Zoe's Place Trust

Zoe's Place Liverpool

Inspection report

Life Health Centre
Yew Tree Lane
West Derby
Merseyside
L12 9HH

Tel: 01512280353
Website: www.zoes-place.org.uk

Date of inspection visit:
19 December 2016

Date of publication:
18 January 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service in August 2016 when five breaches of legal requirements were found. We found a breach in regulation regarding the safe management of medicines and we took enforcement action in respect of this breach. We served the provider with a statutory Warning Notice regarding medicines not being managed safely. We found a breach of regulation as the service had not followed agreed protocols for reporting allegations of abuse to the local authority and to us the CQC (Care Quality Commission); there was a lack of monitoring of potential risks to children's safety; care needs were not planned effectively to meet the needs of the children; and there was a lack of an effective system to assure the safe management of the service. We asked the provider to take action to address these concerns.

After the comprehensive inspection, the provider wrote to us to tell us what they would do to meet legal requirements in relation to the breaches. We undertook a focused inspection on 19 December 2016 to check that they had they now met legal requirements. This report only covers our findings in relation to the specific area / breach of regulation. This covered three questions we normally asked of services; whether they are 'safe', 'responsive' and 'well led.' The question 'was the service effective' and 'was the service caring' were not assessed at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Zoe's Place Liverpool on our website at www.cqc.org.uk.

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

Zoe's Place in Liverpool is part of the national organisation, Zoe's Place Trust. The service provides care and support for up to six children who have life limiting illnesses with special and complex needs to varying degrees. The service offers respite, palliative and terminal care to children aged from birth to five years.

Families also receive support through the parent support network and sibling groups. The organisations' website states, 'Zoe's Place offers our parents and carers a chance to recharge their batteries or to spend time with their other children'. Registered children's nurses and support staff (carers) look after the children during their stay. The organisational structure included a board of trustees and clinical lead manager who oversaw the three services, Zoe's Place Liverpool, Zoe's Place Coventry and Zoe's Place Middlesbrough.

The hospice offered an in-patient palliative and respite care to children up to the age of five who had life limiting or life-threatening conditions. There was also the provision of a day service from 10am-6pm during the week and a sibling support group. Referrals to the service were made from families, health professionals, hospitals or by contacting the hospice direct. Referrals to the service were dealt with promptly and parents were provided with a minimum of two nights respite care each month for their child. At the time of the inspection the hospice was not providing end of life care. Three children were receiving in patient care

during our visit with a further admission later that day.

At the previous inspection in August 2016 we found medicines were poorly managed and medicine practices at that time put children at risk. At this inspection we found improvements had been made. This included verifying what medication a child was taking before being admitted to the service, the administration of feeds via a stomach tube and lessons learned from medicines incidents being fully recorded and discussed with staff to minimise the risk of re-occurrence. This breach had been met.

At the last inspection we had concerns that the service was not following agreed local authority protocols for reporting allegations of abuse with the local authority or with us the Care Quality Commission (CQC). At this inspection our findings showed staff were aware of the safeguarding protocol to follow and on-going training was provided around the safeguarding of children. This breach had been met.

In respect of ensuring children's safety, we found at the last inspection a lack of recorded safety checks for care and equipment. We found at this inspection that significant changes had been made to systems and records to improve the safety of the service. For example, a more detailed form had been introduced of observations checks required on each child throughout the day and overnight. For example, whether a child was asleep or awake, a record of their respiratory rate and use of oxygen and suction equipment. The observation charts were completed in detail to evidence the safety checks undertaken. This breach had been met.

We found at the previous inspection that children's plan of care lacked detail or the information recorded was not in accordance with their current needs and treatment plan. At this inspection we saw improvements had been made. Care documents were now sufficiently detailed and inclusive of children's needs. We saw this in respect of the care needs assessments and care records we viewed. This breach had been met.

In light of the overall concerns we had at the inspection in August 2016 we found the service's overall governance arrangements were not robust to assure a safe effective service. At this inspection we found the overall management of the hospice had improved. We saw how changes had been made to ensure a more robust system was now in place to monitor how the service was operating and to drive forward improvements. The clinical governance framework was effective thus ensuring good standards of care. This breach had been met.

The registered manager appreciated that although significant improvements had been made, the changes made need time to embed and consideration needs to be applied to the future development of the service.

Feedback from staff was complimentary regarding the registered manager's leadership and management of the hospice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was safe

Medicines were managed safely by the hospice staff.

Staff were following agreed protocols for reporting allegations of abuse to the local authority and received on-going training around the safeguarding of children (protecting people from abuse).

