Annual Quality Account

1st April 2017 to 31st March 2018

Naomi House & Jacksplace

hospices for children
and young adults

Care and support for good days, difficult days and last days.

Introduction

Wessex Children's Hospice Trust runs two hospices, Naomi House and Jacksplace, and also provides an Outreach/Community Service and a Long Term Ventilation (LTV) unit. Naomi House has 10 children's bedrooms and an additional flexible 2 bedded care suite (11th bedroom); Jacksplace has 7 bedrooms. The LTV unit consists of three beds, two for LTV and a room for emergency care package breakdown.

The hospices support neonates, children, teenagers and young people with life limiting or life threatening conditions and provide inpatient services for respite (short breaks), emergency care, end of life care and post bereavement care. Both hospices have bereavement suites.

The hospices are in the village of Sutton Scotney, 8 miles north of Winchester, and are easily accessible from major roads and motorways in the region. Referrals for Naomi House are considered from the counties of Berkshire, Dorset, Hampshire, the Isle of Wight, West Sussex, Wiltshire and Surrey. Referrals for Jacksplace may come from any county. We accept referrals for children aged 0-18 years for Naomi House and for young people aged 16-35 years for Jacksplace.

There are facilities for computer games, music, art and specialised activities for people with sensory needs. The hydrotherapy pool, gardens, special entertainments and outings add to the enjoyment of respite stays. Food is locally sourced where possible and freshly cooked in our kitchens, catering for a wide range of dietary needs.

We offer counselling and support services to referred children and young people, as well as to the siblings and families of the children and young people who use our hospices. We also provide family accommodation for respite stays in Naomi House and in both hospices at end of life.

Individual assessments will determine the age of transition from Naomi House to Jacksplace. In consultation with young people, their families and other professionals, we will work out a smooth, safe and suitable transition from Naomi House to Jacksplace from the age of 14 years onwards. The detail and process of transition is tailored to meet the needs of each young person.

We are able to support young people in Jacksplace, without restriction, from 14 years of age onwards as long as they are already known to us, and in the transition process. They may stay at Jacksplace when over 18s are present as long as proper assessments have been made, relevant permissions have been given and that staffing takes account of the ages of people staying with us, so that everybody has proper safeguarding, taking into account the needs of both vulnerable children and young people.

We organise the transition of younger teenagers to Jacksplace through special events and we make the transition gradual, for example with younger teenager weekends and day visits. Our CQC registration gives us flexibility to do this at the pace that suits each individual, based on their age, maturity, cognitive ability and personal preferences. In addition, for those under 18 years of age, we must take into consideration the wishes of their parents/carers as well as those of the individual themselves.

The services in the hospices are nurse led and supported by a Paediatric Palliative Care Consultant who oversees and leads a team of doctors who visit daily and provide 24 hour on-call cover. The nursing staff is a mixture of children's, adult and learning disability nurses who are supported by carers, a play and activities team, family support team, housekeeping and catering teams. We have a dedicated Practice Education Team and work closely with University Hospitals Southampton (UHS) for additional specialist input from a Paediatric Palliative Care Clinical Nurse Specialist, Long Term Ventilation Nurses and support with preceptorship programmes and new starters requiring additional acute skills before starting at the hospices.

The Trust is run by a Board of Trustees advised by a number of specialist committees, including a clinical committee and a healthcare governance committee.

Vision, Mission, Values

Our Vision - Is that every child, young person, and their families receive the care services they need, when and where they need them and for as long as needed.

Our Mission - Is to provide high quality care services to children, young people and their families through innovation, partnership working, good governance and leadership, and to ensure their sustainability for the future.

Our Values - reflect and demonstrate how we will deliver our promise to the children, young people, and families we support, to our volunteers, supporters and donors and all our colleagues.

People Focus
Putting people first.

Openness
Engaging well and respectfully with our communities.

Pride
Demonstrating excellence at all times.

Ambition
Becoming the best – striving to develop.

Resourcefulness
Thinking about the future.

Part 1 - Quality Statement from Chief Executive

It gives me great pleasure to present our Quality Report for 2017-18 on behalf of the Board of Trustees, our staff and volunteers, to everyone who supports us and to those families who use our services. Naomi House and Jacksplace hospices for children and young people and their families, are proud to commit to quality throughout everything we do; from the care services provided to families; to the service we provide to everyone who supports us with time and money; and to our staff, to provide an environment where a quality service can be delivered. Above all, we strive to create a culture that has quality at its heart.

I am responsible for the preparation of this report and its contents, with the support of my Senior Management Team and in particular the Director of Care. To the best of my knowledge, the information reported in this Quality Account is accurate and a fair representation of the quality of health care services provided by Naomi House and Jacksplace.

Annual statement of assurance re Equality of Access

Referrals to Naomi House and Jacksplace are considered purely on medical grounds. Any child or young person who meets the criteria to receive services and is within our nominated area will be accepted, regardless of their race, creed, ethnicity, gender, disability, sexuality or language. Every effort is made to ensure that the needs of ALL referred children and young people are met.

Our Equality & Diversity policy and Referrals, Acceptance & Review policy are attached at appendices 1 and 2.

We have not had any complaints or reports of either Naomi House or Jacksplace failing to adhere to Equality of Access during 2017/18.

During 1st April 2017 to 31st March 2018 the hospices provided 844 bed nights that attracted an NHS contribution or were funded via Personal Health Budgets. The LTV unit provided a total of 176 funded nights.

Part 2 – Priorities for Improvement

Review of Services

Since the newly refurbished Naomi House opened in September 2015 services have continued to develop.

A service development that opened in November 2017 is the long term ventilation (LTV) unit. Each year the number of technology dependent children continues to rise with an increasing number being started on long term ventilation every year. The increase of technology dependent children is also causing an increase in demand for care packages in the home, as these children have very complex needs it can take many months to train sufficient numbers of staff to support these children at home, with the parents also requiring training. Although the children are medically fit for discharge they often continue to be cared for in the high dependency unit (HDU) due to the high level of care and nursing skills required.

With the average length of stay from identification of the need for long term ventilation to discharge being seven to nine months, the aim of this unit is to enable hospice staff to reach out to families with medically vulnerable children earlier in their journey, introducing them to the range of services available at the hospice. We can then assist families by bringing healthcare agencies together to build appropriate and stable care packages more quickly and allowing them to benefit from a caring and supportive environment in which they can spend quality time with their child.

Going straight home from a specialist clinical environment such as an HDU can be very difficult for many families. The LTV Unit offers step down from the care given at hospital, and allows parents to take on some of the care for their children, preparing them to provide this at home with reduced intervention from medical staff.

The LTV Unit is situated above the hospices and comprises of two fully equipped children’s bedrooms, an emergency care room for use during care package breakdown at home, high quality accommodation for families and communal spaces for play and relaxation.

This service transforms the way in which newly ventilated children are cared for, and immediately improves not only their quality of life but that of their family too.

Clinical Audit - Annual Audit Schedule

The Audit Schedule for 2017/18 attached at appendix 3.

Care Plan Documentation – Documentation Audit – July 2017 and February 2018

Results

20 records were audited in both July 2017 and February 2018, on each occasion compliance for Records of Care was 94% and Care Plans 91%, with an overall result of 92.5%. This was an increase from the 2016/17 audits which demonstrated an overall compliance of 86%.

Evaluation – Record of care

Statement	**Number**		**%**	
	Jul 17	**Feb 18**	**Jul 17**	**Feb 18**
Complete contact details	18	20	**100%**	**100%**
Legible	18	20	**100%**	**100%**
Timed	16	18	89%	**90%**
24 hour clock used	16	17	89%	85%
Dated	16	18	89%	**90%**
Chronological order	18	20	**100%**	**100%**
Numbered in relation to care plans	12	15	67%	75%
Signed	16	18	89%	**90%**
Name printed	17	17	**94%**	85%
Designation	17	16	**94%**	80%
Empty space crossed through	16	17/18	89%	**94%**
Student entries countersigned	5/5	N/A	**100%**	N/A
Alterations simply marked and original information still legible	5/6	2/3	83%	66%
Notes in good state of repair	18	20	**100%**	**100%**
Securely bound	18	20	**100%**	**100%**
Accurate record	18	20	**100%**	**100%**
Totals	316/335	338/361	**94%**	**94%**

The first section of the audit looks at the contact details and the record of care. The main area for concern was numbering in relation to care plans, which is particularly helpful when reviewing the record of care. There were 2 occasions when the notes weren't signed or name printed and 4 occasions when the designation wasn't recorded. Otherwise all but 2 categories scored 85% or above with 6 scoring 100%. An action plan was put in place to address areas identified for improvement.

What others say about us

The hospice is subject to periodic reviews by the CQC. The last on-site inspection was in December 2015.

The hospice had no actions to take and no points were made in the CQC's assessment. The hospice was fully compliant and rated as Outstanding.

The hospice has not participated in any special reviews or investigations by the CQC during 2017/18 and there has been no Exception Reporting required during 2017/18.

CQC Compliance Report

In December 2015 we had an unannounced inspection from the CQC. Two inspectors visited Naomi House and Jacksplace for two days. They were impressed with the facilities, care and in particular the way in which staff interacted with children and young people.

In February 2016 we received our inspection report and were delighted to have been awarded 'Outstanding' – One of only 17 providers out of 1017 providers who were given their inspection results that month.

