

Shooting Star House

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

| | | |
|----------------------------------|------|---|
| Overall rating for this location | Good |  |
| Are services safe? | Good |  |
| Are services effective? | Good |  |
| Are services caring? | Good |  |
| Are services responsive? | Good |  |
| Are services well-led? | Good |  |

Overall summary

Shooting Star House is operated by Shooting Star Children's Hospice. The hospice runs a number of services including eight inpatient beds and a hospice at home service seven days a week, and a specialist palliative community nursing team that conducts assessments and provides children, young people and their families with care, support and advice in their own homes.

The hospice provides care and treatment for children and young person with a life-limiting condition who are aged from pre-birth to 21 years.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection from 2 to 3 December 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services:

Summary of findings

are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

Our rating of this service stayed the same. We rated it as **Good** overall.

- Staff kept children, young people and their families safe from harm and abuse. Risks were assessed, monitored and managed appropriately.
- Staff followed best practice in relation to infection prevention and control.
- Care and treatment records were accurate, stored securely and provided comprehensive details of care and treatment.
- Staff recognised incidents and knew how to report them. Managers investigated incidents and made improvements to the service.
- Staff had the appropriate skills, training, knowledge and experience to deliver effective care and treatment.
- Staff delivered care and treatment in line with evidence-based practice.
- Staff involved children, young people, their families and carers in decisions about their care and treatment.

- Staff cared for children, young people and their families with compassion, treating them with dignity and respect. Staff truly respected and valued children and young people as individuals and empowered them as partners in their care, practically and emotionally, by offering an exceptional service.
 - The service was proactive in meeting the needs of children and young people from the whole community. The services provided reflected the needs of the population served and ensured flexibility, choice and continuity of care.
 - The service was proactive at engaging with groups that were hard to reach to ensure equitable access to its services.
 - There were clear processes for staff to manage complaints and concerns.
 - There was an open and transparent culture, with engaged and experienced leadership.
- However, we also found the following issues that the service provider needs to improve:
- The storage of equipment did not always keep people safe. We found that equipment was stored in toilets and other areas of the service which were not in line with good practice.
 - Not all outcome measures collected by the service were reported on during governance meetings meaning that outcome measures did not always shape and improve services.

Nigel Acheson

Deputy Chief Inspector of Hospitals (London)

Summary of findings

Our judgements about each of the main services

Service

Hospice services for children

Rating Summary of each main service

We rated this service as good overall because:

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. Staff had access to a robust training and competency programme to ensure they had the skills required to provide good quality care.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff of different kinds worked together as a team to benefit children, young people and their families. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The service planned and provided services in a way that met the needs of local people. The services provided reflected the needs of the population served and they ensured flexibility, choice and continuity of care. The facilities and premises were appropriate for the services that were delivered.
- There was compassionate, inclusive and effective leadership at all levels. There was a strategy, and supporting plans, aligned with the wider health economy that were stretching, challenging and innovative, while remaining achievable. There was a demonstrated commitment to system-wide collaboration and leadership.
- Staff felt positive and proud to work in the organisation. The culture centred on the needs and experience of people who used services. Staff told us that they felt pride in the organisation and the work they carried out to ensure children, young people and their families received good quality care.
- There was an extensive team of volunteers who helped support the service. There was a volunteer

Good



Summary of findings

strategy, a volunteer induction and training programme. Volunteers were valued members of the service who were provided with support and who felt part of the hospice team.

Summary of findings

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Good 

Shooting Star House

Services we looked at

Hospice services for children

Summary of this inspection

Background to Shooting Star House

Shooting Star House is operated by Shooting Star Children's Hospice. The service opened in 2003 and underwent significant refurbishment in 2018. It provides specialist end of life care for children and young people with a range of life-limiting conditions living in West London and Surrey including all 15 boroughs to the west of London.

The service provided care to babies, children and young people who had been diagnosed with a life limiting condition and are unlikely to live beyond the age of 18 years. The care provided by the hospice extends to the child/young person and their extended family.

Shooting Star House (SSH) is a purpose-built hospice facility which has family accommodation as well as

facilities to care for a child after they have died. The service had a Hospice at Home team based at SSH. This team also provides end of life and respite services in the community, at hospitals, and other respite and community settings to ensure choice to the families.

The hospice currently offers eight inpatient beds for specialist palliative care. There was a large community palliative care service led by a specialist registered nurse. There was a team of health care assistants that provide practical and emotional care in the home for children and young people in approximately the last few weeks of their life. This service can provide up to 1000 visits per month for children and young people who needed palliative care input.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in palliative care. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

Information about Shooting Star House

The hospice had one inpatient unit with eight bedrooms, two of which are ensuite and further assisted bathrooms and toilets.

The service is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury.
- Personal care.

The hospice had recently undertaken an extensive piece of work to change their care model. This was to ensure they remain responsive and sustainable and direct their resources to children and young people in their last year of life, or where it is needed most. The hospice provided charitable and statutory funded respite care which can be accessed as planned care or emergency care to support urgent situations.

The practice education team at the hospice provided internal and external teaching courses and clinical training in hospice related subjects on site.

During our inspection, we visited the inpatient unit and attended a home visit with a member of the specialist palliative care community nursing team. We spoke with 12 staff including; registered nurses, health care assistants, reception staff, medical staff and senior managers. We spoke with two children and their families. During our inspection, we reviewed six sets of children and young people's records.

There were no special reviews or investigations of the hospice ongoing by the CQC at any time during the 12 months before this inspection. This was the first time the service was inspected using the hospital methodology and was rated overall good.

Summary of this inspection

Track record on safety (1 October 2018 to 30 September 2019). There were effective processes to report and record incidents. The service learnt from incidents and shared this learning effectively with staff. The service had:

- Zero Never events
- Zero incidences of hospice acquired Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA), hospice acquired E-Coli. The service had one instance of hospice acquired Clostridium difficile (c.diff). There service said they were not reporting on any of this

- One serious incident
- One complaint
- 67 written compliments.

Services provided at the hospice under service level agreement:

- Clinical and or non-clinical waste removal
- Maintenance of medical equipment
- Pharmacy services.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Our rating of safe stayed the same. We rated it as **Good** because:

- The service provided mandatory training in key skills and made sure everyone completed it. Mandatory training was comprehensive and more than 98% of all staff groups completed it.
- The service controlled risk infection well. Staff kept themselves, equipment and premises clean. We saw staff observing 'bare below the elbow' guidance and using protective equipment appropriately. There was access to alcohol hand gel for staff and visitors at the entrance to the hospice.
- Staff completed and updated risk assessments for each child and young person on admission to the hospice. They kept clear records and asked for support when necessary.
- Staff followed best practice when prescribing, administering and recording medicines. Children and young person's received the right medicines at the right dose at the right time.
- Staff kept detailed records of children and young people's care and treatment. Records were clear, up to date and easily available and accessible to staff providing care. Care plans were person centred and recorded children and young people's needs, preferences and choices.
- Staff knew how to protect children and young persons from abuse and worked well with other services to do so. They knew how to escalate any concerns to senior staff in line with the organisation's safeguarding policy.
- The service had suitable premises and equipment and looked after them well. The registered manager had good oversight of all contracts relating to equipment checks and servicing and made sure these were done on time.
- The service had enough nursing, care and medical staff with the right qualifications, skills, training and experience to keep people safe. Daily reviews meant that staffing could be increased or decreased according to the needs of children and young persons.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave children, young people and their families honest information and feedback.
- Staff collected safety information and shared it with teams. Managers used this to improve the service.

However,

Good



Summary of this inspection

- The storage of equipment did not always keep people safe. We found that equipment was stored in toilets and other areas of the service which were not in line with good practice.

Are services effective?

Our rating of effective stayed the same. We rated it as **Good** because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff assessed and monitored children and young people regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to manage pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared and benchmarked their results with those of other services to learn from them.
- 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 monitor the effectiveness of the service.
- Staff of different speciality worked together as a team to benefit children, young people and their families. Nurses and other healthcare professionals supported each other to provide good care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support children and young people experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Good



Are services caring?