Risks to children's safety and well-being for their care and treatment were recorded and monitored by the staff.

While improvements had been made we have not revised the rating for this key question. To improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for 'safe' at the next comprehensive inspection.

Is the service responsive?

Requires Improvement

The service was responsive.

Children had a care needs assessment and plan of care that reflected individual care needs. Care documents were reviewed and updated to reflect any change in care or treatment.

While improvements had been made we have not revised the rating for this key question. To improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for 'responsive' at the next comprehensive inspection.

Is the service well-led?

Requires Improvement

The service was well led.

Robust systems and processes were in place to assure and monitor the service. These arrangements however should be reviewed on a regular basis to ensure the overall monitoring of medicines is robust.

The service had a registered manager. Feedback from staff was complimentary regarding the registered manager's leadership and management of the hospice. We saw that the registered manager was providing an effective lead.

While improvements had been made we have not revised the rating for this key question. To improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for 'well led' at the next comprehensive inspection.

Zoe's Place Liverpool

Detailed findings

Background to this inspection

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

The inspection team consisted of two adult social care inspectors and a pharmacy inspector.

Before our inspection we looked at the notifications and other intelligence the Care Quality Commission had received about the home.

During the inspection we spent time with children who were receiving an in-patient service from the hospice staff. We met with the registered manager, two registered nurses and two care staff who were on duty at the time of our inspection. Additionally, we reviewed a range of documents and records including, four care records for children who were receiving care at the hospice, five children's medication administration record sheets (MARs), safeguarding records, accident and incidents reports and range of quality audits and management records to assure the service.

Requires Improvement

Is the service safe?

Our findings

We previously visited this hospice in August 2016 and found the provider to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in respect of the poor management of medicines and monitoring of risks to children's safety. We took enforcement action in respect of the poor management of medicines. We served the provider with a statutory Warning Notice regarding medicines not being managed safely. We also found the service to be in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in respect of the service was not following agreed local authority protocols for reporting allegations of abuse with the local authority or with us the Care Quality Commission (CQC).

We asked the provider to take action to address these concerns. The provider submitted a provider action report which told us the improvements they had made to meet this breach. At this inspection we checked the progress of the action plan by speaking with staff and looking at relevant records including; care records, incident forms and safeguarding referrals. We found improvements had been made to meet necessary requirements. These breaches had been met.

At this inspection we found that significant changes had been made to systems and records to improve the safety of the service. For example, a form had been introduced which detailed the checks to be made on each child throughout the day and overnight. A registered nurse was now available on each shift who did not have direct caring responsibilities. They were required to provide oversight and guidance to staff as well as completing essential paperwork and safety checks. We saw from staff rotas that this role had been available on a regular basis. However, staff sickness had sometimes meant that the additional nurse was deployed in a direct caring role. We spoke with the registered manager and nursing staff about this and were told that two additional nurses had been recruited to accommodate the new role and were due to start in early 2017. One member of staff commented, "They're bringing in two new nurses. There's a lot of staff. Keeping the nurse out of the [direct care] numbers has helped."

At the last inspection we identified risk in relation to the monitoring of oxygen saturation levels. We looked at the checklists for four children and saw that they had been completed as required. Each checklist indicated that a series of checks including oxygen saturation and heart rate throughout the day and at 30 minute intervals throughout the night. At the previous inspection we identified a risk relating to the positioning of wired remote controls for adjusting cots. At this inspection we saw the remotes had been repositioned out of reach and were monitored regularly as part of the checklist process.

We also looked at records of incidents and accidents including a spread sheet which was held by the registered manager. The spread sheet detailed the nature of the incident and what action had been taken. The spread sheet allowed the registered manager to analyse incidents and accidents to establish patterns or triggers. We saw that the number of incidents recorded was low since the last inspection and that appropriate action had been taken following incidents. For example, one potentially serious incident had resulted in performance management measures being implemented for a staff member. The matter was also reported as a safeguarding concern and notified to the Care Quality Commission. We were told that

there had been no other incident since the last inspection that required a safeguarding referral. We checked incident and accident records and found that referrals and notifications had been made appropriately. We also spoke with staff about safeguarding procedures and looked at written guidance. Each of the staff that we spoke with was clear about what action they would take to safeguard a child and made reference to the written information and flowcharts available to aid their decision-making. Staff told us they received safeguarding training.

Other measures introduced included a clinical decision form that gave nursing staff a process for assessing clinical risk where they identified discrepancies in records prior to admission. The form was used to assess the completeness and accuracy of information 48 hours prior to admission, but could only be used once. We saw records of these checks in care files. If any discrepancies had not been corrected prior to the next admission, registered nurses were instructed to refuse to provide a service until the necessary information was updated. This meant that important information relating to medicines and care was more likely to be accurate and regularly reviewed.

