

East Anglia's Childrens Hospices

The Treehouse

Inspection report

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Ratings

Overall rating for this service

Good 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Outstanding 

Is the service responsive?

Good 

Is the service well-led?

Good 

Overall summary

This unannounced inspection took place on 25 and 29 June 2015.

The hospice services for end of life support to children, young people and their families are based both in the community and at the hospice building. The hospice is a six bedded unit, over one floor with level access throughout. This service had appropriate facilities to meet the people's needs that used it. Ceiling track hoists were available throughout the building where personal care would be needed. There was also a suite containing family accommodation adjacent to a child's bedroom for use by end of life care/bereavement support. There was a

multi-sensory room, music therapy room, a large wooded area that was used for events and to enable the children to play outside and a hydrotherapy pool (out of use at the present time).

The newly appointed manager was awaiting the outcome of his application to become a registered manager with the commission. He has since been confirmed as registered with the CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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.

People said this was a valuable resource that they had trust and confidence in to support them and their family. Everyone said staff were kind, caring and compassionate. People had confidence in the staff's ability to respond to need. There were sufficient staff that were well trained and supported in their roles. These staff ensured children and young people were safe when using the service. Risk assessments were completed to keep people as safe as they could be and medicines were administered as prescribed.

Families were included in all aspects of assessment; planning and children were listened to with consent and choice being sought. Families described the support they received as being very child focussed and they valued the range of services, such as short breaks, bereavement support, siblings groups, specialist play, music therapy and counselling.

There was good leadership and management of the service which resulted in children's care meeting their needs and the needs of the family. The organisations values were known by staff and embedded in practice.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

We saw examples of good practice to show children's safety was importance.

Excellent staffing levels and individual risk management ensured children were safe at all times.

There were thorough procedures in place to minimise the risk of infection, to manage children's medication and to ensure children were safeguarded.

Good



Is the service effective?

The service was effective.

Staff were skilled in their roles and well supported to develop knowledge to meet the needs of the children.

Care planning and delivery was firmly focused on each child's needs and the needs of their family.

There was an emphasis on ensuring children had high quality, meaningful experiences when using the service.

Good



Is the service caring?

The service was caring.

Staff were passionate and committed to their roles and the service was family-orientated with good emotional support in place for children and their families.

Families praised staff highly for their warmth, positive welcome and their willingness to listen.

Outstanding



Is the service responsive?

The service was responsive.

Staff were knowledgeable about children and families' needs and had children had personalised assessments and plans in place that were regularly updated.

Systems were in place to obtain families feedback. Managers used these to learn and improve the service on offer.

Good



Is the service well-led?

The service was well-led.

There was good leadership developing. There was a culture of open and transparent communication with shared values.

There was responsibility and accountability within the organisation with robust auditing and monitoring of the quality of the service.

Good



The Treehouse

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 25 and 29 June 2015 and was unannounced.

The inspection team consisted of two inspectors, a specialist professional advisor in children's palliative care and a pharmacist who looked at medicines.

Before the inspection we reviewed information we held about the service. This included statutory notifications sent

to us by the provider. Statutory notifications are events that the provider must legally tell us about. After the inspection we spoke with three external healthcare professionals who have links with the service to seek their views of how the service was operating.

We used a number of different methods to help us understand the experiences of people who use the service. We spoke with five families of children who used the service, nine members of staff and the registered manager. We spent time observing care and support for children.

We looked at three children's care records and other documentation relating to the management of the hospice service, such as six administration of medicines charts, policies and procedures, training records and staff recruitment and training files.

Is the service safe?

Our findings

Feedback from families described the experience of the hospice service as being safe for their children. One parent said, "It is immaculately clean. There are no germs to be caught or dust to be seen".

We spoke with eight staff about how they safeguarded children from harm. Staff could tell inspectors what procedure they would follow if they had concerns about a child. 'Body maps' were completed on admission detailing any marks on a child's body and this was updated during their stay if needed. Staff were able to give a recent example of when a child had unexplained bruising. We were confident they dealt with the matter appropriately as they involved medical professionals, sought appropriate consent and parents were involved and knew about the enquiries being made. Records were extremely detailed and no assumptions were made. Staff acted appropriately to ensure the child received the care and support they required with their health matter as opposed to a safeguarding concern.