Our rating of caring went down. We rated it as **Good** because:

- Staff cared for children and young people with compassion. Feedback from children, young people and their families confirmed that staff treated them well and with kindness. Children, young people, their families and carers told us that staff went over and above what they expected.
- Staff provided emotional support to children and young people to minimise their distress. The service looked after staff and supported their wellbeing.

Good



Summary of this inspection

- Volunteers and all staff groups contributed to help those in need of support. Children, young people and their relatives told us they could ask any questions and were supported when upset.
- Feedback, thank you cards and regular questionnaires confirmed that children and young people and those close to them valued the services and the emotional support offered by the hospice.
- Staff involved children and young people and those close to them in decisions about their care and treatment. It was clear from the care records reviewed, that care and treatment was provided collaboratively.

Are services responsive?

Our rating of responsive went down. We rated it as **Good** because:

- The service planned and provided services in a way that met the needs of local people. Services were focussed on the needs of those using them. There were strong links with local organisations. Children, young people and their families were routinely signposted to additional support.
- The service took account of children and young peoples' individual needs. Care plans were tailored to capture people's choices and preferences. These were comprehensive, and person centred. A voluntary chaplaincy service provided spiritual and emotional support for children, young people and their families and a quiet room with multi-faith equipment was provided.
- Children, young people and their families could access the service when they needed it. 95% of new referrals were seen in the community within 24 hours, and the inpatient unit admitted and discharged children and young people seven days a week.
- Children and young people individual needs and preferences were central to the delivery of tailored services. The service was flexible and provided informed choice and ensured continuity of care.
- The service had identified where people's needs and choices were not being met and used this information to inform how services were improved and developed.
- There were clear processes for staff to manage complaints and concerns and staff at all levels in the organisation were engaged with improving services as the result of complaints.

Good



Are services well-led?

Our rating of well-led stayed the same. We rated it as **Good** because:

Good



Summary of this inspection

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, children, young people, their families and local community groups.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The service engaged well with children, young people, their families, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Hospice services for children

| | |
|------------|--|
| Safe | Good  |
| Effective | Good  |
| Caring | Good  |
| Responsive | Good  |
| Well-led | Good  |

Are hospice services for children safe?

Good 

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

Mandatory training

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

The service operated a full mandatory and statutory training programme for staff. This ensured relevant knowledge and competence was maintained and updated throughout their employment within the service. There was a structured induction programme for staff to ensure they had the skills needed for their roles.

At the time of our inspection, the service target for completion of mandatory training amongst the nursing staff were met at 96%. The mandatory training covered all key areas staff needed to keep children and young people safe.

The mandatory training was comprehensive and met the needs of children and young people and staff. Most nurses felt mandatory training was appropriate and clear. Managers monitored mandatory training and alerted staff when they needed to update their training through their online training data. Staff told us they were up to date with their mandatory training.

Mandatory training for all staff included, data security awareness, infection prevention and control, moving and

handling, paediatric and adult basic life support, pool watching, anaphylaxis, equality, diversity and human rights, record keeping. Compliance for completion of the training ranged from 98% to 100%.

Safeguarding

Staff understood how to protect children and young people 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 and medical staff received training specific for their role on how to recognise and report abuse. Most staff were trained to the appropriate level for safeguarding children. On inspection, we saw that all staff requiring safeguarding children level 3 training had completed the training. We were told the service manager who had been the safeguarding lead with an overall responsibility for safeguarding completed safeguarding children level 4 training.

The safeguarding systems were externally audited every year and we saw the report for 2018-2019, which stated that the service had strong safeguarding arrangements and showed a commitment to staff training and responsibilities. The audit did not highlight any areas for improvement. Senior staff attended safeguarding conferences to discuss safeguarding incidents and share best practice. Learning was shared, and staff received safeguarding supervision. All the staff we spoke with were able to describe their responsibilities if they had a safeguarding concern and how they were able to escalate their concerns to safeguarding leads or where appropriate, make a referral to the local safeguarding authority.

Hospice services for children

Staff knew how to identify children at risk of or suffering from significant harm and worked with other agencies to protect them. A safeguarding policy supported staff to protect people's welfare. The policy was electronic, in date for review and included the definitions of abuse as well as recognising children and young peoples' rights under equality and diversity legislation.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff showed us how they could access safeguarding referral information through the intranet.

Staff followed safe procedures for people visiting the hospice. Staff we spoke with were aware of child safeguarding procedures including those children who were visiting the hospice and other clinical areas. Staff were aware of who the service's safeguarding lead was, where to go for advice and how to make a referral if they needed to. The registered manager was the named safeguarding lead for the service.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and measures to protect children and young people, themselves and others from infection. They kept equipment and the premises visibly clean. However, we found some areas cluttered with equipment which was a hazard to effective infection control.

The service had an infection prevention and control policy, which was in date. The policy referenced up-to-date national guidance and current legislation.

The hospice was visibly clean, but we found some areas were cluttered with equipment such as wheelchairs in toilets and other areas within the service. There were a few areas within the hospice which required some attention, the sluice room on the ground floor was untidy and dusty, the storage room on the ground floor needed tidying as there were boxes of consumable products on the floor which could fit on the shelving with some organisation.

There were clear systems in place to make sure each bedroom and communal area were cleaned regularly. The ward areas were clean and had suitable furnishings which were clean and well-maintained.

We observed all staff adhering to 'bare below the elbows' when delivering care. Personal protective equipment, such as aprons and gloves were used when required.

Nursing staff completed several audits relating to cleanliness and infection control including, sharps' disposal and hand hygiene. Audit records from October 2018 to September 2019 demonstrated 95% compliance with infection control and hand hygiene audits which was in line with the service target. Hand hygiene and infection prevention and control audits were a standing agenda item at the monthly team meeting.

There were designated bins for waste and we saw sharps bins were locked away and not over full. Waste was stored safely in line with guidance.

Clinical areas had flooring which was washable and compliant with the Department of Health building note (HBN 00-10).

Cleaning materials were stored in a locked storage room in a locked cupboard, and the cupboard key kept by the lead nurse. This complied with the Control of Substances Hazardous to Health Regulations (2002). The storage room was accessible via a proximity card system.

The service had their own laundry facilities. The service provided laundry facilities for any in-house family to ensure that all their needs were taken care of.

Environment and equipment

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

The service had suitable facilities to meet the needs of children, young people and their families. There was flexible moving hand wash basin suitable for children of all ages. Resuscitation equipment was suitable for the type of children and young people been cared for at the hospice.

There were eight rooms for inhouse children and young people on the ground floor of which two were ensuite and further assisted bathrooms and toilets. The rooms were designed with access to the gardens. Bedrooms were spacious and all had ceiling track hoists. There were facilities for making hot drinks, a fridge for families to use and a microwave for preparing light meals for relatives.

Hospice services for children

The music room, the art therapy room and the sensory room did not have enough space for equipment such as wheelchairs and breathing equipment for children and young people.

The service had a hydrotherapy pool, sensory room and room designed by teenagers which housed gaming equipment and pinball machines. There was a music therapy room and an art studio which were used by children and young people for music and art therapy sessions. Regular risk assessment of the hydrotherapy pool was completed by the service.

Maintenance records for small and large pieces of equipment were all up-to-date. We saw a maintenance programme with dates of servicing and next review dates documented.

Airway support equipment was in date and staff completed weekly checklists to ensure items were available and in date. Oxygen cylinders were well secured.

Call bells were accessible for children and young people in their rooms to alert staff if a child required assistance.

The service had appropriate arrangements for the management of sharps and clinical waste. Arrangements for storing, classifying and labelling clinical waste kept children, young people and staff safe.

Rise and fall sink units were installed the communal bathrooms to ensure all service users could use the facilities while maintaining their independence.