Inspection

The CQC carried
inspection of
service on 8th
December

Summary

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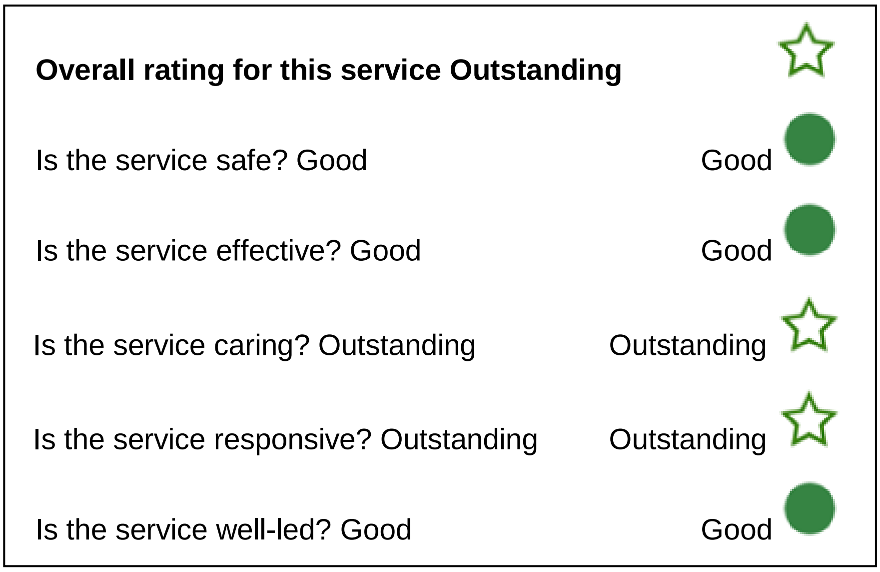
this care
and 9th
2015.



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

Inspection summary:

Most of the children and young people we met had complex needs and were not able to tell us their experiences because of their complex ways of communicating. We observed how the staff interacted with the children, young people and their families.

Parents told us their children were safe at the hospices. Children and young people sought reassurance from staff and were relaxed with them. This indicated they felt comfortable and safe with staff. Staff knew how to recognise any signs of abuse and how they could report any allegations.

We saw children and young people received care and support in a personalised way. Children and young people had access to the specialist healthcare support from the medical and nursing teams at the hospices. Their complex medical needs were well managed and staff were trained to meet these specialist complex needs. Risks were assessed and managed and there was focus on positive risk taking so children and young people could safely try new experiences. All parents and professionals were happy with the care provided by Naomi House and Jacksplace. Staff knew children and young people well and understood their complex needs.

Staff were very caring and showed children, young people and their family’s kindness and compassion. Staff were very motivated and demonstrated a commitment to providing the best quality care in a compassionate way. Parents told us they and their children were cared for to a high standard and this included ongoing bereavement support for families. They spoke of excellent relationships with staff who understood their needs and preferences and who devoted time to them. Siblings and other family members such as grandparents were also cared for. Staff treated children, young people and their families with respect and dignity. Children and young people's privacy was maintained at all times during the inspection. Sensitive planning for end of live care and post death care and support was provided to children, young people and their families. Bereaved families told us that the ongoing support and care provided had been invaluable.

There was a holistic approach to children's and young people's care with the physical, well-being, social and spiritual needs of each child and young person given equal importance, together with the needs of those closest to them.

Children and young people and their families received a very responsive service. Their needs were fully assessed, planned for and met. The service was creative and responsive to the changing needs of children and young people and had developed services in response to the local communities changing needs. Children, young people and families were involved in developing the service and this was based in their needs.

Children, young people and staff had fun together and there were lots of play and activities that were based on their preferences and needs. Children's individual sensory needs were met by the specialist equipment available.

The head of adult services was aware of their responsibilities in regard to the Deprivation of Liberty Safeguards (DoLS). These safeguards aim to protect people living in hospices from being inappropriately deprived of their liberty. These safeguards can only be used when there is no other way of supporting a person safely.

Parents and professionals gave positive feedback about the qualities, skills and knowledge of the staff. Staff were recruited safely and received an induction, core training and specialist training so they had the skills and knowledge to meet children and young people's complex needs.

There were safe systems in place to safely manage and administer medicines in both hospices. Children and young people were protected from the risks of infection by the systems and equipment in place.

We found the hospice and equipment was well maintained. The hospice was designed and decorated to meet the specialist needs of the children and young people.

There was a children, young people and family focused culture at the service. Children, young people, families and staff were involved and consulted about all aspects of the service. Staff were proud of the service they provided and were fully committed to the children, young people and their families. There was a clear management structure and staff, children and young people and their families felt comfortable talking to the managers about any concerns and ideas for improvements.

There were systems in place to monitor the safety and drive the continuous improvement of the quality of the service provided.

Care workforce and training report

- **Staff sickness/absence** – 4,104 total of hours.
- **Staff vacancy rate** – average of 18% over the year.
- **Agency and Bank use and spend**. In total agency and bank use for nurses is 2,828.5 hours and carers is 582 hours.
- **Statutory and Mandatory training attendance**
  As at March 2018 96.9% of staff available to work had completed their statutory and mandatory training. During 2017/18, 7 members of staff took maternity leave; 5 have completed mandatory training since returning; 2 remain on maternity leave.
- **Fitness to practice** - There have been no issues raised in the last 12 months.
- **Staff appraisals** – 100%
- **Induction attendance rates** – 100% - 5 new staff, all completed their 3 week induction programme.
- **HR report on DBS checks, pre-employment checks**
  All staff who are required to make an enhanced disclosure have done so within our agreed timescales.
- **Public Interest Disclosure (whistleblowing) – Reporting Concerns**
  There have been no reports or issues raised under our policy. A copy of the policy is attached (appendix 4).

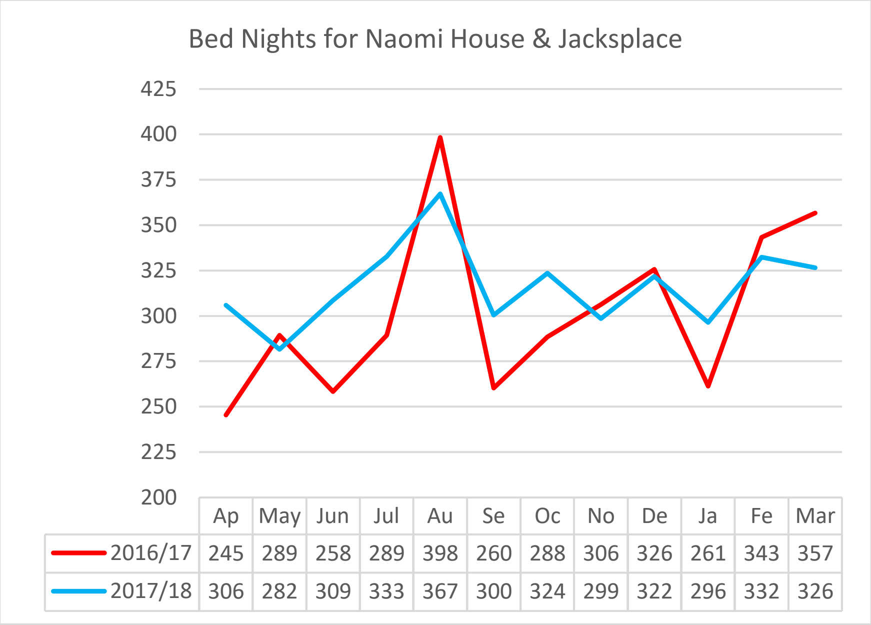
Lone Worker policy and assurance of compliance

As a service providing Community Services we are aware of the needs to protect staff who are working alone. Our Lone Worker Policy is attached at appendix 5.

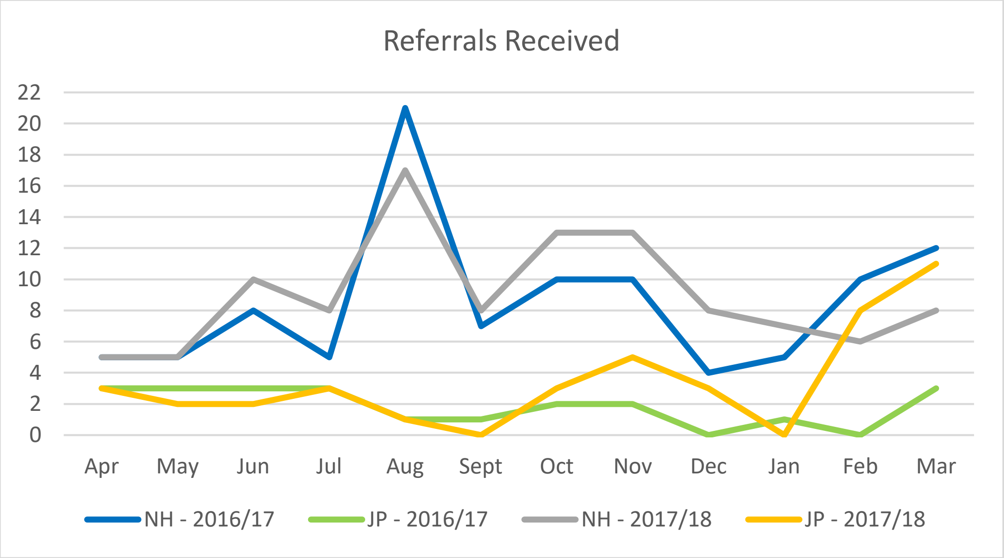
During 2017/18 we complied on every occasion with the Lone Worker policy and guidelines.