We noted that the quality of the records on a shared computer system demonstrated effective information sharing between school staff, healthcare professionals at the acute trust as well as in the community. This demonstrated how the mechanisms were in place for good information sharing that would support good safeguarding practice.

There were systems in place to ensure children were safeguarded from abuse. These systems were supported by all staff, including volunteers, maintenance, housekeeping, catering and trustees all attend annual safeguarding children training to keep their knowledge up to date. Every member of staff we spoke with, including housekeeping staff, confirmed that they had safeguarding children training. They described the signs that may indicate that a child was at risk, whether at the hospice or at home, and were aware of the accurate reporting procedure. All were confident that any concerns they raised with their line manager regarding a safeguarding matter would be taken seriously and dealt with effectively.

Potential risks were well managed. It was evident that great care had been taken to ensure children's safety. The environment was child friendly with floor surfaces being appropriate indoors and outside. One parent told us that

their child's needs could change rapidly between visits and staff went through these changes each time they visited to ensure they had the most up to date information and minimise risks.

Children's bedrooms were of a sufficient size and there was a variety of different beds and chairs to suit all needs, as well as fully adaptive bathrooms. Staff explained how a safety check was carried out in each room before a child used the facilities. All plug sockets were midway up the wall and accessible to children. Not all of these sockets had protective safety covers on the day of our visit. Similarly not all alarm cords pulls were tied up out of the way when a potential risk was identified. This was brought to the attention of staff and they immediately rectified and agreed to add to the safety checks made.

Risk assessments within the child's notes provided a robust overview of the vulnerabilities of the child and how risks associated with the provision of care could be mitigated. Risk assessments include: hydrotherapy, moving and handling, travelling in minibuses and cars, nutrition, use of equipment.

The hospice had a moving and handling trainer who carried out training on site so that it could be done as soon as new staff started. It was personalised to individual children. The hospice had occupational therapists and they were involved as part of the child's initial assessment so that they could make sure that all staff have had the training before the child arrived. Staff and nurses we spoke with confirmed that this took place and that they were prepared for children before they arrived.

One parent we spoke with said that they had trust and confidence in the staff at the hospice. All of the care and nursing staff we spoke with said that the staffing levels in the hospice were worked out based on the children who were going to be staying/spending the day there. Rosters were devised by working closely with the booking team so that staff with the correct skill and gender mix were on duty. All of the staff confirmed that they always had plenty of staff to provide the care that the children needed. They said that there were rarely more than three or four children at the hospice at any one time. If a child was at the end of their life then the staff always had time to support them and their family on a one to one basis for as long as was

Is the service safe?

needed. This was confirmed by one family we spoke with who felt the time they were given when their child died was just right. Staff were present, supportive and there for them, taking the lead from the family at the time.

Each shift was led by a qualified nurse who had access to clinical nurse specialists both in office hours and on call out of hours. Play staff were present in the hospice every day and at weekends. Staff stated that there were always senior nurses around to support staff if they ran into difficulty with new equipment, or if they needed assistance with a child. This showed that children's potential changing needs were met.

As well as the hospice building and team the service had a 'well being team', that consisted of music, art, play staff, activities co-ordinator, spiritual advisor, chaplain and counsellors. They deliver support on a one to one basis that was identified during assessment of the child or during a review. People's experience of this was positive and they told us there were sufficient staff who were suitably qualified to deliver this work either in the hospice or in people's own homes.

The most recently appointed member of staff told us that the recruitment process was thorough, that this included references including most recent employer, checks on identity and criminal records checked. We examined the recruitment files for the five most recently appointed care staff and nurses and the files for two volunteers. They contained the necessary checks required by law. However one person did not have two references as per the services own recruitment procedure.

Parents we spoke with were confident that medicines were appropriately managed and given to their children as prescribed. One parent in an end of life situation said that the hospice prepared them well and supplied all the medicines they required at that given time. Another parent said that the hospice were very careful to get medicines right. They ensured that medicines were in their original packages, when arriving from home, so nursing staff could administer as per the prescription. They told us that they were confident that nurses knew about 'tube feeding' and the correct way and amount for 'flushing the tubes with water'.

