relation to revalidating their nursing registration with the Nursing and Midwifery Council (NMC).

The Mental Capacity Act 2005 (MCA), which applies to people aged 16 and over, provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf

must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Staff demonstrated sufficient knowledge of the principles. For the majority of the children and young people who used the service their parents were their legal guardians. We noted in care records that parents had signed their consent to various aspects of their child's care, such as using the hydrotherapy pool. All staff had undertaken some training in the MCA and DoLS and the manager told us further training for all staff was in the training plan for 2017. The provider told us in their PIR that all staff received mental capacity act training on induction and annually, which we confirmed. We saw that the provider assessed a child or young person's level of understanding and capacity at their initial assessment and throughout their involvement with the hospice and/or its community service. A parent told us, "They [staff] are very careful and take the time necessary to ensure [young person's name] understands everything". We observed that consent was sought, obtained and recorded before any aspect of a child or young person's care and/or treatment was carried out. This meant that young people who lacked capacity to make their own decisions had their rights protected.

Children and young people gave us positive comments about the quality and choice of food and drinks available to them. They said, "The food is delicious" and "I like the food here". Parents told us they were offered and had access to food and drinks whenever they visited. Staff considered the child's/young person's specific nutritional and dietary needs, their likes and dislikes and eating habits when supporting them to eat and drink. Special diets were provided for children and young people who needed them and staff passed this information on to the chef. The chef kept records of each child's/young person's nutritional needs, preferences and any allergies to certain foods. Children and young people's nutritional needs were assessed and care plans were developed to reflect their individual needs. Where necessary the advice of the speech and language therapy service was sought by staff in regard to how to support each child or young person with their nutrition appropriately.

We saw lunch being served in the dining room where children and young people, staff and visitors were seen sitting and eating together. Children and young people were escorted to the dining room for social interaction, even if they received their nutrition through a tube in their stomach and were not able to eat. One young person who received their nutrition in such a way told us staff would give them a 'taste of chocolate' in their mouth which they 'loved'. Lunchtime had a homely friendly feel with choices of food for those who did not like the food on the menu for the day. One of the young people requested fish fingers for lunch as they required a soft diet, which were provided. The chef described how specialist diets were prepared freshly at the hospice each day, such as pureed food, which was separated and moulded to improve the child or young person's experience of eating. We observed a child eating a pureed soft diet and their food was clearly separated into meat, potatoes and vegetables, which made it look more appetising. The provider told us in their PIR that a 'dietary needs group' attended by both care and hospitality staff met three times per year to review how they were meeting the nutritional needs of those requiring special diets. We saw that these meetings were also used as an opportunity to identify any training needs of staff and to review individual care plans. This meant that children and young people had all aspects of their nutritional needs considered, reviewed and catered for in order to stimulate their appetite and optimise their food intake.

The provider employed a range of healthcare professionals who supported the health and well-being of children and young people. Parents were positive about the support provided to their children, one told us, "They [staff] accessed the help we needed from the hospital and liaised with the doctors for us". Two local GP's provided medical cover to the hospice, including daily visits from Monday to Friday. Out of hours cover

came from the GP on call service 'Shrop Doc'. Additional on call cover for end of life care was provided by the senior GP medical lead. The variety of health care professionals employed by the provider enabled children and young peoples' health and wellbeing to be responded to effectively when their needs changed, for example through a specialist nurse or counsellor. We saw children and young people were also referred to external healthcare professionals when necessary. On the day of our inspection we saw there was a good skill mix of nurses and care assistants on duty to help in making sure children and young people's health needs were effectively met. We saw one young person having their wound dressing changed whilst on a short break.

Is the service caring?

Our findings

Feedback we received and our observations demonstrated to us that staff developed caring relationships with children, young people and their families. Comments we received included, "The staff are brilliant, so kind and thoughtful", "They [staff] are so kind" and "I like the staff and I get good care". We saw staff were very caring and compassionate towards children and young people, ensuring they were content, comfortable and having fun wherever possible. Staff showed genuine concern and responded quickly when a child or young person was unsettled or upset.

