Butterwick Limited

Butterwick House

Inspection report

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Date of inspection visit: 02-03 August 2022
Date of publication: 08/12/2022

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location improved. We rated it as good because:

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and measured patient outcomes. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and all staff were committed to improving services continually.
- Leaders had made significant improvements since our last inspection which included oversight of clinical and service risks. Managers had good awareness of the challenges the service faced and were implementing key changes to address previously imposed restrictions.

However:

- The service did not use a recognised scoring tool to monitor patients for deterioration.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Hospice services for children	Good 	Our rating of this service improved. We rated it as good because: • The service had enough staff to care for children and young people and keep them safe. Staff had training in key skills, understood how to protect children and young people from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to children and young people, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. • Staff provided good care and treatment, gave children and young people enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of children and young people, advised them and their families on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week. • Staff treated children and young people with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to children and young people, families and carers. • The service planned care to meet the needs of local people, took account of children and young people's individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of children and young people

Summary of findings

receiving care. Staff were clear about their roles and accountabilities. The service engaged well with children, young people and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service did not use a recognised tool is monitor deterioration. Staff used professional judgement. Clinical observations were not always repeated in a timely manner.

We rated this service as good because it was effective, caring and responsive and well-led. Although safe requires improvement.

Summary of findings

Contents

Summary of this inspection

Background to Butterwick House

Butterwick House is operated by Butterwick Limited. The service provides hospice services for children and young people from Stockton, Middlesbrough and surrounding areas. It is registered as a charitable trust and receives funding from the NHS. The hospice has six inpatient beds for the provision of respite care. Butterwick House is registered to provide diagnostic and screening procedures and treatment of disease, disorder or injury.

We previously inspected Butterwick House in September 2021 and raised significant concerns with the provider by issuing a warning notice under Section 29 of the Health and Social Care Act 2008, relating to breaches of Regulation 12 and 17. In addition, we issued the provider with a notice of decision to impose conditions on the providers registration. In response, the provider issued an action plan outlining how the service had taken action to address the concerns outlined within the warning notice. The conditions limited the provider to admit a maximum of two service users, already known to the provider, for respite care only.

An unannounced comprehensive inspection was carried out on 1-2 February 2022. At the time of our inspection there was a registered manager in post. This inspection was undertaken to check the service had made sufficient improvements ensure compliance with the Section 29 Warning Notice and to follow up on concerns that had been raised with us. The service was rated 'Good' in the domains of Effective, Caring and Responsive, it was rated 'Requires Improvement' in Safe and Well-led'.

An unannounced comprehensive inspection was carried out on 2-3 August 2022. There was a registered manager in post. At the time of the inspection the hospice was admitting a maximum of two children each week, subject to previous conditions.

How we carried out this inspection

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. Our team consisted of an inspection manager, and two inspectors. The inspection was overseen by Sarah Dronsfield Head of Inspection.

We spoke with five staff including; the Quality and Compliance Lead, and the Registered Manager. We also reviewed ten patient files, staff training records, all trustee files and current policies and procedures.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

Summary of this inspection

- The service must ensure that staff use a recognised scoring tool to monitor patients for deterioration.

Action the service SHOULD take to improve:

- Leaders should continue to widen access to communities once restrictions have been lifted.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hospice services for children	Requires Improvement	Good	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

Good

Hospice services for children

Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are Hospice services for children safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Nursing staff received and kept up-to-date with their mandatory training. At the time of inspection mandatory training compliance was 93.9%. Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism.

The mandatory training was comprehensive and met the needs of children, young people and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. All staff had received safeguarding training as per policy in line with their role. The director of care services was the designated safeguarding lead.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff described actions they would take in the event of any safeguarding concerns and would discuss concerns with the designated safeguarding lead in the first instance.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. During our inspection we saw an example of a safeguarding referral being made and the policy being followed.

Staff followed safe procedures for children visiting the hospice.

Good

Hospice services for children

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.

Areas throughout the unit were kept clean and had suitable furnishings which were both clean and well-maintained. Cleaning records were up-to-date and demonstrated that the domestic team regularly cleaned all areas.