The service had a suite and a cold room used by families to spend time with their child when the child died. The families were supported by staff whilst using the suite.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

We reviewed six sets of medical records and all the records included care plans and risk assessments. Children, young people and their families knew what the plans were for their ongoing care. Risk assessments were revisited daily.

Inpatient records included; an integrated nursing and medical assessment, do not attempt cardiopulmonary resuscitation form if appropriate. Children and young people were also assessed for their risk of falls, had a full cognitive assessment and, and if bedrails were used this was clearly documented. There were review dates for all assessments, which were all dated and signed.

Staff carried out risk assessments on admission for each individual child which were subject to daily review. All staff could access an electronic record which supported real time updating whether on or off site. There were alerts for key safety issues for children and young people such as allergies. This meant there was an electronic system accessible by staff to keep each child safe.

Care plans were individualised to cover the psychological as well as physical needs of children and young people. Where a child had changing needs, for example, becoming increasingly ill due to their condition, staff adapted their care plan accordingly. The weekly multi-disciplinary team (MDT) meeting provided an opportunity for further review and amendment of the care plans.

Staff could access more senior review 24 hours a day. The hospice 24-hour advice line was staffed by nurse specialists who could call on doctors and consultants to provide specialist input as needed.

Staff managed the increased risks experienced by children and young people at the end of life. Individual risk assessments were carried out to manage these risks. All children and young people were risk assessed for skin integrity, pressure ulcers, and falls using evidence-based tools. The information was used to form management plans which were stored in patient records.

Risk was identified in the community by clinical nurse specialists as part of the hospice at home community nursing service. Each child receiving care was assessed for their falls risk, moving and handling, and management of pressure areas. These were reviewed weekly or more frequently if needed.

Children and young people reviewed daily by clinical and non-clinical staff such as nurses and physiotherapist. We saw that discussions took into account changing needs such as tolerance of particular formulas of drugs.

Nurse staffing

Hospice services for children

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep children and young people safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough nursing and health care staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The service had determined a minimum safe staffing level using a nationally recognised staffing tool. The lead nurse had discretion to request additional staffing levels based on the acuity of children and young people.

To ensure safe staffing levels at all times, the service used bank staff and staff worked flexibly across different service areas. The service ensured a senior nurse was always on duty on the inpatient unit and that staff had access to an on-call manager in and out of hours to escalate any staffing concerns that arose. The service did not use agency staff.

Children and young people numbers were managed to ensure sufficient staff were available; the service had the ability to decline children and young people if they felt that admitting them would be unsafe due to staffing levels. We saw that planned levels of staffing matched the actual staffing levels on the day of our inspections and that there was a strong skill mix among the nursing team.

Staffing establishment was based on guidance from National Quality Board, June 2018 document Safe, Sustainable and Productive Staff. Nursing establishment was based on current funded establishment of four inpatient beds open Sunday to Thursday and six inpatient beds open Friday and Saturday was 14.6 whole time equivalent (WTE) registered nurses and 9.8 WTE healthcare assistants (HCA's). Each shift had a minimum of two registered nurses, one of whom was a paediatric nurse. During day time hours the shift leader was supernumerary and in addition to this there was usually a lead nurse also on the ward. There were two clinical on call staff for out of hours support to cover both the hospice and community caseloads.

The registered manager provided cross site management support 24 hours a day. The service had a supply of bank nurses and carers to cover short notice sickness and/or

emergency admissions. The rostering system was linked to children and young people dependencies and staffing competencies to ensure that the right staff were available to meet the care needs of the children resident at the hospice. Shift leaders and lead nurses worked together to continually monitor staffing levels. Vacancies were monitored by the senior management team and any expected vacancies were actively recruited to. Short term gaps were covered by bank staff. The bank staff were ex-employees or nurses and carers with extensive experience of caring for children with complex health needs.

Medical staffing

The service had the right medical staff with the right qualifications, skills, training and experience to keep children and young people safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had access to appropriate medical input. The hospice contracted GPs provided 24 hour on call availability 24 hours a day 365 days per year for any child staying at the hospice, they visit the hospices daily as needed.

Children and young people on the palliative care pathway each had a 24 hour on call service which had access to specialist nurses and doctors for use by the service, families and professionals.

We were told by the lead nurse that the hospice had consultant cover from 9am to 5pm on weekdays. The consultants provided support and advice to the inpatient unit and the community teams. There was a consultant on call from 5pm to 9am and throughout weekends to ensure 24 hour, seven days a week cover. The service's consultant out of hours rota was shared with consultants at the local hospitals. Nursing staff told us medical staff cover was effective and gave the service access to consultants with a breadth of experience and allowed joined up working between the services.

We saw from rotas that the actual clinical staff on duty matched the planned staffing skill mix and could be flexed to meet the needs of children and young people when needed. Staff attended the multidisciplinary team catch up meeting every day. The team provided palliative

Hospice services for children

care support for the hospice and the community team, meaning that there was good, joined up communication and planning to meet the needs of children and young people.

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.

Staff used an electronic record system which was holistic and accessible to staff both on and off site. All records we looked at were comprehensive, clear and up to date. The information needed to deliver safe care and treatment was available to staff in a timely and accessible way through their online live documentation. The service used an electronic patient record system for recording of children and young people information and care needs. Information needed for children and young people ongoing care was shared appropriately in a timely way. The service sought and obtained children and young people consent through the parents / carers to share information with other services such as GP's and this was documented in the patient's record.

Children and young people information was shared with referrers, for example, GP's and other professionals updating them of the outcomes. If a child died in the hospice, the GP was informed by both telephone and letter. The team also contacted other healthcare providers supporting the child, for example, district nurses and hospital palliative care teams.

We reviewed six children and young people care records. 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 progress records completed when care was carried out in line with the care plan. Staff reviewed care plans weekly or when children and young people circumstances changed.

Staff could access children and young people specific information from the care plan which included information on communication, psychological and end of

life care. All care records contained a detailed child's needs assessments and preferences and took account of any additional needs such as challenging behaviour needs.

The service undertook a records audit in November 2018 to assess the quality of records. The audit identified concerns with patient identifier stickers as well as accuracy and legibility of documentation. The service formulated a plan to address the concerns including circulating expected standards to all staff, presenting audit findings during training and ensuring that induction packs clearly explained the standards expected in record keeping. On our inspection, we did not find the issues identified in the audit with records.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Children and young people received the right medication at the right dose at the right time.

The hospice had a service level agreement (SLA) with a local NHS Trust for pharmacy support of 8 hours per month. A pharmacist sat on the Medicines Management Group and attended the Governance and Risk Committee. A pharmacist also carried out a controlled drugs audit and reviews all incidents related to medicines management. The hospice also had access to an on-call pharmacist 24 hours a day when needed.

We looked at how medicines were managed. We checked the medication administration records (MAR) for six children. We checked storage conditions and the recording of controlled drugs. All records showed whether the child or young person had any allergies and whether antibiotics were prescribed as per guidelines. The age and weight were recorded, and prescriptions were appropriate to weight where required in all the records checked.

The hospice had a detailed medicines management policy which was regularly reviewed and understood by relevant staff. Prescribers had access to local, regional and national prescribing guidelines relating to medicines used in the hospice.

Hospice services for children

Medicines were supplied by a local pharmacy depending on the time of day. Staff recorded all deliveries of medicine. We checked a sample of medicines, both the patients' own and those in stock, and found that all were in date, and correctly and securely stored.

We checked six sets of medication administration records and found that in all cases where applicable, children and young people's allergies were clearly documented. We saw that children and young people received their medicines as prescribed. When medicines were to be administered at variable doses, nurses had recorded how much and when these were given. Where medicines were being given over a longer time, such as patches or infusions, staff regularly checked these were still working until the next dose was due.

Controlled drugs were recorded in a separate book. This was correctly and fully completed. When controlled drugs needed to be destroyed, this was recorded separately, and destruction was witnessed by an authorised witness accompanied by a nurse or other senior staff member.

Fridge temperatures were checked and recorded daily. These were within an appropriate range, and staff knew what to do if this was not found to be the case.