Part 3 – Review of Quality Performance

Families Supported (as at Feb 18)	**Naomi House**	**Jacksplace**
Open & Visiting	176*	101*
Day Service Users Only ( ) – not yet visiting	26 (8)*	1*
Post Bereavement ( ) Rem Day only	121 (37)*	29*
Community Service only	9*	
Family Support Only	0*	1*
All those receiving services	**332**	**132**
External Post Bereavement	**12**	
Open & Not Visited since 2015 ( ) – JP Out of Area	1	14 (2)
Open & Never Visited ( ) – Pending Funding	94	24 (0)



	Ap	May	Jun	Jul	Au	Se	Oc	No	De	Ja	Fe	Mar
2016/17	245	289	258	289	398	260	288	306	326	261	343	357
2017/18	306	282	309	333	367	300	324	299	322	296	332	326



Fast track referrals since April 2017 – 24 for NH, 5 JP

External post bereavement referrals since April 2017 – 4

Patient Safety

Number of mixed sex occurrences, including bathroom breaches

During 2017/18 there were no mixed sex occurrences or bathroom breaches in either Naomi House or Jacksplace. All bedrooms in each hospice are single-sex, single use and bathrooms are provided and used in such a way that only one child/young person at a time uses the facilities. We have sufficient en-suite and larger bathroom facilities to ensure that there are never any bathroom breaches.

Assurance statement re Safeguarding Adults

As a hospice caring for young people, all of whom are vulnerable we take safeguarding extremely seriously. All staff have completed online safeguarding training appropriate to their role:

Nurses/Carers/Play & Activity Team/Family Support Team/Care Management Team – Safeguarding Adults levels 1 and 2.

All other hospice staff (including Senior Management Team and Trust Board) and volunteers with access to young people – Safeguarding Adults level 1.

The training provider is Skills for Health and all online training is in-date, 100% of clinical staff have completed their training.

In addition staff receive refresher training on an annual basis during their Mandatory Study Days. This is made more relevant to their role in the hospice and complements the online training already received.

During 2017/18 there was one case where safeguarding concerns were raised by the hospice to the Lead Safeguarding Nurse. In addition, in line with multi-agency working the hospice has been involved in safeguarding discussions as required.

Our Adult Safeguarding Policy and Standard Operating Procedure is attached at appendix 6 and 6a.

Our Safeguarding Lead for Adults is Carol Ransome (Head of Jacksplace & Adult Services). Our organisational Safeguarding lead is Sue Wilkins (Head of Family Support Services).

Assurance statement re Safeguarding Children

As a hospice caring for children we take safeguarding extremely seriously. All staff have completed safeguarding training appropriate to their role:

Nurses/Carers/Play & Activity Team/Family Support Team/Care Management Team – Safeguarding Children Levels 1, 2 and 3.

All other hospice staff (including Senior Management Team and Trust Board) and volunteers with access to young adults – Safeguarding Children level 1.

The training provider is Skills for Health and all online training is in-date, at present all clinical staff have completed their online training.

In addition staff receive refresher training on an annual basis during their Mandatory Study Days. This is made more relevant to their role in the hospice and complements the online training already received.

During 2017/18 there was one case where concerns were reported to the Multi Agency Safeguarding Hub (MASH) and another where a referral was made by the hospice. In addition, in line with multi-agency working the hospice has been involved in safeguarding discussions, as required.

Our Children’s Safeguarding Policy and Standard Operating Procedure is attached at appendix 7 and 7a.

Our Safeguarding Lead for Children is Chris Forster (Head of Naomi House & Paediatric Services). Our organisational Safeguarding lead is Sue Wilkins (Head of Family Support Services).

Safeguarding Audit – April 2017

Results

In April 2017 20 notes were audited looking at specific areas including the emergency care plans, capacity assessments, DOLs assessments and body stamps to assess whether these are being completed.

	April 17 Total of 20 sets	
	Number	**%**
Is there an emergency care plan	20	100%
Was it in date for the last stay	19	95%
Have all sections been completed	18	90%
Has it been signed Name printed Designation Date	20 19 20 20	100% 95% 100% 100%
For over 16's has a capacity assessment been completed	11/11*	100%
Have all sections been completed	10/11*	91%
Has it been signed Name printed Date	11/11* 9/11* 11/11*	100% 82% 100%
For those over 16 who lack capacity has a DOLs "acid test" assessment been completed	5/6*	83%
If the DOLs assessment prompts a DOLs application has one been submitted	5/6*	83%
For those with capacity is there evidence of their decisions being recorded/signed for	4/4*	100%
For those without capacity is it recorded who can make decisions on their behalf	4/6*	67%
Is there a body stamp in the care plan for the last stay	20	100%
Has it been completed on admission	17	85%
Has it been completed on discharge	14	70%
Overall %	257/277	**94%**
***** These figures refer to the number of applicable records out of the total sample i.e. in April 2017 there were 11 records out of 20 for over 16's, 11 of which had capacity assessments etc.		

Summary

The overall compliance was 94% compared to a result of 89% in 2016/17. With the following findings:

- The emergency forms are being completed well on the whole
- Capacity assessments have been completed in all cases when required although not all sections were completed on one form and the staff member's name wasn't printed in two cases.
- Body stamp completion is again becoming an issue with a slight increase in completion on admission and the score on discharge.
- There were scores of over 90% in 14 categories as oppose to 8 in the previous audit with 10 of these achieving 100%.

An action plan was put in place to address areas identified for improvement.

Annual report re adherence to National Guidance

NICE guidelines are regularly monitored and any relevant updates and information are shared with the care team on a monthly basis. The Practice Education Team link in with the RCN Education Forum and the National Long Term Ventilation Forum to ensure we are aware of any developments in care. As a result of these links we have incorporated e learning in paediatric palliative care which supports the updated NICE standards for end of life care for children and young people.

The Paediatric Palliative Care Consultant, Practice Education Team and Family Support Team have launched a Palliative Care study day for a group of preceptorship nurses which covered various aspects of a holistic approach to care including spiritual support, play and post bereavement care in addition to the more practical issues such as symptom management and difficult conversations. It is hoped to obtain accreditation for this so it can be expanded and offered to external professionals in the future.

The care team are now required to complete on line learning in positive behaviour support which reflects the pathways for learning disabilities and challenging behaviour and have found this quite helpful in dealing with these issues.

In response to the NICE guidelines on sepsis the Clinical Team Leaders have developed a new observation chart to aid early detection.

Infection control strategy – policy, annual report, and audits

Infection Prevention is led by the Governance Lead Nurse who is a member of the Infection Prevention Society and attends regular external meetings to keep up to date with national developments. The audit is completed on an annual basis using the Hospice UK audit process alongside regular hand hygiene audits. The Infection Prevention & Control Policy is attached at appendix 8.

Infection Prevention Report - Annual Report 2017-18

Audit

Hospice UK Infection Prevention audit completed – 91.5%. Main issues were around cleanliness of communal areas, cleaner’s cupboards, sluice; notices required in public toilets regarding cleaning; guidelines that require updating/developing. Results fed back to care team, housekeeping and cleaning contractors. Re-audit of key areas of infection prevention raised score to 96.6%.

The hand hygiene audit was 94% - 99% with staff showing a good understanding of the importance of hand washing and appropriate occasions for hand hygiene.

Known infection incidences

Various reports of diarrhoea or vomiting over the year but they were isolated incidents. Several staff suffered with cold and flu like illnesses over the winter months.

One case of peritonitis following PD – all procedures followed according to protocol – child was transferred to UHS and subsequently died later the next day. Child had a history of repeated peritonitis in recent months. Review of transfer was undertaken to identify any learning points for the future mainly related to the transfer process rather than the care given in house.

HPV fogging

Fogging of the bedrooms after a child/young person with a trache has been discharged has been achieved in 59% of cases. This was due to the fast turnaround of admissions and discharges meaning there was not enough time to allow for fogging. Rooms that would normally be fogged between admissions were cleaned with Steri 7.

Together for Short Lives Special Interest Group Meeting

There was a presentation on Chicken pox and shingles, updates from a Consultant in Public Health and a discussion forum for current issues within the hospice environment. Issues covered include prevention measures for Legionella which impact us in relation to flushing of redundant or little used water sources. A plan has been developed by the housekeeping team to ensure this is covered

Study days

The Governance Lead Nurse attended an Infection Prevention and Control Study day at the Royal Hampshire County Hospital in Winchester focusing on current infection trends and updates including new resources for testing for flu and bronchiolitis and faster blood culture results to improve treatment times.

Attended the local branch conference and delivered a presentation on the challenges of managing infection prevention in a children’s hospice. Other topics included flu update, managing patients with diarrhoea, superbugs, air testing in theatres, clinical human factors in the acute medical unit, military maritime perspective, animals in healthcare.

NICE Compliance annual report

- On a monthly basis we check published NICE guidance to ensure that we are aware of any applicable to our service.
- Over the past year we have taken on board the following NICE guidance:

July 2017

Guidance on management of constipation in children and young people

April 2017

Guidance on end of life care for adults

Aug 2017

Guidance on nutritional support for adults

Oct 2017

Guidance and quality standards on sepsis treatment

CAS/MHRA alerts and compliance

CAS and MHRA alerts are monitored and actioned by the Head of Governance or Governance Lead Nurse. Updates are cascaded to staff for action at the time and followed up with a monthly email sent to all of the Care Team.