Medicines were safely managed. All nursing and care staff completed training on medicines administration, and their competency was checked. We saw that for care staff who administered medicines, the appropriate delegation of authority document was in place. Staff told us that having senior care assistants as well as registered nurses trained to administer medication meant that a child or young person could be given their medicine by whoever was caring for them, whether in the hospice or at home.

A comprehensive medicines policy, approved by the Pharmacy Strategy Group, and a range of standard operating procedures covering all aspects of medicines management were in place. There were arrangements with a local GP practice and a hospital medicines information service to deal with any medication queries. We also saw that where it was unclear how a medicine should be given, (as medicine came from home) there was a process for resolving the discrepancy.

There was a process in place to check and record all medicines brought in by families as they arrived, and returned to them when they left. We noted that it was the hospice's policy for new entries on Medicines Administration Records (MARs) to be signed by the registered nurse making the entry. It would be good practice for new records to be checked and countersigned by a second person.

For medicines to be given when needed, for example in the event of a seizure, we saw a description in the care plan to support staff to administer the medicine as prescribed. The hospice had a range of over-the-counter medicines available, and we saw that families, or young people themselves if able, were involved in deciding which of these medicines should be given if needed during their stay.

Medicines were stored safely. There were no controlled drugs on the premises at the time of our visit but we saw that facilities were available for secure storage and record keeping.

Is the service effective?

Our findings

We found that children's care was provided by a staff team that were appropriately trained and supported. There was regular and robust specialist training offered to staff. The clinical educators provided training for specialist clinical equipment such as ventilation and intravenous equipment. Appropriate professionals and outside bodies such as occupational therapists and school were used and consulted in training staff. An example being that one staff member had recently spent some time in school to see how a particular child communicated and the aids that they use to do this.

There was a formal competency assessment process in place for all care and nursing staff. Where a member of staff failed to reach the required standard during a competency assessment further training was provided. The member of staff was reassessed after the training to ensure the training had been effective and they were now reaching the standard. The competency assessments covered clinical skills (even for care staff) and within each competency they also covered issues such as privacy, dignity and confidentiality. It also covered the children's spiritual and cultural needs and record keeping and infection control. We found this approach to be comprehensive and led by children's needs.

A new staff member had recently completed the induction and had felt that it was thorough and gave the skills for the role. The first two weeks were more classroom based training and then the rest of the six months was a mix of working in the hospice, on the job training, competency assessments and formal training. They said "I have definitely had great training and supervision."

All staff expressed they received extensive training and supervision.

Supervision was carried out every six to eight weeks. There was a different focus at each session. This included care provided to the children, end of life care, safeguarding, assessment of competencies, as well as an annual appraisal. This gave structure to the process to ensure all areas were covered and people were prepared. Staff said that they felt that they were able to discuss their roles, their

feelings about working with the children, the specific needs of children and their training needs. They all said that they felt very well supported and that they could discuss issues with any of the line managers at any time.

Parents we spoke with were clear that the service was child focussed and that staff were engaging with the child first and foremost to understand their needs. A parent explained how staff knew their child so well that they could read their non verbal communication to understand consent to care and treatment. The nurses and the member of care staff we spoke with were clear about explicit and implied consent. They were aware of the legal responsibilities of families regarding consent and when a child may be able to legally make their own decisions about care and treatment.

We found that issues of consent were covered within the induction training. This covered Mental Capacity Act and the Deprivation of Liberty Safeguards. There were updates for all care and nursing staff.

In care plans we found consent had been obtained from carers for permissions for photography, and activities. These were reviewed annually and a parental signature obtained.

One parent told us of the positive experience they had with food. "My child had specific intolerances of food and the chef went out of their way to make exactly what was needed. Nothing is too much trouble and my child felt very included in the meal times" This parent found that staff did not make assumptions and were not afraid to ask about very specific elements of their child's diet. Other people we spoke with said that choices of food were based around a child's likes and dislikes of food and that the mealtimes were made special.

We spoke with the lead chef who provided meals for children, families, staff and volunteers. They said that the care and nursing staff told them about each child's dietary needs and preferences but that they also had access to look them up on the computerised care plan system. They felt that the system was effective so that catering staff had the knowledge they needed to ensure that dietary needs were met and that the children could have things that they liked to eat and drink. If a new child came with a dietary

Is the service effective?

need they didn't know about they would refer to the nurses and parents or talk to the other chefs or look it up online to make sure that they were giving the child appropriate food and drink.