Staff adhered to processes designed to control the risk of spreading COVID-19. Visitors were required to wear masks, record their temperature and complete a COVID-19 questionnaire before being allowed to move further into the premises. Staff and visitors could wash their hands and use hand gel provided, and there were clinical wipes on hand to wipe down surfaces or equipment used.

Each area of the hospice had a daily checklist detailing what needed to be cleaned and when. There were dedicated 'touch point' places where cleaning happened more frequently because of high intensity of use and footfall. Healthcare staff followed this checklist and signed when completed. We observed staff cleaning clinical areas after use.

The provider's hand hygiene audit showed consistent high compliance.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Staff entry to the inpatient unit was by keycode and an intercom system enabled relatives and patients to access the unit.

There was a welcome poster with pictures of staff at the entrance of the unit to introduce staff to visitors.

The unit had a friends and family feedback board with positive statements displayed.

The hospice was over two floors with a stairlift available to the overnight accommodation that was provided for families on the second floor. The accommodation was equipped with a kitchen, sofas, tables and chairs, TVs, toys and entertainment for children. Families could stay overnight as it had two bedrooms and a cot.

The unit had six individual bedrooms that all had direct access onto the garden, there was a large play area, craft room, a sensory room and the sunflower room. The sunflower room was a private place equipped to accommodate and care for the deceased.

The inpatient unit was located on the ground floor and patients arriving by ambulance could be accommodated. Most patients were wheelchair users and the environment met their need, with wide corridors and double doors. Accessible toilets were available for patients, staff and families. Private access for ambulances or funeral directors was available in the sunflower room for the dignity of deceased patients. The unit was secure and access was restricted for safety. Staff ensured that doors remained securely closed

Staff disposed of clinical waste safely. The service had appropriate arrangements in place for the management of clinical waste and sharps. Arrangements for storing, classifying and labelling clinical waste kept patients and staff safe.

The service maintained up to date risk assessments. This included risk assessments of all clinical areas and for individual risk such as the use of bedrails. There was a call system in each bedroom that could be used to ask for help. Staff were able to explain how this works.

Water flushing took place daily with logs signed and recorded as complete.

Resuscitation and emergency equipment was available onsite and easily accessible. We checked the emergency equipment in the unit and all bag contents were correct as listed. The resuscitation bag was secure with a tamper proof seal tape.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Whilst staff identified and quickly acted upon children and young people at risk of deterioration, the service did not have a recognised tool to support staff in deciding how to respond to deteriorating patients.

Staff did not routinely use a nationally recognised tool to identify children or young people at risk of deterioration. Staff told us that they would contact other healthcare services if a child or young person's health was deteriorating. We saw an example of observations being taken, with results be recorded outside of normal parameters, we found the action taken in response was not clearly recorded. There was not a scoring system in place to guide staff with how to respond, and there was a significant time gap between retaking observations. When we raised this on inspection, managers told us this was an area for improvement they had recognised and were working on.

Staff completed risk assessments for each child and young person using a recognised tool, and reviewed this regularly, including after any incident. We reviewed six sets of patient notes. These included up to date care plans and risk assessments. Risk assessments included paediatric tissue viability with skin condition documented on a body map, moving and handling and the use of medicines, for example for treating seizures.

Staff knew about and dealt with any specific risk issues. These issues were detailed on each child or young person's Emergency Health Care Plan (EHCP).

Shift changes and handovers included all necessary key information to keep patients safe. Staff shared key information to keep children, young people and their families safe when handing over their care to others. There was a morning meeting before admission where staff discussed the children or young people attending that day.

The pre-admission assessments were undertaken a week prior to admission. No child would be admitted on the day if they were unwell or did not have the medicines needed for the stay.

All children and young people were for active treatment and resuscitation unless the EHCP or a Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) was in place. Any protocols were agreed with the individual's parents and their consultant paediatrician and kept in the nursing documentation.