We observe that overall staff were kind and caring and compassionate in their dealings and communication with the children and young people at the hospice. However we witnessed one incident in the dining room where a young person was not engaged appropriately by a staff member whilst being supported to have their lunch. The approach of the staff member did not demonstrate caring. We shared our concerns with the registered manager who after our inspection investigated the incident and provided us with their findings. This included the learning and changes made to the young person's care plan to be adopted by staff as a result of their investigation. This demonstrated that as a result of our observations the provider had investigated, taken action and used this as an opportunity to learn and improve.

The provider told us the PIR they sent to us that all care staff received training on meeting the diverse needs of children, young people and families that included disability, race, religion/beliefs, gender and sexuality. This confirmed what children, young people and their parents told us. One young person said, "Everything they [staff] do is age appropriate, they don't treat us all like kids". The environment was equipped to meet the needs of the different age groups served. For example with activity/hobby rooms which contained a range of toys and specialist non touch IT equipment. Additionally, there was a well-equipped sensory room which could be set up flexibly for the use of different age groups.

The provider encouraged young people to participate in the 'Young Adult Group [YAG]' which promoted their involvement in future service design. For example following recent feedback from YAG an upgrade of the Wi-Fi had been completed. In addition, plans to fully refurbish the young adult lounge to include facilities that support greater independence including a kitchenette and improved technology/entertainment systems were in place. We saw the provider had invited representatives from the group to make a presentation to the board of trustees where they explained how the hospice met their needs and also to ask what could be improved. This demonstrated that the provider was keen to listen to and make changes to meet the age specific and individual needs of the children and young people using the hospice services. We saw there were wide corridors and spacious rooms providing good wheelchair access around the hospice and beautifully maintained gardens and play areas.

Young adults and families we spoke with confirmed that they were involved in making decisions about the care and support that they or their child received. A young person told us, "I am part of the YAG and we have been asked to look at how care plans can be improved to make sure we [children and young people] are fully involved in care planning". This meant that the provider encouraged young people to be involved in planning and making decisions about their care. An area was accessible within the hospice that contained a

range of items to support children, young people and their families' cultural, spiritual and religious needs and preferences.

Positive relationships were developed at the hospice where children and young people could retain routines with those who were important to them. We saw that families were able to access the hospice without restriction and visit or stay with their children. Facilities were provided for the families of children and young people using the service to stay nearby in designated self-contained rooms. This meant that children and young people could retain and find comfort in routines with their loved ones.

The environment was furnished and equipped sensitively to meet the needs of children and young people with disabilities or complex care needs and their families. For example with access to a hydrotherapy pool, tracking hoists in all rooms, piped oxygen in bedrooms and other key areas. The use of sensory equipment in many areas of the hospice supported children and young people to reduce any discomfort, distract them and/or support their ability to relax, for example by using lights, bubbles and music in bathrooms or in the pool. A young person said, "I like the bath and the water jets. I have music on too". A staff member said, "I have the opportunity to provide one to one care, being able to get time to spend with the child and family and this enables me to develop a strong relationship with them".

Children and young people told us they felt fully involved in planning all aspects of their current and future care needs. They told us they were involved in all discussions about their care and treatment and were able to express their views, preferences and wishes in this regard. They described how they had been supported to make decisions about their care, including their wishes in relation to end of life care. A parent told us, "They [staff] set up a series of appointments to discuss [young person's name] end of life care. [Young person's name] wanted to do it and trusts them [staff]. If they asked questions, they [staff] answer them honestly". Records we reviewed contained a document called 'wishes' which detailed the care children and young people wanted at the end of their life.

The hospice was furnished and equipped to support the delivery of end of life care. This included a purpose built bereavement suite with 'chilled bedroom' where children could lie in rest until their funeral, with private access for funeral directors. The family accommodation available was also accessible without going through the main hospice. A private garden and sitting room for the specific use of bereaved families was situated next to the chilled bedroom. A chilled cuddle blanket was available to enable families to cuddle their babies after they died. Items for memory making, such as making hand and footprints were available for families to use.