Children and young people's symptom control needs such as pain, nausea and vomiting were assessed by staff during the medicines round.

Children and young people who were being discharged, were given their medicines back.

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.

An incident reporting policy was in place, was in date and was accessible to staff. This was in keeping with best practice for incident reporting. All their serious incidents were reported and investigated in line with serious incident framework.

We found that the staff we spoke with were aware of the process to report incidents and could describe the types of incidents that should be reported. They were able to provide examples of incidents that had occurred in the service recently, such as medicines management incidents.

Incidents were graded in levels of harm caused by the incident to the child. These were graded as follows; level one which was low harm, level two was low harm, level three was moderate harm, level four was severe harm and level five was death. Incidents were monitored for trends and themes. Managers used this information to target areas for improvement and offered awareness raising sessions and additional training.

Incidents were discussed at team meetings and governance meetings and learning was posted on communication boards in staff areas. Action plans were produced and monitored, and learning was shared by various means amongst staff. Team meetings were held monthly and minutes were recorded and shared with staff who were not able to attend. Incidents were a standing agenda item and we saw evidence from the minutes that incidents and learning was shared.

Any member of staff could report an incident. Incidents were investigated by the lead nurse or head of care. Feedback was given individually.

Safety Thermometer

Staff collected safety information and shared it with teams. Managers used this to improve the service.

The service collected data on pressure ulcers using body maps for skin integrity regularly. This data was reviewed by lead nurse and brought to the clinical governance group. Reporting was completed monthly throughout the year.

The service monitored safety information through their incident reporting system. For example, pressure ulcers were recorded as incidents and managers analysed themes regarding any clinical incidents. The service did not monitor infection rates as children and young people only stayed at the hospice for a few days.

Are hospice services for children effective?

Hospice services for children

(for example, treatment is effective)

Good 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people in their care.

The service used a combination of national guidelines to assess and treat the needs of end of life and terminally ill children and young people. This included guidance produced by the National Institute for Health and Clinical Excellence (NICE), and the hospice UK. Examples of those we looked at included guidelines on the management of pain, breathlessness and symptom control.

NICE guidance NG61- End of life care for infants, children and young people with life-limiting conditions: planning and management was embedded in their care and treatment of children with life limiting condition. The guidance involved children, young people and their families in decision making about their care and treatment.

There was an evidence on the use of end of life care for infants, children and young people Quality standard QS160. This quality standard covers end of life care for infants, children and young people (from birth to 18 years) who have a life-limiting condition.

We saw anticipatory medicines for pain, breathlessness, pain management, nausea and vomiting, distress, agitation and seizures were prescribed and given in line with NICE guidelines for care of the dying children and young people in the last days of life and palliative care for children and young person.

Care planning was implemented as early as possible and care plans were identical in both the inpatient and community settings and transferred between the two areas of the service. Children and young people relatives confirmed that care was delivered in line with their

wishes. Care planning included discussion about support for the child's family and we saw evidence of families and friends being emotionally, and practically helped to support the person using the service.

The hospice had increased its early identification of preferred place of death for children and young people and were actively reducing admissions when a child indicated they would prefer to stay at home.

The service contributed to the national policy on children's end of life care by proactively working with national charities who set standards and guidance for the sector. We were told senior staff at the hospice were frequently invited to speak at national events and advise other services on best practice.

Children and young people attending the hospice for day therapy service or as an inpatient had the opportunity to develop an advance care plan. Children and young people had a clear personalised care plan that reflected their needs and we saw that these were up to date. Staff delivered care to children and young people in the last days of life that met the 'five priorities of care of the dying person'. Individual care plans took account of symptom control, psychological, social and spiritual support and we saw evidence of discussion with children, young people and their relatives recorded in care plans. This gave us assurance that care plans were agreed and developed with the consent of children and young people.

Shooting Star received a letter of recognition from the Child Death Overview panel in October 2019 in recognition of Shooting Star House's contribution to the care of a dying child.

Nutrition and hydration

Staff gave children and young people 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 and young peoples' religious, cultural and other needs.

Children and young people received a nutrition and hydration assessment on admission. Families and carers were asked on each admission what the child or young person's likes and dislikes were for their oral diets. The hospice catering team provided nutritious, homemade

Hospice services for children

meals taking into account the cultural and religious needs of children and young adults. The whole dining experience was relaxed, homely and friendly. We observed staff chatting with the children and young people and making mealtime a pleasurable experience.

The hospice had a five-star food hygiene rating from the local authority. Staff we spoke with told us that the catering and clinical teams would work together to fulfil catering requests for special events, such as birthdays for children, young people and their family members.

The needs of children and young people that had feeding regimes were clearly recorded and staff had good knowledge of the regime. The care plans included information about specialist equipment, likes and dislikes and whether the child used the dining room.

Staff took detailed information about the nutrition and hydration needs of children and young people before the respite stay. This was always reviewed before every respite stay and following a change in health.

Staff fully and accurately completed children and young peoples' fluid and nutrition charts where needed. We saw evidence of this when reviewing children's records. All the records we reviewed showed staff had completed the child's nutritional assessment. Children and young peoples' nutrition and hydration were assessed and monitored as part of the children and young people personalised care plan.

Specialist support from staff such as dietitians and speech and language therapists were available for children and young people who needed it, however these staff were not based onsite but can be contacted when needed.

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.

Staff assessed children and young peoples' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We observed staff checking

children for any symptoms of pain and offering analgesia in line with the service medication policy. Children and young people received pain relief soon after it was identified they needed it, or when they requested it.

Staff prescribed, administered and recorded all pain relief accurately. We saw that pain was regularly assessed using pain assessment chat and pain relief given where appropriate in all the children and young people records we reviewed. Two children we spoke with told us that their pain had been well managed by staff.

The hospice managed the pain of children and young people who were approaching the end of their life effectively. Staff assessed and monitored children and young people's pain as part of their intentional rounding.

Anticipatory medicines were prescribed appropriately in people identified as approaching the end of life. Anticipatory medicines are a small supply of medications for people to keep at home just in case they are needed.

Staff could access different pain assessment tools including those suitable for people who were not able to verbalise their pain. Staff used an appropriate tool to help assess the level of pain in children and young persons who were unable to communicate verbally. We saw that staff documented in children and young people notes when pain was present and adjusted pain medication accordingly. At a morning multidisciplinary team (MDT) meeting, we saw that all children and young people pain and symptom control were discussed as standard and plans were made to adjust these as needed.

We observed a member of the community nursing team assessing a new patient. As part of a comprehensive review, they discussed a pain management and symptom control plan with the child and their family.

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.

The service monitored and benchmarked the quality of the services and the outcomes for children and young people receiving care and treatment. When benchmarked against similar services the hospice performed better than expected.

Hospice services for children

The service audited its quality standards against the Hospice UK Guide. Managers used information from the audits to improve care and treatment. Information about the outcomes of children and young people care and treatment were collected and monitored by the service to ensure good quality care outcomes were achieved for children and young people. The hospice monitored its outcome and reported to the relevant CCGs on its effectiveness against the quality standards of the Hospice UK Guidelines.

All children and young people care records we reviewed had an individualised care plan that set out their advanced care preferences. It covered activities of daily living, family and carer support, infection control, mental capacity, tissue viability, advance care planning and symptom management. There was provision for recording preferred place of care and death within the electronic record. The records were regularly reviewed and audited.

Managers carried out a comprehensive yearly audit programme which was created using tools from the Hospice UK. The service participated in clinical audits and quality improvement initiative for hospice care. We saw that this included participation in national, regional and local audits. We saw that each audit report showed the service performed well in the audit and had identified areas for improvement. The audits had detailed action plans which had actions assigned to named members of staff. Each audit contained a re-audit date indicating when the audit needed to be repeated. The service reported the results of audits and progress with their associated action plans and shared learning with staff during team meetings. Audit outcomes were also shared with the wider multidisciplinary team. Senior staff told us that the service 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.