Nurse staffing

The service had enough nursing staff to operate with reduced opening. Staff had the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Good

Hospice services for children

Senior leaders planned nurse staffing levels in advance against planned admissions. Senior leaders reviewed the clinical needs of all patients and planned staffing levels in accordance with this to ensure staff had the required clinical competencies to deliver care and treatment.

There were five registered nurses and five health care assistants. The registered nurses were a combination of paediatric nurses and learning disability nurses.

The hospice used a clinical decision tool to calculate the dependency needs of children using the service for respite care. Staffing was planned based on the calculated dependency of those children booked to come in.

The service was not offering emergency placement at the time of our inspection and had restricted opening to three days per week. The service had enough staff to work the reduced number of shifts that were in operation, however, there were staff vacancies and ongoing recruitment.

There was a staffing board visible to patients and visitors showing a photo of the staff on duty and their job role.

Records

Staff kept detailed records of children and young people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily.

We reviewed ten sets of care plans, including medicine records and nursing notes. The records contained comprehensive and person-centred care plans which clearly identified patients' emotional, social and spiritual needs alongside their physical health needs. Staff completed care plans appropriately and we saw they recorded when care was carried out in line with the care plan. Staff reviewed care plans particularly when a patient's circumstances changed.

All care plans were patient specific and were updated as the patient's condition or need changed. They included personal information for each patient from birth to present day.

Each child and young person had an 'All about me' document which included the names of family members names, pets, teachers, siblings, and grandparents.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to transcribe patients own medicines on admission so these could be safely administered. All transcribing and administration of medicine was checked by two members of staff.

The hospice stocked a limited amount of medicines as patients brought their own medicines for their stay. For the medicines they did stock, a monthly audit of the stock was completed. Medicines were stored safely and securely, in locked medicine cupboards within a treatment room.

Staff kept a log of stock medicine that was disposed of, the log included how and when the items were disposed.

Safety alerts were displayed in the treatment room.

Good

Hospice services for children

Allergies were recorded in patient care records and on a white board that detailed specific needs of the patients currently on the unit.

Controlled Drugs (CDs), medicines that required additional controls because of their potential for abuse, were managed effectively. The controlled drugs were stored appropriately, and the service had a key management system to monitor which staff member had the keys.

Treatment room and fridge temperatures were checked and recorded daily to ensure optimal temperatures for storage of medicines were maintained.

The service had an agreement with a local pharmacy to provide medicines. Staff told us they had no issues and could get medicines when they needed them.

The service stored medical gases in line with manufacturers best practice guidelines. Oxygen were stored in a ventilated room.

Patient records included a 'when required' medication plan for medicines that were not a regular medication. The plans included details of which medicine was to be used and when it should be administered.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

No serious incidents or never events had been reported since the last inspection. Incidents were reported using a paper-based system. Staff told us that they knew how to report incidents and were encouraged to do so.

Incidents were reviewed at the governance meetings and meeting minutes indicated that staff were actively reporting incidents within the children's unit. The incident tracker showed lessons learnt, initial action taken and incident investigation. Lessons learnt and actions were identified for incidents and monitored by managers. These lessons learnt were shared with staff via team meetings or staff bulletins. However, there was a backlog of incidents waiting to be actioned and closed.

Staff were aware of duty of candour and the service had a policy in place.

Staff told us that a patient safety alert log was circulated to ensure staff were aware of changes and updates in medicines and equipment.

Are Hospice services for children effective?

Good

Our rating of effective stayed the same. We rated it as good.

Good

Hospice services for children

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver care according to best practice and national guidance.

Policies appropriately referenced current good practice and national guidelines from organisations such as the National Institute for Health and Care Excellence (NICE) and Royal Colleges. The policies we reviewed were in date and version controlled.

At handover meetings, staff told us they routinely referred to the psychological and emotional needs of children, young people and their families. We saw evidence of this documented in patient records.

The service had an audit schedule in place that included records, medicines use and infection prevention control. The audit schedule was updated to implement follow up audits where needed. The audit schedule had been introduced since the last inspection. Managers did more audits than scheduled as they were conscious of the need to improve and learn. An external pharmacist attended site to audit medicines. Audit results were shared with staff by email and at team meetings.