The hospice had a homely feel and we saw that it was a social atmosphere where children and young people were encouraged to chat if they wished, and were listened to. A parent told us, "[Child's name] loves it at the hospice; he goes for respite and has outreach [community services] support too. He uses the pool and music room or computer. They [staff] do listen and have found the best ways of communicating with [child's name]". Another parent told us, "The written and verbal communication we get from the hospice is really good". We saw that staff were smiling and engaging when they stopped to listen to children and young people and responded to them with interest. We observed staff approached children and young people in a caring manner, demonstrating calmness in their approach and followed their pace of communication when they conversed with them. Friendly and appropriately humorous interactions between children, young people and staff were witnessed.

There was spiritual support for children, young people, their families and friends at the hospice. A parent told us, "The emotional support and counselling has always been available to me and it has been a comfort to know it was there if I needed it, which more recently I have". Both pre and post bereavement counselling

was also available to families known to the hospice and also those unconnected who had lost a child in any circumstances. The on-going support for families following a child's death was for as long as families wanted. Children and young people could also be offered counselling if they had been bereaved of someone close through sudden death or trauma.

We observed that personal care was offered discreetly. Staff showed a good understanding of the balance between maintaining children and young people's privacy whilst also acknowledging the need to monitor their complex health needs. They gave us examples of how they considered privacy and dignity issues when providing support, such as closing doors and curtains. Young people and their parents confirmed they had their independence maintained in the way their care was provided.

Children and young people had access to advocacy support if it was needed. For those children and young people who did not have a family member or representative who was appropriate to support them to make decisions, staff knew how to access advocacy support.

Is the service responsive?

Our findings

Young people and children's parents told us they felt the service was responsive to their needs and wishes. They told us, "It's a fabulous place, if there is something that isn't quite right they listen, act and make sure it's put right" and "It [the hospice] meets our needs and they [staff] go above and beyond to make sure we get what we need".

When we looked at children and young people's care plans we saw they reflected their individual needs and wishes. They contained information about areas such as personal care needs, mobility and any support needed with nutrition. They had more specific plans in place reflecting their physical and mental health needs as well as their diagnosis. However we found that the care records for each child or young person had more than one folder, for example one young person had four separate folders containing important information about their care and treatment. We found the care records were not uniform and the folders were not in a good state of repair, with potential for paperwork to fall out or be mislaid. Others care plans and risk assessments we found in the files were out of date or no longer appropriate but they had not been removed from the care files, which could lead to confusion or misunderstanding. The registered manager told us that there had not been an audit of care records since 2014. She said the hospice had begun work to review and update records as they recognised that they needed to be reviewed and improved. Staff we spoke with were clear about the current needs of children and young people. However, this meant that staff less familiar with a young person or child's needs may not have a clear record of their current needs to reference, to ensure each child or young person was provided with consistent care and treatment which effectively responded to and met their current needs..

Young people and their parents told us their care and support needs were assessed and their care was planned in partnership with them and where appropriate their family. We observed staff provided personalised care, including engaging children in activities they enjoyed, whilst giving consideration to their level of ability. A young person told us, "I like coming here; we go out and about to the park, shopping and bowling". Another young person told us, "I like being in the hobbies room" and went on to tell us they had been involved in activities in the hobby room and made a cake to take home for their family. We saw the hospice was well equipped with a variety of activities and play items that were suited to children and young people of all ages. We saw that children's abilities in relation to communication and physical limitations had been thoughtfully catered for in the activities on offer, for example air wands and touch screens for using computer equipment. The needs of children and young people who were restricted to receiving their care in a reclined position had been considered through the use of sensory items that were located on ceilings and high up on walls to provide additional sensory stimulation.

Parents told us they received support, specialist advice and care they needed for their child. One young person told us, "The transition nurse helped me get my wheelchair sorted out". A parent told us, "The social worker has been great and has helped us to sort a lot of things out" and "The transition nurse helped us to find a college, they actually took us around to see them to make sure we got the right one". The provider employed a Transition Nurse [TN] who was a clinical nurse specialist. The TN supported young people from the age of fourteen upwards clinically, emotionally and socially as they moved between health and social

care services that were child-centred to adult orientated. Young people we spoke with and parents spoke highly of the specialist knowledge and support they had received from the TN. A Neonatal Link Nurse (NLN) was also employed by the provider and had been the driving force in developing effective links with local hospitals and services in promoting the hospices antenatal and neonatal service. The service was available to families who had a baby born from 24 weeks of pregnancy who has a life threatening condition or who had sadly died. They also offered support to families who had received a life limiting prognosis for their baby during the ante-natal period. The NLN worked closely with the neonatal and midwifery units within the catchment areas of both Hope House and their sister hospice in Wales.