The staff we spoke with were very positive about the changes that had been introduced and the impact that the measures had on the children's safety. One member of staff said, "We have clinical decision forms now. We do a 48 hour phone-call with a check on medicines, treatment plans and feeds." Another member of staff told us, "There's been lots of changes. Overnight observations have changed, fluid balance checks are better too. Cot checks are better. It feels safer and clearer. It's easier."

We told by each of the staff that we spoke with that they had been involved and consulted about the changes. They also told us that they were given time to review incidents, issues and care practice at regular meetings. Each spoke positively about the manner in which the changes had been implemented by the registered manager. One member of staff said, "There's been loads more training and opportunities to come together and review paperwork and systems."

At this inspection, we checked the medicines and records for five children. We spoke with three members of staff including the registered manager and two registered nurses regarding the safe management of medicines.

At the previous inspection, concerns were found with how the service verified what medication a child was taking as different sources used before admission did not always match. The service had improved on the sources used and a pre-admission form had been introduced which asked parents or carers whether any additions or changes to medicines had been made.

Concerns were found with how feeds that were administered into a stomach tube were managed and how fluid boluses were recorded. There had been incidents where competent, assessed carers had put liquid into the wrong stomach tube and there was no record of when a feed or bolus was given and who had started it. The service have since put all feeds and fluid boluses to be administered on the medicines administration record sheet (MARs) and the carer had to have a double check by a registered nurse before the feed was started.

There had been 11 medicine incidents from January to August 2016 and the lessons learned from these instances were discussed at staff meetings, but the specifics of the lessons learned were not documented in detail within the team meeting's minutes. There had been less medicine incidents since our last inspection; some discrepancies in the number of tablets counted on admission had been reported as an incident and this was recorded within minutes of meetings, which is an improvement since our last visit.

At the previous inspection, a child was prescribed Thick and Easy, which is a thickening powder used to thicken fluids for people with swallowing difficulties. The service was not recording when the powder was used and whether the fluids were thickened to the correct consistency. Not having fluid thickened to the correct consistency, may increase the risk of the person choking. We were unable to assess this at this inspection as the five children who were staying at the hospice were not on fluid thickening powder. The staff however told us how the use of thickening agents would now be recorded and monitored to ensure their safe use.

Requires Improvement

Is the service responsive?

Our findings

We previously visited this hospice in August 2016 and found the provider to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in respect children's care not being planned effectively to ensure their care needs were met.

We asked the provider to take action to address these concerns. The provider submitted a provider action report which told us the improvements they had made to meet this breach. At this inspection we checked the progress of the action plan by speaking with staff and looking at relevant care records. We found improvements had been made to meet necessary requirements. This breach had been met.

At the previous inspection we found children's care plans were not sufficiently detailed or had not been updated to reflect their current needs and treatment plans. At this inspection we found the care documents to be sufficiently detailed and inclusive of the children's needs. Staff told us any change was now picked up through the assessment process and this included the completion of a care needs assessment. The registered manager told us the care needs assessment was now a 'live' document and staff requested far more information from the parents and health professionals prior to admission. This included information in respect of each child's medical and social care needs, routine and preferences. We saw this in the assessments we reviewed. Staff comments included, "We pick up on things a lot quicker now from the point of the assessment" and "The needs assessment and care documents are updated as we go along, it's a much better system now. Children's needs also change as they are growing up."

The care files we looked at recorded details in respect of each child's care needs. For example, care plans were in place for, mobility, personal hygiene, maintaining a safe environment, communication, playtime, breathing and enteral feeding. An enteral feed is the delivery of nutritionally complete food via a tube directly into the stomach, duodenum or jejunum. At this inspection we found care plans were consistent and inclusive of all care needs. The staff had the information they needed to provide care and support to children in accordance with individual need. A staff member said, "The care plans are now much more detailed, the changes are so much better." Where there was a risk to a child's safety we saw this was recorded and linked to the plan of care.

Staff had a good knowledge of potential risks, for example, the delivery of enteral feeds, care of a tracheostomy site and checks of emergency equipment, such as oxygen. We saw examples of these and also where care plans had been updated to reflect a change in risk and/or to the current treatment plan. Staff told us about the observations charts which were used to help monitor each child's safety and clinical issues. The observations charts we saw were up to date and in accordance with each child's plan of care. Staff said, "The observation chart is a massive chart. They're consistent and thorough" and "We have made a number of changes to ensure all the children's needs are met and we monitor them very closely. We record now whether a child is asleep or awake at night."