Nutrition and hydration

Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for children, young people and their families' religious, cultural and other needs.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs.

Children and young peoples' nutrition and hydration needs, including those related to culture, religion and special diets were identified, monitored and met. Dietary preferences were given to the catering team so that arrangements were made in advance of a child, young person or their families stay at the hospice.

Staff assessed the dietary needs of patients on admission, based on discussion with their family or carers. Children and young people were weighed on admission to keep a check on weight loss or gain.

Food was prepared onsite by catering staff employed directly by the hospice. Pureed and other special diets were available. Feeding and managing hydration were undertaken in line with current NICE guidelines.

Each child or young person had a detailed care plan with specific details on dietary, feeding and hydration regimes which was updated at every admission to the hospice. Care plans included enteral feeding routines. Enteral tube feeding is the intake of food via the gastrointestinal tract. Training records showed all nursing and care support staff were competent to give enteral feeds.

Pain relief

Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

The hospice used a tool developed in house by specialist staff to assess pain. The tool had recently been recognised and the service won an award for the assessment tool.

Staff had recognised that while there were a range of available tools to assess pain in children there was little for children with complex needs or those who communicated non-verbally so used this tool. The tool had a pain score of 0-10 with a description for how the child would present for each level of pain.

We saw in patients' notes that this was being used correctly and revisited as needed. Staff explained that the children using the service had been visiting for months or years, and they were used to the non-verbal cue's children used to show they were experiencing pain. Staff prescribed, administered and recorded pain relief accurately.

During the inspection, we observed staff identifying pain in a non-verbal patient based on how they were presenting physically.

The service had processes in place to ensure the accurate prescription, administration and recording of pain relief. Nursing staff double checked medicines to ensure safe and accurate administration.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.

There was a robust approach to monitoring, auditing and benchmarking the quality of the services and outcomes for children and young people receiving care and treatment.

Managers used patient and relatives feedback tools to measure patient outcomes to improve children and young people's experiences of care. The patient outcome tool which had been designed by a manager was based on a range of quality indicators and the findings were then used to make improvements. The quality indicators included, for instance, time spent with a therapy animal or art and sensory play. Families were also asked about outcomes for themselves which were also monitored. Parents often measured how well they slept whilst their child or young person was in the hospice for example. Quality and outcome information showed the needs of children and young people who used the service were mostly being met. In January 2022, six parents participated in the outcome monitoring and 92% of outcomes were achieved.

All children and young people had an individualised care plan, that set out their advance care preferences. It covered activities of daily living, family and carer support, infection control, mental capacity, tissue viability, advance care planning and symptom management. Managers and staff carried out a programme of repeated audits to check improvement over time. The audit schedule included quarterly hand washing audits, audits of complimentary therapies, spiritual care, medicines management, documentation and national guidance.

The audit plan was updated to review new processes. Managers used information from the audits to improve care and treatment.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The service only used permanent staff and had no volunteers. Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. A registered children's nurse or learning disability nurse was always on duty.

Staff told us they felt support in their development needs and that they had regular supervision. We were also told that staff had regular appraisals, 100% of staff had a completed appraisal at the time of inspection.

New staff attended a corporate robust induction day to gain a holistic overview of the service. Managers provided all new staff with a full local induction tailored to their role before they started work and allocated them a mentor. The induction included any relevant clinical competencies that needed to be undertaken.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

The service was nurse led and had no other healthcare professionals permanently based on site. However, staff worked with the community healthcare teams responsible for the care of children and young people admitted to the hospice. Managers told us the hospice had a good relationship with the local NHS trust.

Staff worked closely with social workers, occupational therapists, physiotherapists, dietitians and community nurses to deliver collaborative care and treatment for children.

Managers identified that relationships needed to be fostered with other organisations and they were working to better this. Managers had set up a group with other hospices in the north east of England to benchmark and share best practice with each other. Links had been made with palliative care networks, specialist support services and the clinical commissioning group.