May 2017
Gastrostomy balloon tubes

July 2017
Novo pens

August 2017
Baxter Peritoneal Dialysis

October 2017
Fisher Paykel catheter mounts
Res Med ventilator internal batteries
Maxter neonatal and paediatric NG tubes end cap

November 2017
Kato support and harness for wheelchairs

Dec 2017

Buccal Midazolam pre-filled syringes end cap

Incidents

- There was some confusion around ventilator settings for a young person recently as there was a discrepancy between the settings on the care plan and those on the ventilator – please make sure you always update the care plan with the most up to date information on admission and check the ventilator is correctly set up before parent/carer leaves
- Please ensure when taking children or young people swimming that if the life jacket or flotation device becomes loose once in the water it is best to hoist them out to refit on the poolside rather than try and adjust in the water
- Please ensure when setting up the syringe driver that if the line is being changed the syringe is measured in the driver before priming the line in order to set the rate correctly for the whole infusion including the amount in the line over 24 hours – see the T34 SOP for further information (it is also in a folder in pharmacy for ease of access when you are preparing infusions)
- Please ensure parents accommodation swipe cards are returned to the cash box in pharmacy once parents have gone home

The full report is available in the communication folders in both houses and the LTV – please make sure you sign one of the folders when you have read the communication folder – this is a means of auditing that everyone has received the information

Audits

- **Medical gases – 97%** generally good compliance with policy and procedures just a few updates required to SOPs
- **Bedroom Cleaning – 95%** there was one instance in JP where the floor needed hoovering and one room in NH needed hoovering and was dusty – this room is seldom used and LTV scored 100%.
- **Documentation – 91% -** a consistent score with the previous result with the main areas of concern: numbering in relation to care plans, designation, discharge checklist, daily routine and circulation care plans. Care plans were well filled in but there were some areas that were missing. The new Risk assessments are being completed with only a couple that have not been signed/dated. The new Braden scoring was completed in all cases with only one out of the five that required an additional care plan not being followed up please make sure this is done if the score indicates a care plan is required
- **Moving and handling – 96.5% -** almost all areas scored 100% with the only area that didn't being the visual checks of hoists by staff – this was on only 2 occasions but please make sure you always check the equipment before you use it
- **Medicines Management – 91.6%** - overall a good score some amendments required to SOPs to reflect changes in ordering and receipt process and minor reorganisation of stock cupboards
- **Discharge – 87% -** this is now a monthly audit and is completed on 10 discharges – main area for concern is completion of body stamps on the discharge form – please ensure these are completed even if there are no marks the body stamp should say so as it the information we give to parents and very often they do look for this information

Swim assessments – just to update you all we have discussed how we manage swim assessments particularly for children on their first stays and we felt it was best not to take any child swimming on their first stay as we are still getting to know them and assess how their behaviour, seizures and general care such as trache, ventilator may impact how we manage them in the pool. Risk assessments should be undertaken with the play team and especially the physio if they have a trache and/or ventilator or there are moving and handling issues you are concerned about. They should be discussed and signed by a nurse who is aware of the clinical issues around taking a child in the pool. For further information please speak to Fenella who will be updating the pool SOP.

There are no updates from NICE or MHRA alerts that are relevant to us this month.

Clinical Risk Register

The hospice maintains a clinical risk register, which is updated as required and reviewed at our monthly Clinical Committee meetings. See appendix 9 - Risk Log March 2018.

There are no outstanding high risks.

SIRI's (Serious Incidents Requiring Reporting)

During 2017/18 there were no Serious Incidents Requiring Investigation (SIRI's) that met the reporting criteria or significant incidents that required investigation as a Serious Incident internally.

Coroner reviewed deaths

During 2017/18 there were no exception reports regarding Coroner reviewed deaths.

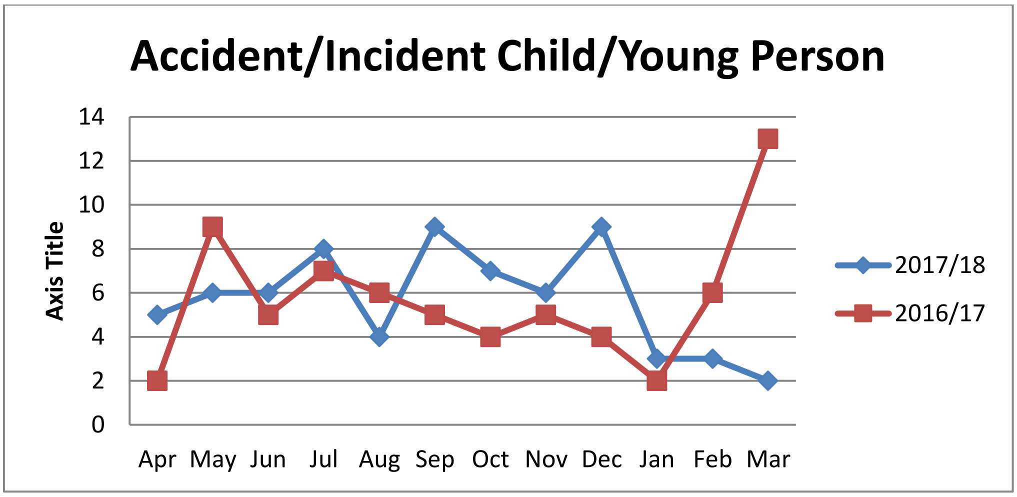
Patient Safety incident reports

At Naomi House and Jacksplace we have a robust incident reporting process and staff are encouraged to report concerns and incidents in order that we may learn from and improve our standards of care. All incidents are reviewed by the Head of Governance and/or Governance Lead Nurse on submission who assess them, give them an initial grade based on information known and commence investigation as appropriate. Depending on seriousness of the event and investigations findings, this may be escalated to formal clinical investigation with statements, interviews and further evidence collected for examination. Following the investigation staff involved are advised of any action that is required – such as the need to repeat their medicines competency, supervised practice via the Practice Education team for a period of time or the need for them to provide a reflective account to demonstrate their learning and commitment to raising their standards of care.

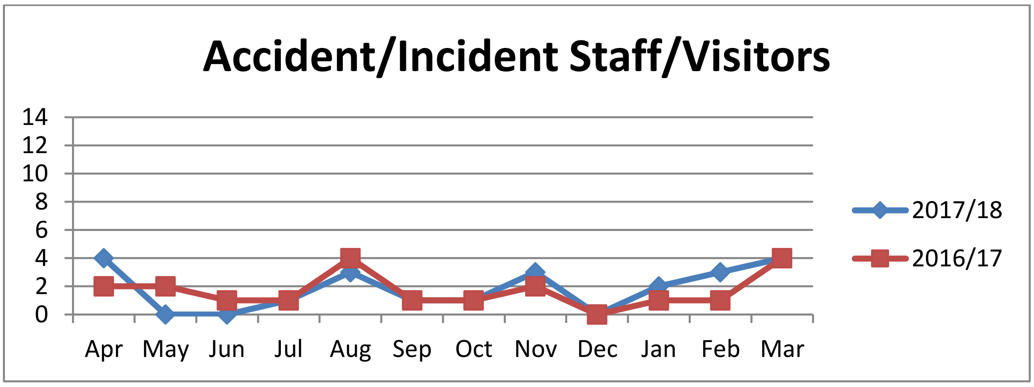
All incidents are tracked on a spreadsheet to enable us to undertake trend analysis, identifying areas of concern, or members of staff who are frequently involved in incidents, for example, medication incidents.

Incidents where action is required immediately is communicated to staff at the time, but as a minimum the Head of Governance or Governance Lead Nurse sends an email communication to all clinical staff outlining the incidents that have occurred in the preceding month and advising or reminding staff about any necessary actions to prevent a recurrence of the incidents.

During 2017/18 there were 201 incident forms submitted as follows:



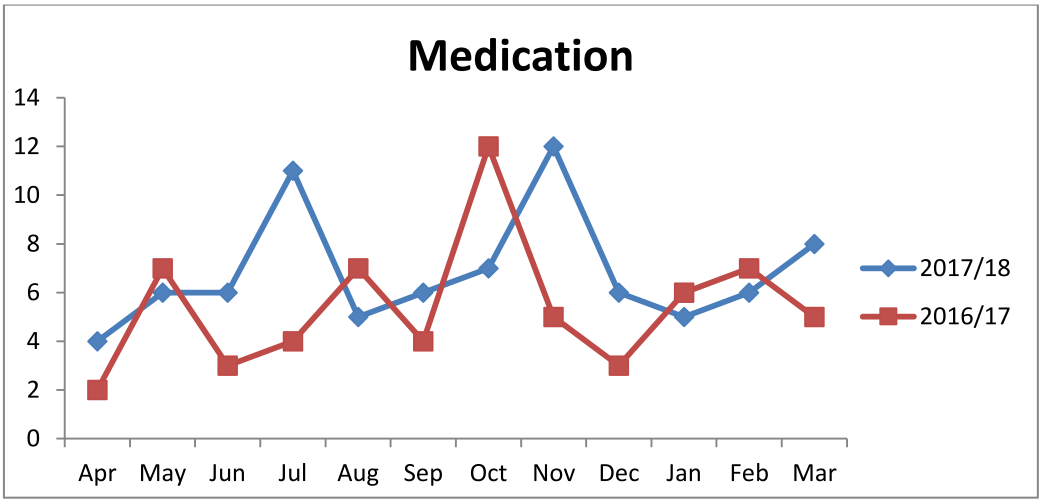
	2016/17	2017/18
Q1 April - Jun	16	17
Q2 Jul - Sep	18	21
Q3 Oct - Dec	13	22
Q4 Jan - Mar	21	8
Total	68	68