Staff had access to the kitchen and store cupboards so even when the chef was not there they could get whatever food and drink they needed for the children. Staff ate with the children but if a child needed support then they got that first before the staff had their meals. We saw that the mealtime experience was positive. However, we saw that staff providing support to children during the meal were interrupted by other staff which meant they were distracted away from supporting that child.

One parent described how they liked the detailed information sheet they received following their child's stay. Their child had no verbal communication and therefore they could not ask them how their stay was. The information supplied gave them confidence that staff had supported their child's healthcare needs appropriately during their stay.

The Treehouse used a system called Paediatric Early Warning Score to identify if a child's health was deteriorating. If there is an increased score from a selection of routine observations e.g. pulse, respiratory rate, respiratory distress, and conscious level, nurses would respond appropriately. This may mean reviewing care, contact the local GP who will attend the child or calling emergency services through 999. There were clinical nurse specialists in the hospice in office hours

to provide support to staff, and one was available on an on-call basis out of office hours. Individual queries about the child's medication could be made through the computer system used at the service.

In an emergency, the child would be transferred to hospital, but if this happened at night when there are only two staff on duty, the child may attend hospital accompanied by the attending paramedic. Parents were aware that during their child's stay they needed to supply an emergency contact for unforeseen events. All children and young people had a detailed care plan indicating actions to be taken in the event that they required resuscitation. However, these forms were in the process of being changed as the present ones were not entirely clear. The system assumes full resuscitation for all children unless there is a care plan in place, authorised by appropriate people, that indicates in detail the measures that are/are not to be taken.

In reviewing records we saw a detailed care plan about pain control for one young person. It described how the child exhibited non-verbal signs of pain and what needed to be done to alleviate it, for example, position changes and distraction therapy. Evaluation notes demonstrated clearly how staff had detected that the child was in pain during their stay and also what measures they had taken to ensure the child was made comfortable and free from pain.

We spoke to external medical professionals about their experiences of this service. They told us that The Treehouse offers comprehensive emotional support to families. The service had good staffing ratios and they were able to follow clear guidelines that had been set by a multidisciplinary team when meeting the needs of children with complex needs.



Is the service caring?

Our findings

We spoke with a parent who has used the hospice. They said, "It is the most amazing place. My tragic experience was made as positive as it could have been". They described to us the kindness and compassion shown by staff when using the end of life suite and the time and consideration given by all staff. They explained how plans had been put in place and options given to them to be as prepared as they could be. They described how they have used the additional services since their child had died and had found the sibling days, one to one and spiritual support invaluable for them and their family. We saw superb accommodation within the hospice that was designed for the use of families and offered excellent facilities; this had private and sensitive independent access including access to outside space. This gave people the space they needed when dealing with difficult situations.

A parent described staff as, "Lovely, smiling, waving - always happy to say hello and talk to me and my child". We observed caring interactions between staff and children demonstrating that staff knew the children they were caring for. The children concerned did not use verbal communication. Staff all lowered themselves to the child's level and spoke gently and clearly, maintaining eye contact. Staff were friendly, using the child's name and keeping up conversation despite the non-verbal response, explaining what they were doing and involving the child in what was happening around them. For example, a child arrived who had not had any lunch. The staff member immediately took them to the dining room, talking to them all the time, explaining that they were going to have lunch and what activities they would do afterwards. The child listened intently, responding with smiles. When the staff member asked if they would like their favourite sandwich for lunch, the child again responded with a huge smile and a nod, indicating his assent.

Another relative told us, "It is a wonderful place. Comfortable, my child feels at home. My child is relaxed and can be himself". A member of staff was observed

working with a child on an activity of their choice. The child was made comfortable and the staff member suggested what they could do next. The child responded with smiles. During the activity the staff member remained focussed on the child to ensure they were enjoying it and actively engaged with the activity. This was then recorded in the evaluation, indicating that the child had responded well with suggestions for how this activity could be adapted for next time. It was evident in the way children respond to staff and feedback from their families that people were involved in determining their care and had their choices respected.

Staff understood and promoted compassionate behaviour. All of the staff we spoke with spoke very kindly about the children and families. They were mindful of confidentiality when speaking to us. They used respectful language when speaking about the children.