There were now team meetings on site and staff felt that they had positive working relationships with each other. They welcomed recent managerial changes that enabled the team to work well together

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each child and young person's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

The service had an up to date consent policy. Staff could describe and knew how to access policy and get accurate advice.

Good

Hospice services for children

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff recorded consent in the children and young people's records. Staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance. Staff did not provide any care without first asking their permission. In the patient records we looked at, we saw copies of signed consent forms and observed that consent to treatment was obtained appropriately.

The service had two safe space beds that were available to certain children or young people. These were only used if a child or young person had one in their home. These beds were used in the best interest of the individual and after a risk assessment was completed before use. The use of these beds was always undertaken in conjunction with consent where possible, or a mental capacity assessment and best interest process.

Are Hospice services for children caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

The direct patient care that we observed showed staff to be very caring, compassionate and understanding of the young person's needs. Staff knew of individual likes and dislikes and this was observed on multiple occasions during the inspection.

Care and activities were facilitated and modified as appropriate to needs. Staff took account of children and young people's individual needs, for example children could personalise their rooms and use their own bedding if preferred.

Feedback from friends and family was positive and the unit had a displayed board with comments from feedback received.

There was a hospice chapel that had recently been modified to become a more suitable multi faith space.

Staff told us that they sent birthday cards to all the children and young people. They also told us that as some of the children liked magazines, they would buy these in for when they would be coming to the service. This was done using their own money and in their own time.

The service had the sunflower room which was available for the deceased. Staff ensured care after death included honouring the spiritual and cultural wishes of the deceased child or young person and those close to them. Families were able to stay with their child or sibling in a private space. Leaders told us that following feedback from families, they were going to be changing the furniture within the space to make it more comfortable and relaxing for the loved ones.

Good

Hospice services for children

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff understood the emotional and social impact a child or young person's care, treatment or condition had on their, and their family's wellbeing. Staff ensured care was child centred, with children and young people consistently at the heart of the service. Children, young people and their families were given every opportunity to express their views and be involved in making decisions about their care.

Emotional support was given even when children or young people were not inpatients. Staff gave us examples of when families had called for advice or to update the service on their child's situation.

The service had a designated room called 'the sunflower room'. This room enabled families to be with their loved one after death.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Families were treated holistically and support for families was arranged if needed. Children, young people and their families were supported to undertake a variety of activities, these included arts and crafts and supported play. We saw examples of staff actively engaging children in activities during inspection.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. Children's and young people's families, carers, advocates and representatives were identified, welcomed, and treated as important partners in the delivery of their care. Staff described the children and young people as 'our family'.

The service was able to refer families for holidays provided by a charity. Managers completed applications and paperwork.

When a child or young person died, memory boxes were made, and gifts prepared for siblings. Every child or young person received a gift on special occasions even if they were not at the hospice.

Are Hospice services for children responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers were unable to plan and organise services to wholly meet the needs of the local population. Due to restrictions, just two patients were admitted at any given time and these children or young people needed to be known to the service. There was a referral list of children and young people waiting to access the service and each child or young person was prioritised according to need. Following our inspection, the restrictions on the service were amended to increase the number of patients able to access care. The service was permitted to increase the number of patients who could be admitted to the service from two already known to the service to four, including one patient who was new to the service. The service was permitted to have more patients whilst still providing regular reports to CQC to provide assurance that patients continued to receive safe care.

Leaders told us that there were plans to analyse the demographics of the local population and identify groups who were not using the service or were less likely to do so. However, managers had not yet had the opportunity to do this and resources were limited. Leaders knew that they could do more to access specific communities but had struggled to achieve this. Managers told us this was because of the limited service being provided at the time of inspection. The service had an equality and diversity policy.

Managers had started to forge links with other similar providers in the region. Having a better regional support system was a key objective and this was underway.

The service had systems to help care for patients in need of additional support or specialist intervention. If a child or young person needed other support or medical help, the service reached out to community workers allocated to them or used the individual EHCP for instruction.