	2016/17	2017/18
Q1 April - Jun	5	4
Q2 Jul - Sep	6	5
Q3 Oct - Dec	3	4
Q4 Jan - Mar	6	9

Total	20	22

Total Medication errors:

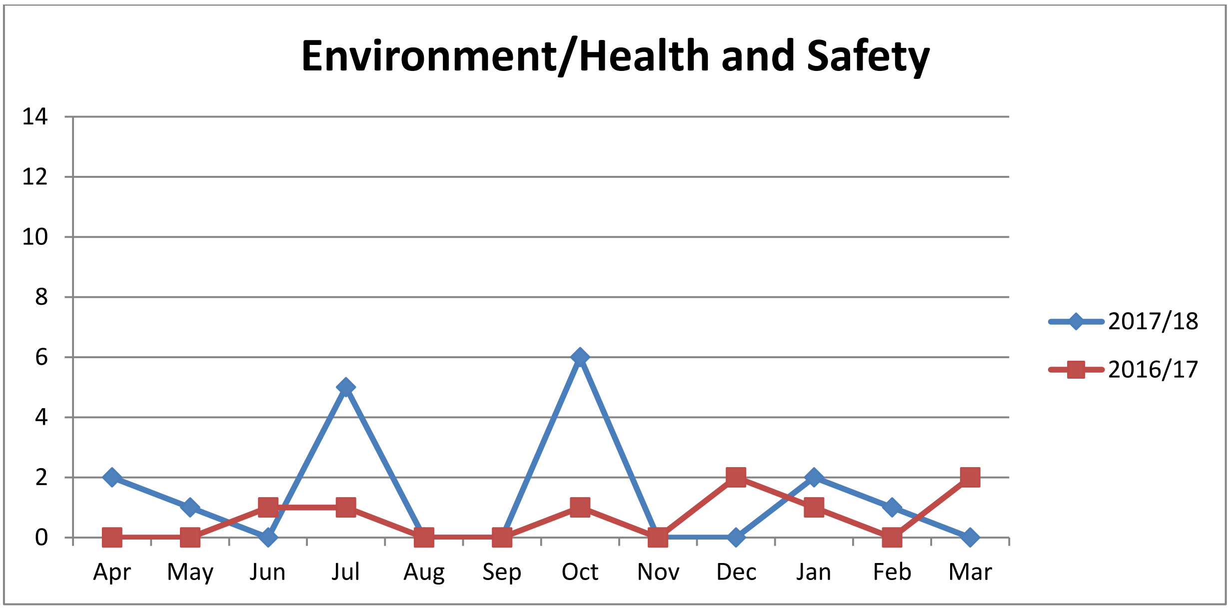


	2016/17	**2017/18**
Q1 April - Jun	12	16
Q2 Jul - Sep	15	22
Q3 Oct - Dec	20	25
Q4 Jan - Mar	18	19
Total	65	82

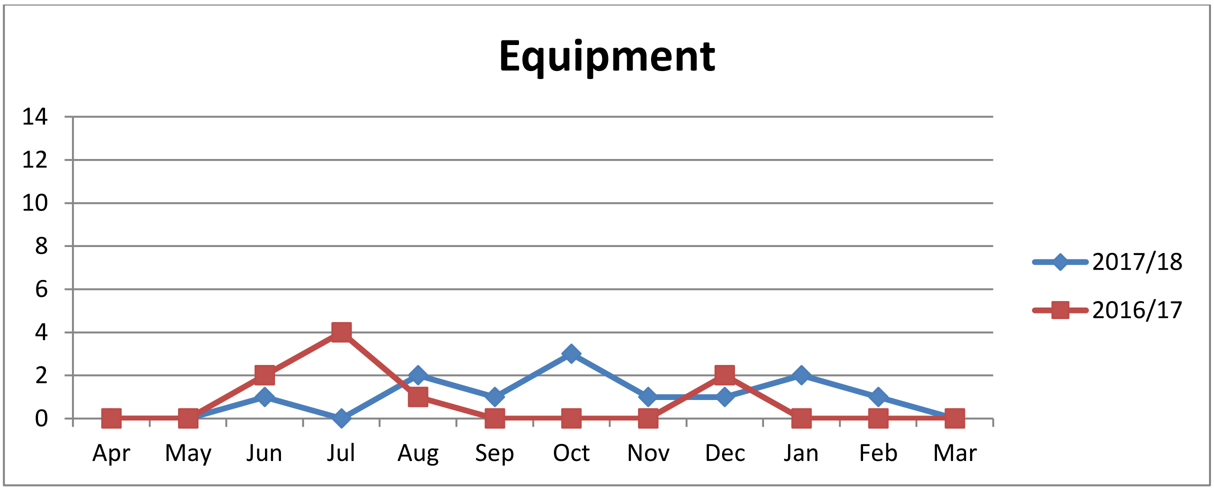
Medication errors by detail:

Incident	**2016/17**				**Total**	**2017/18**				**Total**
	Q1	**Q2**	**Q3**	**Q4**		**Q1**	**Q2**	**Q3**	**Q4**	
CD	0	2	0	0	**2**	1	1	1	4	**7**
Transcribing	1	1	0	0	**2**	1	0	1	0	**2**
Prescribing	1	1	2	3	**7**	4	3	2	2	**11**
Administration	6	10	15	7	**38**	8	14	15	12	**49**
Storage	1	1	3	6	**11**	2	2	2	0	**6**
Trans/Pres	0	0	0	0	**0**	0	0	2	0	**2**
Trans/Pres/Admin	1	0	0	2	**3**	0	1	1	0	**2**

Trans/Pres/Stor	0	0	0	0	**0**	0	0	0	0	**0**
Pres/Admin	2	0	0	0	**2**	0	1	1	0	**2**
Admin/Stor	0	0	0	0	**0**	0	0	0	1	**1**
Pres/Admin/Stor	0	0	0	0	**0**	0	0	0	0	**0**
Total	**12**	**15**	**20**	**18**	**65**	**16**	**22**	**25**	**19**	**82**



	2016/17	**2017/18**
Q1 April - Jun	1	3
Q2 Jul - Sep	1	5
Q3 Oct - Dec	3	6
Q4 Jan - Mar	3	3
Total	8	17



	2016/17	**2017/18**
Q1 April – Jun	2	1

Q2 Jul - Sep	5	3
Q3 Oct - Dec	2	5
Q4 Jan - Mar	0	3
Total	9	12

Example learning outcomes

- Review of child with challenging behaviour to assess appropriate support
- Cough assist care plan to be reviewed
- Medicines error rate to be calculated
- Fire evacuation SOPs reviewed
- New process discussed with maintenance team for reporting results of pool testing
- Information governance to be incorporated into mandatory training for non-care team
- Feed button issues followed up with manufacturer
- All equipment to be checked on admission to ensure there is sufficient for the stay
- Date of feed button insertion to be recorded on admission
- Feeds checked more frequently when they are due to finish to ensure they don't over-run
- Catheter care SOP to be updated
- Children to have an initial day visit or stay, to include multi professional swim assessment, prior to first swim
- Review of how we involve resident parents in child's care to ensure staff have open discussions about how much care parents are willing to undertake
- Staff to ensure attention to detail in managing personal care and documentation

Patient experience report

Our last Patient Experience report was conducted in late 2016, with the report released in December 2016. The results of the survey were reviewed in comparison with the results from the 2014 survey, enabling us to identify notable differences, similarities and areas for improvement. We have historically conducted these surveys/reports on a bi-annual basis therefore the next survey is due mid to late 2018.

Notable Differences to User Survey Conducted in 2014

The age range of service users in 2016 is more evenly split – 41% aged from 6 to 10 years, 38% aged 11 to 18 years and 22% aged 0 to 5 years.

There has been a marked increase in the amount of families that said their motivation for accessing the hospice was for the help and support provided to children – 32% in 2016, compared to 13% in 2014.

There was also an increase in the number of service users who advised their reservations of using a hospice were overcome after visiting Naomi House and speaking with staff – 70% in 2016 compared to 51% in 2014.

The majority of respondents advised their expectations of Naomi House were exceeded, with a marked increase advising this is due to the quality of staff - 79% in 2016 compared to 50% in 2014, along with the provision of 24/7 support – 66% in 2016 compared to 21% in 2014.

The main aspects noted by families as to why they like the care and support provided by Naomi House are:

- Staff are caring and excellent - 14% in 2014 to 35% in 2016
- 'Can do' attitude and positive atmosphere - 14% in 2014 to 29% in 2016

There has been a reduction in the amount of service users who wished to address concerns with staff – 41% in 2014 compared to 28% in 2016, suggesting care has improved. Almost all of those who had concerns went on to address these with staff (97%), an increase from 89% in 2014.

In 2014 65% of service users advised they felt comfortable discussing concerns with staff because they are approachable, which has increased to 85% in 2016.

For those that did not feel comfortable discussing their concerns with staff, reasons included not feeling concerns were taken on board, feeling generally uncomfortable discussing concerns and not wanting to offend staff.