Children and young people had their needs assessed by staff with the right skills and knowledge. The service ensured that staff competencies were assessed regularly by a practice educator. Staff were assigned mentors

responsible for signing off their competencies on palliative care for children and young persons. Staff mentors oversaw mentoring, clinical and group supervision. The competency framework used by the service was in line with the Royal College of Nursing guidance on competencies for palliative care for children and young people.

Staff told us that they completed annual appraisals with their line managers and that they found these meaningful. The services appraisal rate for all staff was 98%.

The practice education team at the hospice provided internal and external teaching courses and clinical training in hospice related subjects on site. The service had a journal club once a month. There was good evidence of creating and updating an environment for on-going learning and development for staff.

The service had an established induction process in place for all grades of staff. The induction process included competencies to be signed off once completed. Staff also shadowed another member of staff as part of their induction program. Bank staff received the same induction that permanent staff received. The hospice offered staff continuous learning opportunities to enhance their current roles. Staff told us at the time of inspection that the training courses provided included courses such as 'Effective communication to support families through loss and grief', 'End of Life Care, loss and grief – the Bereavement key worker role' and a range of other end of life care and palliative care courses were provided by the organisation. Staff told us the training was extremely well received and had been useful for their role at the hospice.

Staff were encouraged and given opportunities to develop. Managers made sure staff received any specialist training needed for their role. This included providing specialist in-house training courses on breaking bad news, symptom control and breathlessness in end of life care. Managers supported nursing staff to develop through regular reflection and clinical supervision of their work. All newly qualified members of staff were provided with monthly one to one sessions and yearly appraisal.

The service's two social workers had completed Surrey Young Carers training course and they are now recognised as Surrey Young Carers Guardian Angels.

Hospice services for children

Multidisciplinary working

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

There were weekly multidisciplinary team meetings and these meetings were attended by nursing staff, health care assistants and therapy staff.

Doctors at the local NHS hospital worked alongside colleagues at the hospice, to enable co-ordinated care to children and young people. The service employed a 0.4 whole time equivalent (WTE) Paediatric Palliative Care Consultant. They also had a service level agreement with a London based children's hospital for advice and support.

We observed multidisciplinary team meetings and saw positive working relationships between all staff. We saw that the care and treatment of every child was discussed at the meeting and a management plan put in place and reviewed as necessary.

Nursing staff, including bank nurses, told us that doctors were approachable and worked as part of the team. Clinicians including doctors told us they supported the nurses to do their job and felt proud to be a part of the team. Health care support workers told us they felt able to contribute actively to the team.

Staff worked in partnership with external providers of end of life care in assessing, planning and delivering care and treatment. This included GPs, primary care nursing teams, allied health professionals, social care providers, secondary care and other voluntary sector workers. Children and young people were taken to school by staff on a daily basis whilst admitted to the hospice.

There was an holistic approach to delivering care and treatment to all people who used the service. This included assessing their nutrition, hydration and pain relief needs, education for children. Children were taken to school in the morning. The service's allied health professionals attended and contributed into meetings to discuss their input for children and young people's needs. The service held morning meetings which were attended by clinical staff. Staff told us this meeting helped target

children and young people who may require greater input across the multidisciplinary team in advance of their work schedule to ensure those children and young people who had greater needs were seen quicker.

Seven-day services

Key services were available seven days a week to support timely children and young people care.

The service ran seven days a week, 365 days a year. People could access the services seven days a week. Staff could call for support from doctors and other disciplines, including allied health professionals such as dietitians and speech and language therapist 24 hours a day, seven days a week.

Children and young people could access most of the services seven days per week. The inpatient unit provided care and treatment 24 hours a day, seven days per week to support timely care for children, young people and their families.

Health promotion

Staff gave children and young people practical support and advice.

There were health promotion materials displayed throughout the hospice to support ongoing health promotion. Leaflets were available in the hospice on topics such as living positively with cancer, managing breathlessness and symptom management.

Nursing staff undertook an assessment of each child and young person's health when admitted, this included a holistic needs assessment for every child and family that were referred to the service. The holistic needs assessment looked at the children and young people's clinical condition in addition to the overall family's overall wellbeing.

Staff identified people who could benefit from extra support and discussed changes to care and treatment with those children, young people and those close to them. Staff supported people to maintain their own health and wellbeing.

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The hospice offered complimentary therapies as part of the day care and drop in services. These services included massage, aromatherapy and relaxation techniques. There were dedicated rooms allocated for complimentary therapies.

Consent and Mental Capacity

Staff supported children, young people and their families to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support children and young people who lacked capacity to make their own decisions.

All nursing staff completed training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff understood the relevant consent and decision-making requirements of legislation and guidance, they knew who to contact for advice. Staff could describe the principles of the Mental Capacity Act and felt confident in completing assessments. Staff knew this applied to children over the age of 16. Staff understood how and when to assess whether a child had the capacity to make decisions about their care and treatment. They followed the service's policy and procedures when a child could not give consent.

Staff gained consent from children and young people (through their family/carers) for their care and treatment in line with legislation and guidance. Staff within the hospice confirmed they sought consent from children and young people /their parents/their carers before providing care and treatment. We saw written consent within the children and young people's files were completed fully and were legible.

When children, young people or their families could not give consent, staff made decisions in their best interest, taking into account their wishes, culture and traditions. Managers and nurses we spoke with understood 'Gillick competence' (a term used in medical law to decide whether a child under 16 years is able to consent to their own medical treatment, without the need for parental permission or knowledge).

We saw evidence of resuscitation status of children in records. Nursing staff told us this was completed by health professionals prior to the child and young person's been admitted to the hospice.

Are hospice services for children caring?

Good 

Our rating of caring went down. We rated it as **good**.

Compassionate care

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

Staff knocked on children and young people's room doors, called out to introduce themselves and ask permission to come in before entering. Staff followed policy to keep children and young people's care and treatment confidential. Staff closed doors and curtains when providing care to children and young people. Staff closed computer screens and turned papers face down to protect children and young people confidentiality.

Staff were discreet and responsive when caring for children and young people. Staff took time to interact with children and young people and those close to them in a respectful and considerate way. We observed many caring interactions between all staff, children, young people and their families. Staff used appropriate humour and clearly demonstrated a good understanding of each patients' preferences.

The service had distinct areas for different age groups of children and young people. Children and young people could access dedicated areas which had a substantial quantity of age appropriate games and technology available. They could also access rooms which had a wealth of toys, games and crafts available. Parents we spoke with consistently spoke highly of the service and that the needs of the whole family were considered as part of the overall care package.

Parents said staff treated them well and with kindness. Thank you cards from previous children and young people to ward staff used phrases like "Excellent and friendly care" and "Loving and caring bunch" and "Wonderful care, wonderful people".

Staff understood and respected the personal, cultural, social and religious needs of children and young people

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and how they may relate to care needs. Staff described how they had recently contacted the chaplaincy service to attend a service user who had expressed a wish to speak with a chaplain.

During our inspection, we spoke with two children and their relatives and carers, we received predominantly positive feedback from most people. One child told us the care and compassion received from staff was excellent. We observed staff interacting with children, young people and relatives and saw that staff treated all children and young people with dignity and respect. Staff were caring and considerate to the needs of children and young people in their care.

We spoke with a child who told us the staff were ‘Lovely, they always introduce themselves and explain everything’. The child said they were satisfied with the care they received. Another told us staff were very considerate and respectful.

Other children described the staff as ‘brilliant, friendly and great company’. Children, young people and their families told us that staff do their very best and are happy to do anything for them.

The service had a bedroom where families could take care of their child after they had died in a culturally and dignified way. It was clear from what we were told that ‘pastoral care’ and ‘spiritual care’ was important to all at Shooting Star. The service had a good care plan in place for this aspect of care. This clearly covered all the issues around this aspect of care.