Managers monitored and took action to minimise cancelled admissions. Staff contacted families frequently and helped to resolve issues that might inhibit admission. For instance, if a child did not have medicine that was critical to admission, staff contacted local pharmacies and hospitals to hopefully resolve the problem.

The hospice had a website that showcased its facilities.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Staff made sure children and young people living with learning disabilities, received the necessary care to meet all their needs and all care was individualised to each child. Children and young people who were cared for at the hospice often had complex needs so all their needs, likes, dislikes and preferences were documented in their records. The records also captured sexuality and religion.

There were six individual and private bedrooms. Facilities and premises were appropriate for the services being delivered and could be adapted easily to accommodate different requirements and tastes. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Care records were reflective of each individual needs to help staff care for the children and young people in the best possible way. We saw examples of staff referring back to care records to inform care. One care plan included a printout of NICE guidance for a patient who had a less common illness to help staff better understand the care needs and requirements.

Good

Hospice services for children

All care records contained a 'getting to know me' document that detailed the patient's needs and preferences and included details of the important people in their lives. It also detailed pets and likes and dislikes.

The hospice had a fully equipped sensory room that had multiple features including light therapies, a projector and a soft play area for children and young people to use. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Translation services were available, and staff knew how to access the service.

Access and flow

People could sometimes access the service when they needed it and received the right care promptly.

Staff delivered personalised care to each individual when they had capacity. Most referrals to the hospice were funded by continuing health care packages. As just two children were permitted at the time of our inspection, this impacted on children and young people accessing the service. However, following the inspection the restrictions had been amended to allow more patients to access the service.

Every child or young person had a minimum of one member of nursing staff or member of the care team staff dedicated to their care each day, and in some instances two staff dependent upon their needs. The allocated staff were responsible for all aspects of the child or young person's care, which included their personal and health care needs along with their social needs, which included play and relaxation.

All admissions were planned and booked in advance. There were no emergency admissions but if a vacancy became available unexpectedly then staff worked quickly to ensure another child was able to have the place.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.

The hospice had processes to ensure complaints were dealt with effectively, including prompt acknowledgement of the complaint, a written response to the complaint and whether changes had been made because of the complaint. Face-to-face meetings with the complainant were also offered, when indicated. The provider displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. The service had an up to date complaints policy. Staff described the actions they would take if anyone raised a complaint. Where possible complaints were resolved immediately. Emphasis was placed on listening to the patient or relative to identify their needs and to address their concerns in a manner that improved outcomes for them.

There had been no complaints since the previous inspection in February 2022.

Are Hospice services for children well-led?

Good

Our rating of well-led improved. We rated it as good.

Good

Hospice services for children

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Following a previous enforcement action, the provider had implemented appropriate systems to evidence adherence to the requirements of the Fit and Proper Persons Regulation. The service had commissioned an independent advisor to assist with the meeting of this regulation.

Trustee files consistently evidenced checks with appropriate professional bodies and regulators.

Senior leaders had instigated an action plan to address the concerns raised in the warning notice they received following the previous inspection in 2021. The service had split the action plan down into sections to look at staff responsibility for different areas. The service had weekly meetings to review the action plan and look at progress and potential barriers. A key focus was placed on the warning notice and demonstrating improvement. We saw evidence of significant progress through the action plan and warning notice.

Leaders had made significant improvements in the structure of addressing actions required to improve. We saw improvements in the quality of clinical governance meetings, knowledge and mitigations of the service's current risks, and in the oversight and support of staff.

The service had a registered manager in place at the time of inspection.

Staff we spoke to told us that leaders supported them to develop their skills and there were opportunities to take on more senior roles. Staff told us that leaders were visible and that this had been a positive improvement.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Following the last inspection, the service received a notice of decision which imposed conditions limiting the service to offer respite care for two children at any one time who were known to the service.

The service had a strategy in place, and leaders were working toward progressing the service strategy. Leaders were aware of the necessary staff and recruitment requirements and this was seen as a priority in opening the service back up to capacity.

The service did not intend to open to the full six beds, the opening would be incremental and would be dependent on recruitment of staff with the right skills and competency. Leaders told us as a hospice they needed to consider end of life care and the unmet need in the service currently on offer. Leaders had been making links with other hospices and services in the area.