The spiritual advisor employed by the hospice had links with other religious faiths around the area and so could ask someone to come in to support a family with their faith. They also had provided information to staff about different faiths so that the staff had a better understanding of a family's religious beliefs. The service have used and has on going access to interpreters when needed if a family's first language was not English.

One mother we spoke to said that she gained much support from being in the choir at The Treehouse. The group practiced regularly together and performed at events. The hospice has a 'wellbeing team' who offer support for immediate family including siblings, extended family such as grandparents and those important to the family such as school friends. Siblings can be referred by the family or professionals and can receive support either at home or in the hospice individually or as part of a group event. Support offered ranges from structured play sessions to talking therapies, according to the child's assessed needs. Feedback was regularly sought in a child friendly way using pictures where possible to demonstrate involvement and self-determination of the child where possible.

Is the service responsive?

Our findings

The hospice was proactive in planning children's care and support. A family told us of their first visit as a family when they were shown around. Their child had a gentle introduction from two hours that then built up to an overnight stay. They told us, "They were led by us." We saw family-led care planning underpinned the work the staff carried out with the children. Care plans we looked at were holistic, considering all elements of children's care including their physical, social, emotional and spiritual needs. Care plans illustrated families chose where and when to receive care and their needs, wishes and preferences were fully considered. We spoke with five families, who told us they found the service was very responsive to their children's needs. They said they felt care was individualised and staff knew their child's particular preferences. One family said, "The initial assessment was very thorough. My child's needs change and they are always updating their information. We have an annual review that looks at everything."

We found that the initial assessment was done by one of the care managers. This assessment identified the whole family's needs and goals for care and support. A weekly panel considered what services they could offer the child/family. Even if the child had not been formally assessed for a specific service it was provided on an informal basis. For example, one of the young people had written a song and the music therapist helped them put it to music. This child had not been assessed as requiring music therapy. The service also provided counselling support to bereaved families if the child would have met the criteria for hospice support before they died.

Care was provided in a manner which was centred on the person. Care and nursing staff told us that the care plans contained good, detailed information about the child and their needs. They said that it included information about risks as well as information about the child's likes and dislikes. They also had a one page personal profile which was a quick reference to the child's needs. A member of care staff told us that they always referred to the care plan when getting a bedroom ready so that they knew the risks, as well as what the child is interested in. For example, one of the children was a big football fan so they always made sure that the duvet cover on their bed was the team they supported when they stayed.

Care plans were updated on each admission to ensure the child's needs were accurately reflected. Care plans reviewed were well-written, clear and up to date. Practitioners could see clearly the instructions they needed to follow, for example, how to manage a child's mobility needs. On admission, the practitioner recorded who had provided the information, this could be the child's carer, or the child themselves.

However, in one set of notes, there were two entries, written on the same day, with two different instructions regarding the amount of feed a child was meant to have. The staff member advised that the correct one to follow would always be the 'latest one written', but when she checked that was not, in fact the case. The correct regime was written on a piece of paper and stuck on a medicine cabinet in the clinical room that is used for medicines and feeds. This was merely a handwritten note with no signature. It is important that instructions regarding a child's nutritional requirements are correctly and accurately recorded on each admission within the child's notes and those informal pieces of paper are not relied upon for this purpose. We fed this back to the manager to ensure this matter was addressed.

The computer system was a shared system, used by GPs, community staff and schools. This enabled information to be added to a child's record by any practitioner, subject to consent having been obtained from the child's parent or child themselves if competent to do so. This enabled professionals to effectively share information about the child's care so that staff at the hospice had access to the most up to date information.

Evaluation of the care provided to the child was reviewed with the involvement of parents. Evaluations were very detailed and provided an excellent summary of the child's changing needs throughout their stay and how those needs were effectively met. Evidence of good communication was seen. Records of telephone conversations with parents, updates on new concerns or information about changes to the child's condition and input from other professionals was all clearly documented.

There were two teams in the hospice: the children's team and the young persons' team. A child was transferred to the care of the young person's team at the age of 12. Whilst there was no particular arrangement for same age children to attend the hospice at the same time to share mutual age appropriate activities this was enacted on an informal

Is the service responsive?

manner. For example, there were days out and activities organised outside the hospice, where a group of young people of similar age went sailing together. There were transition pathways in place with the local adult hospice and young people began transition visits there when they were 16. This was relatively new to the adult service who were now very proactive in organising events for the young people, for example, they recently had a barbecue.