Emotional support

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

Staff gave children and young people and those close to them help, emotional support and advice when they needed it. Nursing and medical staff made time to speak with children, young people and their relatives. We heard a doctor telling a family member “If you need me come and find me and we can have a discussion”

Staff supported children and young people who became distressed in an open environment and helped them maintain their privacy and dignity. Staff took family

members into a private room to have difficult conversations. Nursing staff told us they kept tissues out of sight in this room as family members often assumed they were about to receive bad news if they saw tissues.

Staff demonstrated empathy when having difficult conversations. We saw nursing staff displayed appropriate support to a family member who was clearly distressed. Offering a gentle touch as they guided them to somewhere more private.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

Carers, family and siblings of young people could access emotional support and information at the right time. Staff care planned and reviewed at every interaction.

The service ensured that children, young people and their families religious needs were met by the chaplain services provided to support them. We were told the hospice engaged with religious groups within the community to provide the chaplaincy services.

During the inspection we noted that staff were working well with children, young people and their families. We observed clear, caring and sensitive interactions throughout the day that were both empathetic and compassionate in nature. We observed nurses and carers working very effectively with children and parents in developing positive caring relationships that were about building trust.

The service had a “Family Fact File” which detailed the support that was on offer and we saw that the support for children, young people and their families were being delivered.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure children and young people and those close to them understood their care and treatment.

Staff communicated well with children and young people so that they understood their care, treatment and

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condition and any advice given. Throughout the day of inspection, we observed good interactions between children and young people and staff around day-to-day care issues and activities. We observed staff sitting down with children and parents and actively listening to them – being truly present to the person in front of them and not what was going on around them. They had a ‘You said We did board’ – this was very good and useful feedback to services users. They also had a very good leaflet asking for ‘Your Feedback – we would like to know what you think of us’. This also contained information on how to make a complaint, which is very helpful.

Staff made sure that children and young people who used services and those close to them were able to find further information, including community and advocacy services. They could ask questions about their care and treatment. They were supported to access further information through direct conversations with staff, leaflets, inhouse services and partner agencies who worked on or off site.

Children and young people were empowered and supported, where necessary, to use and link with support networks and advocacy, so that they had a positive impact on their health, care and wellbeing. Family support was offered both pre and post bereavement.

Staff talked with children, young people, their families and carers in a way they could understand, using communication aids where necessary. We saw that conversations with relatives were documented in care records. We spoke with the relative of one child who told us they were happy with the care their relative had received and they felt communication from staff was good.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. We saw and heard about changes made to processes and facilities as a result of the service (hospice) seeking children and young people feedback. The service regularly carried out patient surveys in order to obtain feedback from children, young people and their families.

Staff supported children and young people to make informed decisions about their care. Medical records evidenced children, young people and their relatives were given choices about their care and were included in decision making about the care.

A high proportion of children, young people and their families gave positive feedback about the service in the patient survey and this was positive for all areas of the service provided by the hospice. Children, young people and their families consistently spoke positively about the care they had received. One child told us “You can talk to them (nurses) and they listen”

When a child was in an end of life stage, the music therapist provided an opportunity for the family to share a music therapy session together to ensure that this time was personal and meaningful for family. The music therapist created a unique composition on her harp for the child. This was created together with the child and family, using the letters in the child’s name to form a theme for the melody. The family often shared the reasons for the names they had given the child and special moments from the child’s life– representing this in the notes and rhythms they choose for the piece. The child’s piece was often performed on harp at their bedside with the family there, or in the summertime, out in our garden under the trees. A recording was given to the family to keep.

Are hospice services for children responsive to people’s needs? (for example, to feedback?)

Good 

Our rating of responsive went down. 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 children, their families and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service planned and provided in a way that met the needs of local children and their families. Children and young people were usually referred through their GP or

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local hospital, but children, young people and their families were also able to self-refer through telephone or completion of an online form. The service provided end of life care for individuals requiring care and support outside of their NHS care.

The service offered a range of appointments to meet the needs of the children and young people who used the service. Managers told us there was mixed demand for appointment times and they would offer appointments to suit the needs of children and young people.

The hospice had recently undertaken an extensive piece of work to change their care model. This was to ensure they remain responsive and sustainable and direct their resources to children and young people in their last year of life, or where it was needed most. The hospice provided charitable and statutory funded respite care which can be accessed as planned care or emergency care to support urgent situations.

Shooting Star House had met the standards of non-verbal communication and had been appointed as a “Makaton Friendly” organisation which recognises best practice in communication with children who were unable to communicate by verbal means. The Makaton Friendly scheme recognises organisations that strive to make their services accessible to people who use Makaton to aid their communication.

The environment was appropriate, and patient centred with comfortable seating and access to facilities such as child appropriate toilets. Two of the rooms were ensuite and spacious and allowed for several family members to be together.

There was local access to the service by public transport or car, with a dedicated car parking. The reception area was clean and tidy with access to leaflets about palliative care and fund-raising initiatives.

The service had arrangements to access translation services for children and young people. Staff we spoke with could tell us how they would access these services and provided examples of occasions that they had done so.

The service had a multi-faith quiet space that held services and prayers as well as being available for children, young people and their relatives if they wished to use it as a space for reflection.

The service recently undertook research-based change of care model to ensure that their service was responsive to the needs of children, young people and their families. This work was developed in collaboration with all the stakeholders including acute services, hospice staff, service users and families. At the time of our inspection, the hospice had been invited to present this work at the “Together for Short Lives” national conference in March 2020 as an example of best practice to the wider hospice community.

Meeting people’s individual needs

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

Care plans were in place for inpatients on the wards and community patients. These were person centred and we could see that children, young people and their carers had the chance to discuss them and contribute.

The hospice had a bereavement suite where families could stay with their child after they had died for up to a week. We noted that the suite was patient-centred and family friendly.

We undertook a home visit with a community nurse specialist making an introductory visit to a child and their family in the community. We found the nurse was very respectful and professional of being in the patient’s home and gave a full overview of services available including day care services, complimentary services and information about the inpatient unit. The community nursing staff developed a plan of care collaboratively with the children and young people. We noted during the home visit that a comprehensive assessment of children and young people’s symptoms was conducted, and advice given on symptom management. The nurse obtained a clear picture of the patient’s family and wider support network and assessed their spiritual needs. This assessment and interaction were conducted in a professional manner, which demonstrated a clear understanding of the children and young people needs.

Children, young people and their families could access a therapeutic spiritual suite. The room promoted

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tranquillity. Children, young people and their family members could use the room as a place of contemplation and prayer. Prayer mats and a range of religious texts, for example, a Koran for use by Muslim patients was available.

Shooting Star House had a symptom care team that provided a rapid response outreach into hospitals and the community to reach children, young people and their families who may benefit from the service at an early stage and facilitate rapid discharge. We saw good evidence of this during the inspection when a child was transferred from an acute hospital for compassionate extubation. Compassionate extubation, also known as palliative extubation, is performed to alleviate suffering by termination of mechanical ventilation and withdrawal of the tube, thus avoiding the prolongation of death. Staff actively participated in the transfer and extubation of the child who was previously unknown to the service. The compassionate extubation was done in a well-managed and well controlled environment.

The service focussed on individual needs and goals in planning children and young people's care. Goals would be identified, and a plan put in place to achieve the goals. For example, children and young people could want to achieve the goal of tackling their breathlessness, so a care plan which involved additional physiotherapy sessions had been put into place. Other goals might involve advance care planning and therefore appointments with the clinical nurse specialist to have discussions around advanced decisions, emergency decisions and preferred places of care would be arranged.

Staff monitored and reviewed the changing needs of children and young people through regular 'comfort rounds' and frequent assessment and reviews. The service had a complementary therapy team who offered a range of therapies to children, young people and their relatives including aromatherapy and massage. The hospice provided meals for all families and staff prepared by the in-house catering team.

People with a range of disabilities could access and use services on an equal basis to others. There was disability access for those using wheelchairs and with visual impairment.

The service provided children and young people with social events like, youth clubs, social clubs, Saturday

clubs and chill and chat coffee morning. The social events were a relaxed and informal chance for supported families to get together and have a chat over coffee and cake.