The hospice had a website in which the strategic plan was available to read. The website also has an overview of the hospice's values.

Good

Hospice services for children

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us that they were proud of the service they delivered and described their colleagues and the senior team as supportive. All staff told us they had good working relationships with their colleagues.

Staff were patient focused, and the culture was focused on the needs and experiences of people who used the services. Staff we spoke to told us they were proud of the care they gave to patients and told us they felt the service was patient centred.

Staff we spoke with told us they were openly encouraged to raise concerns with senior leaders. They felt comfortable escalating concerns. Senior leaders had an open-door policy and encouraged colleagues to be open and transparent with one another.

The service had a whistleblowing policy which was available to all staff and information on how to raise concerns was available within this document.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had made significant improvements to oversight and monitoring of risk and key performance indicators. Managers accepted there was further work to do to improve the service and that systems needed to embed. Following our inspection, the restrictions on the service were amended to increase the number of patients able to access care. The service was permitted to increase the number of patients who could be admitted to the service from two already known to the service to four, including one patient who was new to the service. The service was permitted to have more patients whilst still providing regular reports to CQC to provide assurance that patients continued to receive safe care. The amended restrictions balanced the risk and need for continued close monitoring of the service, and also recognised the improvements made to the quality and safety of care the service provided.

We saw evidence of current disclosure and disbarring service (DBS) checks were in place for all staff. The service had a DBS tracker in place and staff files all had evidence to support checks had been implemented and were in date.

Senior leaders held quality safety and risk committee meetings monthly. The meetings had a set agenda to evidence discussion surrounding incidents, learning, action & dissemination, performance & quality audit, inpatient service, complementary therapies, risk register incidents & complaints, policy, projects and appraisal and supervision.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had a comprehensive electronic risk register. Risks were reviewed monthly and escalated appropriately. Leaders of the service were aware of current risks and were sighted on plans to address risks. High risks included staff recruitment, financial risk and the need to complete actions to evidence improvements made against the warning notice following the last inspection.

We reviewed quality safety & risk meeting minutes at these meetings, incidents were reviewed and discussed. The meetings were every other month and examined hospice activity and performance, patient safety, quality of care, education and training, policies and governance. Challenges made from board trustees were seen in the minutes and actions noted.

The committee received several reports regarding different streams of risk including corporate risk, clinical risks and operational risks. This committee looked at and scrutinised key information about risks within the service and ensured action was taken to mitigate them. An example of this was the regular presentation of incidents at the group including their grading and a summary of the incidents.

The service had an up-to-date business continuity plan which was accessible to staff and detailed what action should be taken and by who, in the event of a critical incident involving loss of building, information technology or staff

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Policies and procedures were held centrally and available electronically on the service's shared drive.

The service had implemented a care database system that enabled all care documentation including clinical and patient information to be recorded in one place. An administrative assistant was employed to undertake some information management such as uploading documentation and sending letters to patient's GPs.

Paper based patient notes were stored securely in a locked room.

Computers and laptops were encrypted, and password protected to prevent unauthorised persons from accessing confidential patient information.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service explained that they used the friends and family test to seek views. We reviewed May and June 2022 findings in which 100% of feedback was positive in a sample size of 16.

The hospice had a good presence in the local community, and they had a strategy to develop this further. There were staff engagement mechanisms and opportunities for staff to meet to provide feedback. An information exchange bulletin was produced for all staff as well as a regular email from the senior leadership team.

Good

Hospice services for children

Leaders were collaborating and networking with other hospices in the locality and had good relationships with the local trust.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

Senior leaders recognised the need to continuously adapt and improve policies and processes. Leaders told us that staff recognised the need to take ownership of work that needed to be completed. Staff acknowledged and recognised the need to be cohesive and inclusive in the adaptation of the service moving forwards.

Leaders told us they were more cohesive, they shared information, discussed concerns and were more transparent and open.

The service measured patient outcomes both qualitatively and quantitatively.