The hospice used Patient Group Directions [PGD] that allowed the nurses to administer certain medicines safely without a prescription. A PGD is a direction to a nurse to supply and/or administer Prescription Only Medicines (POMs) using their own assessment of the individual's needs, without necessarily referring back to a doctor for an individual prescription; these directions are agreed and signed by a doctor and agreed by a pharmacist. This meant that medicines could be provided to children and young people as they required them and without delay following an assessment of their health needs by nursing staff.

Communication within the hospice was effective in ensuring that changes to children and young people's needs were responded to in a timely manner. A 'rapid review' meeting took place each week which was attended by lead staff and management to discuss and record the progress of children and young people being cared for, both at the hospice and by the outreach service. Required staffing levels were also considered to ensure the needs of those admitted would be effectively met. We saw evidence of good integrated multi agency working including liaison with external service providers and agencies. For example, we observed a wound dressing being performed where the care plan in place detailed the wound care required and had been developed with input from a Tissue Viability Nurse [TVN] specialist regarding dressing techniques. Liaison with the local infection control team with regard to wound swabs being taken was also apparent.

Children and young people told us how they had been supported by staff to reduce any social isolation they may experience due to their condition through accessing community based support services and facilities. A young person told us, "I am involved in the young adults group, where I meet with others my age who use the hospice. They [the provider] organise young adults weekends too which are good fun". The outreach service supported children and young people to access local leisure facilities to maximise their involvement in the local community.

All the young people and parents we spoke with said they had information about how to make a complaint, comment or suggestion. A young person told us, "I have not needed to complain but I know ways I could if I wanted to". A parent said, "I raised a concern and this was dealt with really well, they do listen. I was pleased with the outcome". We observed that there was an open, inclusive and a listening culture among all staff who worked at the hospice. Staff we spoke with were aware of the ways in which children and young people could make comments, raise concerns, and complaints and described to us how they would support them to do so. Staff said every complaint was taken seriously and dealt with as quickly as possible. A staff member said, "We are always striving to improve our service and that sometimes comes from learning from complaints that are made".

The provider told us in their PIR they sent to us that positive feedback had been received regarding complaints handling. We saw a variety of mechanisms were in place to seek feedback from children, young people and parents where they were either identifiable or anonymous if they so wished. These included a suggestion box and a comments book within the parents lounge. We saw feedback from children, young people and parents was responded to, for example, the registered manager told us a family had provided

feedback about the bed in the family room being too small, so this had been replaced with a larger sized bed.

We found that all complaints were recorded and investigated and responded to by the appropriate departmental head and records were well maintained. The registered manager told us complaints were investigated, the outcomes were discussed at governance meetings, shared with the trustees and senior managers duly informed staff of the outcomes and any lessons learnt. Complaints we reviewed had been addressed in line with the providers own complaints policy. Learning and changes to practice that were identified were actioned as necessary following the investigation of a complaint. For example following the review of a complaint the communication between staff at handover was flagged up as an issue. The registered manager researched a number of approaches to handover and this was discussed with the team. They identified a new approach to adopt around communicating and sharing information at handover meetings. Training had taken place and the new handover process was now being trialled, with a plan to audit its effectiveness later on in the year. □

Is the service well-led?

Our findings

Children and young people told us their experience of the service was 'great' and 'really good'. Parents spoke positively about the service they had received from the staff for their child. They told us, "The service is spot on, there really is nothing else like it" and "It's a fabulous place and they [staff] have been very good to us". Staff we met and spoke with were clearly passionate about their work, telling us, "It's what nursing is all about, true holistic care", "I am really proud of the work we do here, I really believe in it", "It was because of working here that I went on to train as a nurse" and "I can't imagine not working at the hospice, it is in my heart".