The pre-admission service was implemented as a result of the 2014 survey. The aim of this service was to make the on-site admission process more efficient. The 2016 survey reported 64% of service users find this service useful, confirming that the implementation of this service has benefitted users.

Things that have not changed

The average distance travelled to Naomi House is similar to 2014 – 35 miles in 2016 compared to 32 miles. With most advising they do not have any difficulties travelling to the hospice (79%).

Most services users were referred to Naomi House by a Health Professional (63%), with the majority of families' motivation for using the hospice being to access respite care – 55% in 2016, compared to 49% in 2014.

The majority of families' requirement of the service are the same – to receive respite care and a break for the whole family. Families' reservations also remain the same with the main reason being general anxiety about the welfare of their child (30%).

The highly regarded additional services are music therapy, emotional support, sibling support and counselling, play interventions, art therapy and social activities.

The majority of service users advised they are satisfied with the service they receive (97%) and would recommend Naomi House to other families (97%).

Areas for Improvement

There were a small amount of service users (28%) who advised there were aspects of care and support they did not like, the reasons being lack of continuity of staff (6%) and having to repeat themselves to staff (4%).

Service users were asked what they felt is missing from the tailor care and support provided, omissions mentioned were:

- Help with transport
- Expansion of outreach services
- Further awareness of other services offered (e.g. sibling support)

When asked how Naomi House could improve services the top answers were providing more respite nights (9%) and making the admission process more efficient (6%).

Clinical Effectiveness

Complaints and/or Clinical Investigations:

During 2017/18 there was:

- 1 complaint
- 5 cases of feedback that were investigated but weren't raised as a formal complaint
- 2 clinical investigations

Please see the Complaints policy under appendix 10.

Outline of complaints themes, action, resolution and learning

Complaints

1 complaint – regarding issues related to standards of care some of which were upheld. Apology given for any distress caused and concluding letter sent with learning outcomes. Staff informed of learning points for future reference.

1 clinical investigation – regarding admission of a child out of hours – followed up with external organisation. Learning outcome – admission process reviewed and communicated to all relevant staff.

1 clinical review of emergency transfer to hospital – reviewed in house and meeting with family who were reassured by the investigation process. Learning outcome - improved communication process

with ambulance service, Transfer to Hospital SOP and Transfer Checklist developed and shared with the care team.

Feedback

Feedback received in 5 cases regarding issues around care and communication with families –

- in all situations the concerns were discussed with staff involved highlighting the importance of the parent/family's perspective
- teaching sessions for all staff on communication have been planned
- care plans were updated and the importance of accurate documentation was stressed to all staff
- Apologies were given to all families after concluding the investigations with a summary of the findings

On these occasions no parent wished to make a formal complaint.

Trend analysis is undertaken on a monthly basis. All incidents, including actions taken, are reported at monthly Clinical Committee and quarterly at the Healthcare Governance Committee.

Any member of staff involved in a serious incident or having been involved in three minor incidents is investigated and action taken if required – e.g. repeating medicine competency.

Investigation may include statements from staff, written reflection and meetings with Clinical Team Leader or Care Manager.

Following investigation a response in writing is sent to the parents or young person. Staff involved may be invited to a meeting to enable learning to take place. Individual staff members may meet with their Clinical Team Leader to discuss the incident and learning. All staff are informed about the incident and resulting learning via monthly clinical updates.

Family or young person are offered a face to face meeting to discuss further if they wish.

Child or young person's care is reviewed at next stay.

We have promoted our feedback form and placed boxes in reception enabling parents and families to have the opportunity to tell us what it is they found helpful about their stay and what they would like to see improve.

Compliments

We are always thrilled to receive letters, cards or emails complimenting us on our services and staff attitudes and care for the children and young adults with whom we are entrusted.

During 2017/18 we received 67 compliments and a large number of complimentary comments on Facebook.

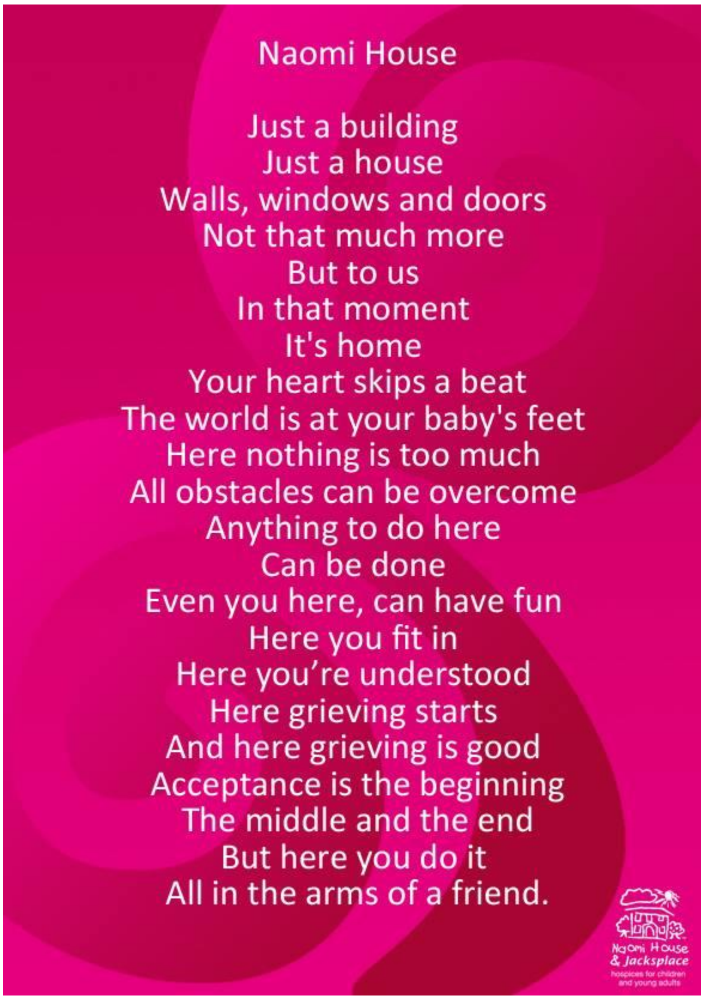
Sample of Compliments 2017/2018

"It was lovely to spend time with other families in the same situation"

"What a lovely way you have, so uplifting in times of great distress".

“Knowing there is somewhere safe for him to be and that he truly wants to be there is a wonderful thing for us all”

“I could just be her mum again for a while”



Naomi House

Just a building
Just a house
Walls, windows and doors
Not that much more
But to us
In that moment
It's home
Your heart skips a beat
The world is at your baby's feet
Here nothing is too much
All obstacles can be overcome
Anything to do here
Can be done
Even you here, can have fun
Here you fit in
Here you're understood
Here grieving starts
And here grieving is good
Acceptance is the beginning
The middle and the end
But here you do it
All in the arms of a friend.

Naomi House
& Jacksplace
hospices for children
and young adults

Commissioner led complaints – by exception

There were no Commissioner led complaints during 2017/18

Nutritional Screening

As part of our pre-admission procedure we complete a Nutrition Care Plan for every child and young adult. This is done largely through discussion with parents/carers or the young person if they have cognitive ability. In addition we request up to date reports from dieticians regarding diets, feeds etc. and our pre-admission nurse will pursue these prior to a booked respite stay if necessary.

Our Catering Manager checks the Nutrition Care Plans of every child and young person prior to their admission or at admission, ensuring that the catering team have sufficient knowledge and understanding of each child and young person's catering needs – be it ordinary diet – with likes and dislikes taken into consideration, pureed or blended diet, or tube feeds (administered by the care team). Allergies and specific nutritional requirements such as protein, calorie controlled or ketogenic diets are also noted and strictly adhered to, with the child/young person's record of care completed to show compliance.

We are currently involved in the Blended Diets Forum, meeting with other professionals from various sectors looking at developing policies and procedures in this area. From this we have launched an agreement form for families to sign if they wish to provide their own food in order to ensure safe transfer and storage of food items in order to comply with food hygiene regulations.

We have a Meeting Nutritional Needs policy (see appendix 11). The Care Plans are audited through the documentation audit.

End of Life Care report

We have an End of Life Care Pathway, developed by our Paediatric Palliative Care Consultant, see appendix 12.

During the year 2017/18 we cared for 34 children and 6 young people at the end of life or post-death. The average length of stay for end of life was 9 days; post-death was 3 days at Naomi House and 9 days Jacksplace.

During the end of life phase our Care and Family Support teams were instrumental in providing care and support to both the referred child or young person and their family. Memory making, funeral arrangements and emotional support was provided and post-bereavement our team of qualified, experienced counsellors continue to provide counselling, support and signposting as appropriate.

Feedback and learning from staff surveys

Attached (appendix 13) is the report prepared for the Board of Trustees from our last staff survey.

Report of CCG visits/monitoring

During 2017/18 the following Commissioner meetings took place:

1. November 2017 – Wiltshire CCG
2. February 2018 – Swindon CCG

Corroborative Statement from Dorset CCG (Appendix 14)

"Dorset Clinical Commissioning Group sees Naomi House and Jack's Place as a key partner in the delivery of end of life and respite care for children and young adult patients from Dorset.
During 2017/18 Naomi House and Jack's Place continued to provide the highest levels of care and support to our service users and their families, working hard to improve their already excellent levels of service by prioritising patient safety, clinical effectiveness, and enhancing patients' and their families' experience.
Naomi House and Jack's Place have an open and welcoming culture which has provided assurance to the CCG that the service they provide meets or exceeds the standards required, and feedback indicates that their support is much appreciated by their patients and families.
Dorset Clinical Commissioning Group is pleased to note that Naomi House opened their Long Term Ventilation (LTV) unit as planned in November 2017. This unit provides a specialist service to assist children and their families in the transition from a specialist clinical environment to the family home. We consider this to be a very important development which will speed up the transfer of these children to a less stressful environment.
Looking forward to 2018/19, Dorset CCG is delighted to have the opportunity to continue working closely with the Hospice as a key partner in helping us to continually improve our services, by providing high quality respite and end of life care to patients and their families."