We were shown an example of a short term plan of care which would be put in to place if a children presented with a new condition, for example, a chest infection and required short term medical

intervention. This helped to monitor any conditions arising during a child's stay at the hospice.

Requires Improvement

Is the service well-led?

Our findings

We previously visited this hospice in August 2016 and found the provider to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have a robust system in place to regularly assess and monitor the quality of the service.

We asked the provider to take action to address these concerns. The provider submitted a provider action report which told us the improvements they had made to meet this breach. At this inspection we checked the progress of the action plan by speaking with staff and looking at relevant records, including audits (checks), systems and processes to assure the service. We found improvements had been made to meet necessary requirements. This breach had been met.

At this inspection the registered manager told us about the service's clinical governance. The service's clinical governance document states, 'Clinical Governance is the way we work to improve the quality of care children and their families receive and to maintain that high quality of care. It is about ensuring that children get the right care at the right time from the right person and that it happens right first time'. Clinical governance for the service included key components, for example, 'accident and incident monitoring', 'clinical audit', 'education, training and continuing professional development', 'evidence-based care and effectiveness, 'patient and carer experience and involvement' and 'staffing, staff management and leadership'. We saw how changes had been made to ensure a more robust system was now in place to monitor how the service was operating and to drive forward improvements. This included us reviewing current service audits (checks), other areas of governance and talking with staff around current monitoring arrangements. The registered manager appreciated that although significant improvements had been made, the changes made need time to embed and consideration needs to be applied to the future development of the service.

We were shown minutes from a recent clinical governance meeting in October 2016; the next meeting was scheduled to be held in January 2017. The clinical governance committee consisted of executive trustees, an executive clinical lead and heads of care for each hospice within the organisation. Team. They in turn fed their findings to the Board of Trustees to provide assurance as to how the service was operating around key clinical incidents and risks. Minutes seen were detailed and included incidents that affected a child's safety and well-being and the actions taken.

The registered manager also told us how the trustees were now more involved on a day to day basis and the time allocated for staff meetings had been increased as it was appreciated that more time was needed for staff communicate and embed the changes and to help share good practice and initiative working. A staff member said, "We have team meetings and we can go to (manager)." We saw minutes of meetings held and these included lessons learned from incidents that had occurred at the service. For example, a medicine related incident. Staff said they received feedback about actions taken following any incident to help minimise the risk of re-occurrence.

Following the last inspection a risk register had been set up to help monitor emerging risks within the

service. We saw for example, a risk which had been identified regarding the environment and the actions taken to minimise the risk. Prompt action was recorded. The use of the clinical decision form had also been introduced, the aim of which was to highlight details of a clinical issue that needs resolving. This was mainly being used for recording medicine issues, for example there may be an issue with verifying medicines before a child's admission to the hospice. We discussed with the registered manager, ways of extending its use, to cover other clinical areas, apart from medicines.

Staff told us they were supported through a good training programme and they received appraisals, internal supervision and clinical supervision from an external provider. The registered manager told us that supervision of staff had been increased internally for the staff. This now included the registered nurses attending monthly 'one to one' meetings with the deputy manager and the registered nurses providing 'one to one' support for care staff. We saw dates of meetings held to discuss staff development and matters arising, such as, care planning and current work load. Staff told us the management team was very supportive in all ways. Staff confirmed the changes instigated by the registered manager had been communicated and managed well to improve the service. Staff comments included, "The handover is loads better, we sit at the tables and go through everything", "We are all on board with the changes" and "The inspection (last CQC inspection) has really helped."

We saw the development of clinical leads for different areas of the service. For example, a registered nurse was appointed the lead for medicine management and another for documentation and audit. We saw a recent audit undertaken for six care files and feedback had been given to the staff where actions were required to improve the content. A case note audit was completed by the executive clinical lead in October 2016 and the registered manager told us there were plans in place to make this a regular audit by senior management to help oversee the quality of care. The registered manager also completed regular mini care note audit as part of reviewing the care planning process.

We saw recent medicine audits and infection control audits. All required actions had been completed in a timely manner. We did discuss with the registered manager some discrepancies we encountered when reviewing medicines which had not been picked up by the current medicine audits. The registered manager said they would review the current medicine audit to ensure it was more robust.

Parents were asked to provide feedback about the hospice. The registered manager told us that satisfaction surveys would be sent out to parents in the summer of 2017.

From April 2015 it is a legal requirement for providers to display their CQC (Care Quality Commission) rating. 'The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided'. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for Zoe's Place Liverpool was displayed for people to see.