The services transition coordinator undertook an outstanding work with children and young people on an individual basis using their excellent knowledge of the mental capacity Act and goes to an extraordinary length using innovative ways to enhance children and young people's opportunities, outcomes and quality of life. An example of this was where the coordinator worked closely with a cognitively able young person with a complex palliative diagnosis who wanted to access college to continue their advanced level study. The young person was unable to travel to meetings where their case was being discussed as they had sudden periods of acute illness. The young person was also extremely shy and found expressing their wishes difficult in large and formal situations. The coordinator used an electronic tablet to interview the young person and recorded the young person's views and then played this at the meeting. This ensured that their views were heard and taken into account.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

The service had processes to manage referral and admission to the service. The service had an admissions and referrals team who monitored and forwarded referrals and admissions to the appropriate service. Referrals came through from the local hospital and GPs. People could access services in a timely way through self-referral.

The community nursing team worked to keep children and young people at home if that was where they wanted to be. A referral to the inpatient unit did not always result in admission. Children and young people's preferences were respected and met where possible. Children and young people had fast track admissions 24/7, either direct from the community or transfer from hospital. This ensured the child's needs were met when needed.

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Clinical staff completed the initial assessment and referrals were discussed at the referral panel. The panel included the GP, consultant, nursing and therapy staff. The service used a scoring system and discussed what options would be most beneficial to families, for example respite or day care. The team monitored the referral to ensure the offer continued to be the right one and best suited the needs of the child or young person and their family.

Referrals for these services could be made rapidly; updates were provided at the next referrals panel. Staff worked hard to put things in place quickly to support children and young people who were discharged home; for example, assessing environments for hoists and assigning staff with the right skills.

Clinical staff provided support across the in-patient and community services, the team were well placed to decide what movement needed to take place that day and what resources could be allocated to support this. The clinical team met daily to discuss children and young peoples' care needs.

Staff discussed service provision at weekly multi-disciplinary meetings. This was to ensure that when appropriate, children and young people were discharged to their preferred place of care. This meant freeing up capacity to admit those on the waiting list.

Managers used an escalation tool to assess the level of demand and activity for the service. This was completed at the beginning of each day. Extra staff were brought in if necessary to meet the needs of children and young people.

New patients in the community were triaged and assigned to be seen for an initial visit within 24 hours. On average, 95% were seen within this timescale. Around 10% of referrals were assessed as not needing a visit, either because they had died, been admitted to the hospital or hospice, or a visit was not convenient.

Each child had their own personalised care plan, which was co-created with them and their family. Each family was offered 10 nights per year from charity funding and some families had funded time as part of their care package from the local CCG. The hospice accepted children from 0 – 21 years. A typical stay at the hospice was from Sunday afternoon until Friday morning for four children, and six children could stay from Friday

afternoon to Sunday morning. The service had a system of red & green booking. Green bookings could be cancelled at short notice if there was an emergency admission. Parents are clearly told about how this system works.

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.

Children, young people, relatives and carers we spoke with knew how to complain or raise concerns and felt comfortable doing so if necessary. We saw information on how to make a complaint displayed around the hospice.

Staff told us that in the event of a child, young people or relative wishing to complain they would ask the nurse in charge to speak to them to resolve the issue in the first instance and provide them with the details of the officer in charge of dealing with complaints. Staff understood the complaints process and had access to policy and procedures to guide them in managing complaints. Managers investigated complaints and identified themes and shared these in meetings. We noted that lessons were learnt on complaints, investigations and outcomes.

We saw documents at the hospice about the complaints process. These were in the reception area and the inpatient areas where people could see them. We reviewed the complaints policy and saw it was relevant, up-to-date and clearly outlined the complaints process and steps people could take if unhappy with the outcome of a complaint.

People who used the system to make a complaint or raise concerns were treated compassionately and given the help and support. Staff received specific communication training to help them respond empathetically and sympathetically to people who were distressed, or who were dissatisfied with the service. Staff were expected to report and escalate any concerns so that they could be addressed promptly and to provide an opportunity for a senior member of staff to explore these with children, young people and their families if necessary where the concern was not resolved immediately. Staff told us in most cases children and their relatives would raise concerns and complaints verbally to them and they would in most cases be dealt with there and then.

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The service proactively asked for feedback in their feedback form which was located at various points within the building during the inspection.

Are hospice services for children well-led?

Good 

Our rating of well-led stayed the same. We rated it as **good**.

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 children and young people and staff. They supported staff to develop their skills and take on more senior roles.

The hospice was led by the chief executive and was clinically led by the director of care and the registered manager.

Staff we spoke with told us that they felt very supported by senior management and they all were friendly and approachable. Staff told us that they felt confident in approaching all members of the management team regarding issues in their professional lives.

There was a strong emphasis on continually striving to improve. Managers we spoke with recognised, promoted and regularly implemented innovative systems to provide a high-quality service. Trustees and the board met regularly, and staff knew lines of accountability. Relationships between different levels of staff were effective. Senior managers were based at the hospice and had an open-door policy which we saw during the inspection.

Senior managers were visible and approachable. We saw positive relationships between staff and managers. The chief executive regularly visited specific areas of the hospice and fed back to staff on their visit. This was discussed at board level and staff were encouraged to have their say on findings.

All managers we spoke with had a clear understanding of the challenges to quality and sustainability of the service. They could identify actions to address these such as investing in staff pay, terms and conditions.

Nursing leadership was provided by the clinical director and the inpatient senior nurse. The clinical director was a registered nurse with a background in hospice care. We saw, and staff commented on positive relationships between staff and their managers. Trustees and managers regularly visited and walked round the hospice talking to staff, children, young people and their families.

Vision and strategy

There was a clear vision and credible strategy to deliver high-quality sustainable care. 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.

The service had an operational plan which encompassed all its services and aligned with their five-year strategy. The service had sought the views of children and young people and staff when creating the strategy and endeavoured to align the plan with Hospice UK guidance, national strategy and the local sustainability and transformation partnership for end of life care. The vision, values and strategy had been developed using a structured planning process in collaboration with staff, people who used services, and external partners.

Staff knew and understood the vision, values and strategy, and their role in achieving them. Staff and key stakeholders were involved in the development of the strategy, vision and values. Carers and Family Support strategy and engagement days were planned with carers and key organisational stakeholders.

The operational plan was discussed, and its progress monitored at board meetings. The executive team reported on the progress of the plan to the trustees on a quarterly basis. We reviewed the updates and saw the service was tracking progress made against the plan and demonstrating actions taken to help them achieve their goals.

The services objectives and plans were achievable and flexible. Strategies and plans were fully aligned with plans in the wider health economy, and there was a

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demonstrated commitment to system-wide collaboration and engaging with the wider community to ensure equity of access to care. There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans.

The leadership team monitored and reviewed progress against delivery of the strategy and local plans. The service strategy aligned to local plans in the wider health economy, and how services were planned to meet the needs of the local people. The leadership team worked collaboratively with staff in achieving their service plan. Teams had work plans, objectives and key performance indicators to allow systematic monitoring and managers regularly met staff to discuss outcomes.

Culture

Staff felt respected, supported and valued. They were focused on the needs of children and young people receiving care. Staff reported that the culture of the service had improved since the last inspection. The service had an open culture where children and young people, their families and staff could raise concerns without fear.

All the staff we interacted with spoke highly of the organisations culture. Staff said they were proud to be part of the team and showed dedication to their work.

The caseload of staff included working in complex and emotionally challenging situations. Staff commented they received training and support to equip them with the necessary skills. Staff were positive in their role and spoke of high job satisfaction.

The service provided an environment which encouraged openness and honesty with the young people, families and staff. The importance of being open, honest and transparent was explained at induction for all staff.

Staff were aware of the whistleblowing policy and knew who their freedom to speak up guardian was. Staff were aware of their responsibilities to duty of candour. This is a duty placed on providers of healthcare to be open and honest about when things go wrong in their care.