The registered manager was aware of their responsibilities for reporting any significant events that affected the service to the Care Quality Commission. We found that the appropriate reporting of any concerns or allegations to the relevant external authorities had been actioned when required. Prior to our inspection we requested information in the form of the Provider Information Return (PIR); this was fully completed and returned to us in a timely manner.

There were systems in place to regularly check and monitor the quality and safety of the service. We saw there was a program of in-house audits such as medicines, infection control, environment, incidents and complaints. We found that management were responsive when issues occurred for example, the registered manager was informed of incidents as they happened and we saw action was taken to minimise the risks of reoccurrence. We also saw completed audits for general medicines and for controlled drugs, with action plans which had been developed as a result and evidence of changes implemented in practice because of the audit findings. However the issues we describe in relation to care records and appropriate refrigeration in relation to medicines had not been identified and/or remedied in a timely manner as a result of the provider's quality assurance systems.

There was an effective leadership team that oversaw the running of the service. There was a registered manager in post and they had relevant experience and expertise to lead the service. We asked young people what they thought of the way the hospice was managed, they said, "It's all very well managed and organised" and "It's well run". Parents told us, "I think it's brilliantly run, the managers are very involved" and "It is great and very well led". All the staff we spoke with told us they had confidence in the way the service was managed. We found the management team demonstrated a strong commitment to provide a safe, high quality and caring service and to continually improve, extend and develop the service to reach as many children, young people and families as possible. For example ensuring young people moving into adult services received the support and specialist advice they needed by the introduction of a Transition Nurse.

Staff praised the leadership team for their approach and consistent, effective support. They told us that they received feedback from managers in a constructive and motivating way. Their comments included, "The managers are very supportive and do a good job" and "They [management] have an open door policy, everyone is very approachable. You can talk to anybody". We saw that managers were visible and that they were known to and approached readily by staff and young people alike. Staff told us they felt informed and were consulted about plans for development of the service. The provider used a number of mechanisms to

ensure staff were kept up to date and able to give their comments and opinions about the hospices future. These included updates through emails, attendance at regular department meetings and surveys. There was a positive and inclusive culture at the hospice. We saw that staff were made aware of the hospice's values and their responsibilities within their role through their induction programme, supervision and ongoing training.

The provider stated in their PIR that they sent to us that representatives from the hospice were active on a number of external groups and panels, for example the local Safeguarding Children's Board and MCA and DoLS operational group. Staff told us how they worked closely with other organisations to ensure that local and national best practice standards were adopted and embedded in their and others service provision. For example, a social worker from the hospice was a member of a local safeguarding committee and the neonatal specialist nurse supported staff from the local hospitals in the care of neonates who had palliative or end of life care needs. This meant that the provider was keen to promote innovative best practice and share their combined knowledge to benefit the local community.

The provider told us in the PIR they sent to us that clinical governance committee which included representatives from the board of trustees and senior clinical staff reviewed all incidents, complaints, audits and surveys and actively monitored any action plans. We were able to confirm during our inspection that these meetings were effective in relation to the provider maintaining an oversight of service provision.

We saw that the provider had developed guidance for staff follow for core areas of care such as tube feeding, pressure ulcer prevention and intermittent catheterisation. Clinical procedures had a comprehensive reference list to show the evidence base used in their development. A clinical guidelines panel met to review guidance documents and these were distributed amongst specific members of staff for update when required. A clinical nurse specialist told us, "We use various sources of evidence to support best practice". They went on to give examples including the work the hospice had done on blended diets, which was part of a research project led by Coventry University and 'Blended Diets UK.' The resulting publication had led to changes at the hospice in preparing blended food for children who received their nutrition via a tube into their stomach. The kitchen and staff team had received training in blended diets which meant they were able to provide regular food blended to a consistency instead of formula feeds for some children.

The provider was asked by us to complete a Provider Information Return (PIR) prior to our inspection visit. The provider had completed and returned this to us within the timescales we gave them. We used the information provided in the PIR to form part of our planning and where the provider had informed us of their plans for improving the delivery of the service, we found evidence of this.