One family told us, “We are delighted with the service. It’s amazing. I do not have any concerns. I was given a leaflet about complaints, but I would speak with the manager if I had any concerns”. All people we spoke with said they had a positive experience and would not hesitate to raise any issues directly with the service. People felt they had ample opportunity to raise matters as they arose from contact with staff and at reviews of their use of the service.

We saw that there were regular opportunities provided in the form of a family forum meeting. This meeting sought feedback on recent events including ‘Treefest’ and Mums night. The feedback was honest and was in quote form, so

that the true meaning was not lost. We saw evidence from an internal memo that some of these views had been followed up internally and changes had been made to processes within the hospice. Other items discussed were the developments in transition arrangements for children over 14 for moving on to the adult hospice.

We found that after a children’s event their views were sought and feedback used to improve events for them. An example being a recent activity day of wall climbing and pizza making. The feedback was based upon ‘what went well’ and ‘what did not work well for me’. This showed us that children are routinely listened to.

The Treehouse had a formal complaints procedure in place and this was currently under review. We made comment on the day about how this could be made more open to receive negative feedback directly to the hospice. This formal procedure did not fit with the rest of the culture found within the service of one of listening and being responsive to people’s experiences, therefore the review process will address this.

Is the service well-led?

Our findings

The hospice was well led and managed with a firm focus on responding to the needs of individual families. All of the staff spoke very warmly about the children and families. They all said that they really liked working at the hospice and clearly understood the aims of the hospice and agreed with them. Conversations with staff revealed that there was a high degree of job satisfaction. One staff member said, “the great thing is, you have a voice, and your views are welcomed, regardless of the band you are in”. Everyone we spoke with was very clear about who their line manager was and if they were a line manager, what the responsibilities were of that role. Some staff told us that the hospice had been without a manager for quite some time and that a replacement had taken too long. Staff also said the new manager was very proactive and listened to staff. They felt he was still learning. The new manager is now registered with CQC.

We had a sense that the culture within the hospice was changing. We found that the highest use of the service was in an evening and weekends, care managers were at the hospice seven days a week. There was a plan in place to change working hours to ensure that the hospice was able to meet the needs of families who use it and that this included the management team working through some issue with staff relating to their working hours.

Staff were all aware of the whistle blowing policy and all were confident that they could raise any concerns and that they would be listened to. No-one we spoke to had had to do this. All staff said that the staff worked well together and that communication was good. They said that there was time for the different teams to get together and ensure that they all understood each other’s roles.

Currently there were very few volunteers providing care. Managers were in the process of planning how to increase the number of volunteers they used in care. Volunteers will have a formal induction process. There were also

developments planned in terms of increasing staff training and formal qualifications held to drive improvement in the quality of service offered. This included the talking therapists. They had started the process of obtaining formal counselling qualifications at a higher level than previously. The hospice were paying for this and supporting people to achieve these awards. The hospice had a new service level agreement with a different organisation to provide the safeguarding training and to advise them on the review of their safeguarding policies. Staff had also recently received training from a different provider in relation to managing children who displayed distressed behaviours.

We saw robust systems in place for auditing the quality of the provision. We saw evidence that staff were taking ownership. The development of groups focused on matters such as infection control, nursing practice, medicines management and service user engagement group will lead to a better safer service being offered. The terms of reference of these groups was clear, looking at developing the policy and procedures and analysing trends of any incidents based upon regular audits. Action plans were quality assured and monitored by the senior management groups who had oversight. We sampled some of the information and found examples that showed incidents and near misses were analysed. There was clear learning and changes made in practice. Where appropriate families were involved and when needed were apologised to with an explanation given about the incident and future prevention plans put in place.

The hospice provided extensive opportunities for families and staff to shape the services through formal family forum sessions, coffee mornings, questionnaires and focus groups. Families we spoke with told us their views were highly valued and they felt able to make suggestions that were genuinely listened to and resulted in improvements. Families told us they felt fully included and involved in the running of the hospice. They said they particularly found the website and the ‘family corner’ newsletter informative.