All the members of staff we spoke with, spoke positively about the service. One person we spoke with told us how

she felt her skills were valued. Another healthcare assistant told us the service was very safe and supportive, with good teamwork and good training and development opportunities.

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 a strong governance structure that supported the feed of information from frontline staff to senior managers and trustees. The hospice held monthly team meetings and clinical governance committee meetings. These meetings in turn fed into the service's monthly care boards. The board meetings were attended by senior members of staff in the organisation including the service leads.

The service held trustee meetings which discussed the services quality dashboard, incidents, risks and financial reports. Both the trustee meetings and board meetings discussed the service's monthly quality dashboard. The dashboard looked at mandatory training rates, hand hygiene audits, bed occupancy and referral rates, children and young people feedback, information governance and quality assessment tool reporting.

Service leads told us they were discussing a potential service development to develop an outcome measures for the service.

Feedback from people who used the services and those close to them was regularly discussed at both care board meetings as part of the dashboard review. The service looked at compliments received, complaints and any concerns that had arisen through children and young people and their relatives. Concerns were discussed by the board and actions identified and assigned to senior staff members to lead on.

There were clear lines of accountability in the service. The service had nominated leads in areas such as safeguarding and infection prevention and control. These leads reported on these areas during clinical governance and board meetings.

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The service had plans in place to ensure continuity of care in the event of an emergency through services emergency plan which could be located on the service's intranet. Staff were aware of the plan and had received training on example emergency situations.

Managing risks, 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. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Leaders strived for continuous learning, improvement and innovation. The hospice ensured that continuous learning took place to help improve performance of staff by providing them with relevant in-house training and development.

The service understood its key risks and had oversight of them. The service kept a risk register, which was up to date and staff knew how to escalate any concerns. The risks on the risk register reflected the risks staff had told us about throughout our inspection. For example, recruitment of experienced registered nurses. Mitigation was in place for the risks and identified staff who were responsible for providing updates to the board on progress made towards managing or removing the risk. There was evidence that the risks were being reviewed and updated regularly. The risks that were on the register had control measures in place and a review date.

Risks were taken into account when planning the service. The top risks for the hospice were; patient safety, staffing and medication errors. We reviewed the risk register and found risks were being actioned in a timely manner to help mitigate the risk. For example, in February 2019 two registered general nurses' positions had been filled to support an extra registered nurse on the night rota.

The risk register identified that medicines errors were a risk for the hospice. Actions that had been taken to mitigate the risk included a review of syringe driver competencies, even though there had been no specific incident.

Medicines errors were monitored, and bench marked against other hospices. We saw that during the period March 2018 to January 2019, there had been 17

medicines errors. These were benchmarked against other hospices through the Hospice UK benchmarking scheme which showed that the hospice performed better than their neighbouring hospices. Although performance was better than other hospices, additional training had been provided together with documentation training.

The service employed a pharmacist for eight hours a month to support their medicines management. The pharmacist attended a weekly multidisciplinary meeting when required to do so. The service also had a local pharmacist support from the local pharmacy where the service procures its medicines.

We also saw evidence that the risk register was part of the agenda for all board of trustee's meetings. It was also discussed at the clinical governance committee meetings, which were held monthly.

Staff told us feedback from people who used the service was collected via patient and service user survey, however, the number of responses had been low. The hospice was aware of this and were looking for an alternative method to gather more patient and service user feedback. The hospice had a positive and collaborative relationship with the local clinical commissioning group and other stakeholders and interested parties.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats

There was a confidentiality and data protection policy in place with a review date of April 2022. The policy contained relevant information such as access and disclosure of personal information, information sharing, reporting breaches of and risks to confidentiality.

The service regularly completed notifications to the Care Quality Commission when a child died or had a serious injury.

Staff kept children and young people records securely. Electronic patient records were kept securely on computers which were password protected. Leaders told us temporary staff were given temporary access to the any electronic systems. Records contained details of children and young peoples' emotional, social and spiritual needs alongside their physical health.

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All staff were provided with handheld electronic devices. Staff could access emails, documents, policies and care plans. Staff used these to input care notes in real time.

Engagement

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

The service engaged well with children, young people, their families, staff, volunteers and the public and local organisations to plan and manage appropriate services and collaborated with partner agencies effectively.

The service collected feedback from children, young people and their relatives in many ways. The community and inpatient teams provided feedback forms in the information packs they provided, and the service had a patient user group who undertook telephone interviews to collate feedback about the service. The service monitored patient satisfaction survey results as part of their dashboard and fed this information back to the care board and trustee meetings.

The hospice could provide examples of where services had been improved and changed because of the views and experiences of people using the service. Examples included changing when support and counselling was offered to bereaved families from six weeks after the death of their relative. This was changed following feedback that relatives would have liked support earlier in the process.

The service engaged and supported its volunteers. The service sent a survey to volunteers that asked them about their experience working as a volunteer, the recruitment process and support they had received in their role. The responses to the survey were largely positive. The service also held volunteer forums quarterly to gain feedback from volunteers and held monthly volunteer social gatherings in the service's canteen.

The hospice was proactive in improving services in response to feedback from volunteers. Staff provided the example that volunteers had requested more support

with communication and bereavement support for families. As a result, the service organised training with the chaplain on communication and difficult conversations.

Staff were engaged in the planning and delivery of the service. Staff attended regular team meetings to share ideas, opinions and feedback their concerns. The service held quarterly staff forums to update the team on changes and give staff the opportunity to input into the service.

Employees completed an annual staff survey. The results of the survey were largely positive with staff answering positively to questions asking if they were proud and satisfied to work for the organisation.

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 and participation in research.

The service was committed to improving services by learning from when things went well or not so well and promoted training and innovation.

The service was proactive in seeking feedback from staff, volunteers and service users and could provide multiple examples of where service improvements had been implemented as the result of this engagement.

The service recently undertook ground breaking research based change of care model to ensure that their service was responsive to the needs of families. This work was developed in collaboration with all our stakeholders including acute services, hospice staff, service users and families. The hospice was invited to present this work at the "Together for Short Lives" national conference in March 2020 as an example of best practice to the wider hospice community.

Shooting House had met the standards of and had been appointed as a "Makaton Friendly" organisation which recognises best practice in communication with non-verbal children.

Outstanding practice and areas for improvement

Outstanding practice

- The hospice had a bereavement suite where families can stay with their child after they have died for up to a week. The suite was noted to be patient-centre and family friendly.
- Shooting Star House had a symptom care team that provide a rapid response outreach into hospitals and the community to reach children, young people and their families who may benefit from the service at an early stage and facilitate rapid discharge. We saw good evidence of this during the inspection when a child was transferred from a local hospital for extubation. This was done in a well-managed way. They also had good use of emergency care plan and symptom management plan for children and young people in their care.
- The service objectives and plans were achievable and flexible. Their strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to systemwide collaboration and engaging with the wider community to ensure equity of access to care.
- The service had a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans.
- There was compassionate, inclusive and effective leadership at all levels. The lead nurse was able to stand in for the head of care and the registered at the start of the inspection, before they came onsite.
- The service provided children and young people with social events like, youth clubs, social clubs, Saturday clubs and chill and chat coffee morning.
- The service recently undertook research-based change of care model was invited to present the work at the “Together for Short Lives” national conference in March 2020.
- Shooting Star received a letter of recognition from the Child Death Overview panel in October 2019 in recognition of Shooting Star House’s contribution to the care of a dying child.
- When a child is end of life, the music therapist provided an opportunity for the family to share a music therapy session together to ensure that this time is personal and meaningful for family.
- The service’s two social workers had completed Surrey Young Carers training course and they were recognised as Surrey Young Carers Guardian Angels.
- Shooting House had met the standards of and had been appointed as a “Makaton Friendly” organisation which recognises best practice in communication with non-verbal children.

Areas for improvement

Action the provider SHOULD take to improve

The provider should consider appropriate storage for their equipment. We found that equipment was stored in toilets and other areas of the service which is not in line with good practice.