Report prepared by:

Lesley Brook
Director of Care & Deputy Chief Executive

Fenella Hill
Head of Governance

Jackie Collins
Governance Lead Nurse

Laura Bond
Funding Coordinator

June 2018

Appendix 1

NAOMI HOUSE AND JACKSPLACE POLICY

Name of Policy	Equality and Diversity Policy
Reason for the Policy	To outline measures to encourage, value and manage diversity, and allow children and young people access to equal opportunities. To protect against discrimination and the action taken in the event of such conduct
Who Needs to Know About it	All Care Staff
Date of Approval and Implementation	14th May 2018

Version No.	2.0
Approving Committee	Clinical Committee
Date of Formal Review	May 2021
Author/Reviewer	Elli Rushton (Lead Practice Educator) Jackie Collins (Governance Lead Nurse)

1.0 Policy Statement

This policy is based on the belief that children, and young people using Naomi House and Jacksplace should have the opportunity to achieve their full potential. They should enjoy the experience of feeling fully included, respected and valued for who they are regardless of age, disability, race, religion or belief, gender, gender identity or sexual orientation. The Trust works proactively to identify and remove, or reduce, barriers and inequalities to any children and young people accessing our services. There is equality of opportunity to take part in activities that seek to inform, provide fun and contribute to better health, wellbeing, and ability.
Staff will respect, recognise and value people as individuals, listen and learn from the views and opinions of children and young people

2.0 Related Policies

- Relationships and Sexuality Policy
- Consent Policy
- Privacy and dignity for Children and Young People Policy
- The Health and Safety Policy
- Clinical Complaints Policy
- Clinical Care Policy
- Code of Conduct Policy
- Disciplinary Policy and Procedure
- Referrals, Acceptance and Review Policy

3.0 Responsibilities

- **The Chief Executive and Director of Care** - are responsible for ensuring that the Equality and Diversity Policy is in place and followed by all staff directly involved in the care of all young people
- **Care Management** – ensure any concerns or incidents of discrimination are investigated and addressed
- **Clinical Team Leaders –** will supervise and support staff to promote equality and diversity; will discuss and report any concerns raised if children, young people, families or staff experience or witness any discrimination
- **Care Team –** will adhere to the policy; report any issues or concerns regarding discrimination that they witness; attend mandatory training on an annual basis

4.0 Implementation and Training

- The Wessex Children's Hospice Trust is able to restrict its services to those children and young people who have a life limiting illness as this is defined in the Referrals, Acceptance and Review Policy and it also forms the ethos of the charity status. This is not considered as discrimination.
- This policy will apply to all children, young people and their families referred to the hospice. This is irrespective of race, disability, gender, age, sexuality religion or belief requirements
- Data is collected on a voluntary basis at the point of acceptance to the service about ethnic background and religious beliefs and is used for monitoring purposes only.
- There may be occasions where children, young people or their families may perceive they have been treated unfairly but the reasoning behind such decisions or actions can be objectively justified – such as isolating a child in their room due to infection risk.
- At all times staff will treat children, young people, and their families in a manner that makes them feel valued and respected irrespective of their diversity
- Young people will receive care in an environment that is informed, open and supportive and actively encompasses their individual values, beliefs and personal relationships
- Staff will encourage children and young people to understand their responsibility towards themselves and others in respect of equality and diversity
- All children and young people are entitled to an environment where no form of intimidation, bullying, or harassment will be tolerated
- Staff training will be incorporated into the mandatory training programme and will be embedded into the Clinical Competency Framework
- Breaches of policy will be regarded as misconduct and could lead to disciplinary proceedings

5.0 Audit

- An annual Privacy and Dignity audit will take place to ensure adherence to the policy and any resulting action plan circulated to all staff as necessary.
- Cultural demographics will be reported on an annual basis in comparison to the local population.

6.0 References

- Equality Act (2010); Available at: http://www.legislation.gov.uk/ukpga/2010/15/contents accessed 25/04/2018

- Human Rights Act (1998); Available at: http://www.legislation.gov.uk/ukpga/1998/42/contents accessed 25/04/2018
- Your rights to equality from healthcare and social care services Equality Act 2010 Guidance for service users (2014 – updated 2015); Available at: https://www.equalityhumanrights.com/sites/default/files/equalityguidance-healthcaresocialcare-2015_0.pdf accessed 25/04/2018

Appendix 2

NAOMI HOUSE AND JACKSPLACE POLICY

Name of Policy	Referrals, Acceptance and Review Policy
Reason for the Policy	To set out the responsibilities and process for referrals and acceptance to Naomi House and Jacksplace and to ensure that an ongoing process of review is undertaken across the service in response to the needs of the individual
Who Needs to Know About it	All Care staff and any external professionals or families seeking to access the service
Date of Approval and Implementation	16/5/16 (Referral Criteria updated 8th January 2017)
Version No.	3.1
Approving Committee	Clinical Committee
Date of Formal Review	May 2019
Author/Reviewer	Clare Robinson (Governance and Contracts Manager) Jackie Collins (Governance Lead Nurse)

1. Policy Statement

Naomi House and Jacksplace supports children and young people between 0-35 years (Naomi House 0-18, Jacksplace 16-35) with a life-limiting/life-shortening medical condition and their families and carers. The range of services cover:

- respite
- symptom management
- transition from hospital to home
- support in the community
- emergency care
- palliative care
- end of life care
- family and bereavement support in accordance with the wishes of the child/young adult and their family

2. Related Policies, Standard Operating Procedures (SOP's)

- Consent Policy
- Resuscitation Policy
- Challenging Behaviour Policy
- Referral, Acceptance and Review SOP
- Admission and Discharge Policy and SOP

3. Responsibilities

Chief Executive/Director of Care

- Has overall responsibility for Referrals, Acceptance and Review ensuring that policy and procedures adhere to statutory requirements and professional guidance.

Care Management

- Will ensure that the policy and procedures regarding referral, acceptance and review are adhered to and that services are provided which are nondiscriminatory, holistic, appropriate and timely.
- Will form part of the Clinical Committee monthly meetings
- Gather record and pass on relevant information to the Clinical Committee as necessary, using the appropriate documents.

Medical Team

- Establish a person's eligibility against the criteria for access to services in regard to their medical condition and likely prognosis with colleagues as part of the Clinical Committee or in discussion with senior care colleagues in the case of Fast Track Referrals
- Review each child's/young person's medical needs on an annual basis or as their condition determines

Clinical Committee

- Will implement eligibility criteria for access to services and ascertain whether these are met by children/young adults referred. (See Appendix 1)
- Record and process enquiries and referrals, initiate procedures for referral, assessment and review and see them through to completion at each stage.

- Ensure that access to the services provided by Naomi House and Jacksplace is non-discriminatory and timely.
- If admission/acceptance is deemed inappropriate, the Clinical Committee will inform the family in writing

4. Implementation and Training

Referral

To secure these aims, Naomi House and Jacksplace encourage referrals from professionals, other hospices and directly from potential young people or families. All referrals are processed confidentially, as quickly as possible and in accordance with principles of non-discrimination and equality - regardless of race, religion, gender or sexual orientation.

Assessment

A clinical assessment of a child or young person’s condition prior to acceptance is undertaken by gathering background information from Consultants and/or GPs who have a valuable insight as to the ongoing health needs and life expectancy of the child or young person. This information is then presented to Clinical Committee meeting once a month where a decision will be reached as to whether they meet the criteria and the appropriate level of service that will be offered eg day visits, overnight stays, specific periods of funded stays. (See Referrals, Acceptance and Review SOP).

Fast Track Referrals for End of Life Care

Emergency admissions will be assessed by the on call Doctor in consultation with the relevant clinicians involved in the care of the individual and Care Management. Funding will be sought for all Fast-Track referrals for end of life care.

Funding

Naomi House and Jacksplace is a voluntary organisation and maintains the position that, unless we receive a financial contribution from a Local Authority, Clinical Commissioning Groups (CCGs) or other statutory services towards a child or young person’s care, the care we provide is additional to a person’s care package rather than integral to it.

For a child or young person in receipt of a personal health budget, living out of area or requesting in excess of the allocated nights under charitable offer we will discuss funding with the appropriate commissioning authority prior to accepting a referral.

Acceptance

Naomi House and Jacksplace does not provide long term residential care, nor do we take admissions where an admission to an acute hospital ward is more appropriate. In addition, Naomi House and Jacksplace recognise that we will not always be the appropriate setting to offer care to children or young people who present with challenging behaviour as part of their condition (See Challenging Behaviour Policy).

Review

All children/young people will be reviewed on an annual basis and if there is any indication that they may no longer meet the criteria they will be presented to Clinical Committee for wider debate and a decision may be made to discharge them from the service. (See Referral, Acceptance and Review SOP)

Appeals

All children/young people and those with parental responsibility have the right to appeal against decisions made by the Clinical Committee. A verbal appeal will be considered by the Clinical Committee and further supporting information will be sought. If resolution is not reached, a written appeal can be submitted to the Trustee with responsibility for Healthcare Governance and later reviewed at a Healthcare Governance meeting.

Training

The referral and acceptance process will be explained to all staff during the induction period.

Information regarding referral will be available on the website, publicity materials and explained to anyone enquiring whether they are healthcare professionals or families.

5. Audit

- An annual audit of the admissions and referrals process will be completed
- Any resulting action plan will be implemented with a re-audit scheduled within 3 months
- Appeals, compliments and complaints will be monitored and reported to Clinical Committee on a monthly basis

6. References

Department of Health, 2010. *National Framework for Children and Young People's Continuing Care*. London: Department of Health.

Department of Health, 2015. *One Chance to Get it Right: One Year On Report*. London: Department of Health.

Together for Short Lives, 2105. Stepping Up A guide to enabling a good transition to adulthood for young people with life-limiting and life-threatening conditions. Bristol: Together for Short Lives

ACT, 2009 (2). *A Guide to the Development of Children's Palliative Care Services*, 3rd Edition. Bristol: ACT.

Together for Short Lives, 2013. *A Core Care Pathway for Children with Life-limiting and Life-threatening Conditions.* 3rd Edition. Bristol: Together for Short Lives.

Appendix 1

Acceptance Criteria

Acceptance to Naomi House is on the basis that the child will not be expected to live beyond 18 years of age.

Acceptance to Jacksplace is on the basis that the young person will not be expected to live beyond 35 years of age.

There are 4 categories of life limiting or life threatening conditions (Together for Short Lives)

Category 1	Life-threatening conditions for which curative treatment may be feasible but can fail. Access to palliative care services may be necessary when treatment fails or during an acute crisis, irrespective of the duration of threat to life. On reaching long-term remission or following successful curative treatment there is no longer a need for palliative care services. Examples: cancer, irreversible organ failures of heart, liver, kidney.
Category 2	Conditions where premature death is inevitable. There may be long periods of intensive treatment aimed at prolonging life and allowing participation in normal activities. Examples: cystic fibrosis, Duchenne muscular dystrophy.
Category 3	Progressive conditions without curative treatment options. Treatment is exclusively palliative and may commonly extend over many years. Examples: Batten disease, mucopolysaccharidoses.
Category 4	Irreversible but non-progressive conditions causing severe disability, leading to susceptibility to health complications and likelihood of premature death. Examples: severe cerebral palsy, multiple disabilities such as following brain or spinal cord injury, complex health care needs, high risk of an unpredictable life-threatening event or episode.

Acceptance for Naomi House day services will be considered for children who are likely to meet the criteria for Jacksplace in order to facilitate access to Family Support services. See separate guidance for specific conditions such as Rett syndrome, cerebral palsy and malignant disease below.

Together for Short Lives Categories of life limiting conditions, http://www.togetherforshortlives.org.uk/changinglives/supporting-care-professionals/introduction-childrens-palliative-care/categories-of-life-limiting-conditions/ Accessed 30/04/2018

Acceptance Criteria for children/Young people with malignant disease

Rationale

Naomi House aims to provide an equitable service that meets the needs of the children and their families, while being an appropriate use of our resources. For this to occur, inevitably discussions have to be made about whether or not we can accept a referral. These criteria have been produced to rationalise our decision making in an evidence-based way.

Background

The outlook for children and young people with malignant disease continues to improve; mortality rates have decreased by 62% in the 0-24 year age range from 1971-73 compared with 2012-14 *(Cancer Research UK 2016).*

Given the complexity of childhood cancer, the child's consultant will be asked to give an estimation of the child's true prognosis on an individual basis.

Acceptance Criteria

- Children with ALL or AML following first relapse.
- Any child considered by a Consultant Paediatric Oncologist to have a less than 40% chance of achieving 5 years disease-free survival.
- Any child with an oncology condition that is known at diagnosis not to be curable.
- Any child requiring end of life care.

References

Cancer Research UK, http://www.cancerresearchuk.org/health-professional/cancerstatistics/mortality/age#heading-Two Accessed 30/04/18

Acceptance Criteria for Children/Young people with Rett Syndrome

Children with Rett Syndrome who meet the criteria for respite at Naomi House would normally have most of the following:

- Genetic confirmation of diagnosis
- Severely reduced or increased tone
- Severely restricted mobility (probably never walked)
- Frequent epileptic fits (other than vacant episodes)
- Interruptions of consciousness due to respiratory disturbance
- Severe feeding difficulties or gastrostomy fed
- Very fragile physique

Since the severity of Rett Syndrome is often unclear until the regression phase is completed and there has been a period of stabilisation, we would not normally expect very young children to be referred. However, every child referred to Naomi House is assessed individually.

Acceptance Criteria for children/young people with cerebral palsy

The following is a guide to the sort of vulnerability factors that make a child with **cerebral palsy** (or other **static** neurological condition) likely to meet criteria for Children's Hospice services and to benefit most from specialist palliative care. Children likely to be accepted would have dark orange / red features in more than one category, and the answer to the last question would be 'yes'.

Respiratory Factors

- Frequent or increasing number of lower respiratory infections
- PICU admission for lower respiratory tract infection
- Requirement for long term oxygen therapy or non-invasive ventilation at home
- Tracheostomy and / or 24 hour ventilation

Feeding Factors

- Gastrostomy
- Jejusnostomy
- Severe uncontrolled reflux despite maximum treatment
- Losing weight due to feeding difficulties
- Pain / distress associated with feeding, necessitating progressive feed reduction

Seizure related factors

- Epileptic activity needing medication
- Poor seizure control despite numerous drugs
- Frequent use of rescue medication (daily basis)
- Episodes of status epilepticus requiring intensive treatment (IV infusions / PICU)

Locomotor Factors

- Spastic quadriplegia / total body involvement
- Poor head control/ fixed spinal curvature
- Dependent on a wheelchair driven by a carer
- Difficulty with maintaining sitting position (Gross Motor Function Classification System Level V)

Other Neurological vulnerability to consider

- Other evidence of severe bulbar involvement (worsening swallow, cough, gag reflex)
- Baclofen pump (as a marker of severe hypertonia / very difficult spasms)
- Severe visual impairment (registered blind)
- VP shunt (particularly with frequent need of review)

In the light of the factors above, would you be surprised if the child was still alive at the age of 18 years?

Harrop, E and Brombley, K (2012)
http://www.togetherforshortlives.org.uk/assets/0000/2861/Final_T4SL_version_of_CAT_4.pdf

Appendix 3 **Clinical Audit Schedule 2017/2018**

Key

Scheduled Audit Below 75% - 🟦 re-audit required 🟥

Benchmark over 90% 🟩 achieved 75% - 89% - action plan in place 🟧

Audit	Apr 2017	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2018	Feb	Mar
Medication Labels				🟦 Deferred to Aug 17	🟧 79%							
Safeguarding Children and Adults	🟩 94%											
Moving and Handling									🟦 Deferred to Feb 18		🟩 96.5%	
Record Keeping (documentation)					🟩 92%						🟩 91%	
Privacy and Dignity										🟦 Deferred to Mar 18		🟩 94%
Infection Prevention (Hospice UK)			🟩 91.5%						🟩 Re-audit of specific areas 96.6%			
Hand Hygiene					🟩 99%		🟩 97%					🟩 99%
Bedroom Cleaning											🟩 **95%** JP- 97% NH-92% LTV- 100%	

Appendix 4

Meds charts												93%
Medical Gases									Deferred to Jan 18	97%		
Meds management (Hospice UK)									Deferred to Jan 18	91.6%		
Admissions and referrals (Hospice UK) Biennial – due 2018												
Transition							83%					
Admission	84%						87%					
Discharge	82%						87%			87%	84%	93%
Pain					91%							
Community service documentation							93%					

Appendix 4

NAOMI HOUSE POLICY

Name of Policy	Reporting Concerns policy
Reason for the Policy	To outline procedures to be followed to ensure compliance with public interest disclosure ("whistle blowing")
What the Policy will Achieve	Outline how staff should raise any concern and ensure their protection following such action
Who Needs to Know About it	All Trust personnel
Date Approved	January 2018
Version No.	3.0
Approving Committee	SMT
Date of Implementation	June 2009
Date of Formal Review	January 2020
Author / Reviewer	June Morton

Reporting Concerns

Scope

All employees of the Trust.

Related policies

Child protection
Code of conduct
Equal opportunities
Health and Safety
Anti-bullying and harassment
E-mail and internet usage
Grievance and disciplinary
Data protection policies
Social media policies

Policy

The Trust has a commitment to conducting itself in accordance with legislative requirements and recognised good practice incorporating family centred care, whilst providing an environment that respects diversity, dignity and privacy and confidentiality

The Trust takes malpractice and breaches of policy very seriously and has a commitment to achieving the highest level of integrity and professionalism. The Trust expects its employees to share this responsibility and wishes to help employees disclose any malpractice, or any threat of or suspected malpractice they identify in the workplace. In accordance with the Public Interest Disclosure Act, 1998, the Trust will protect the rights of any individual who reports suspicious practices.

If there is anything which you think the Trust should know about, including any criminal offence, corruption or bribery, failure to comply with legal obligations, miscarriage of justice, health and safety danger, environmental risk or a concealment of any of these, please use the procedure outlined in this policy. By knowing about malpractice at an early stage the Trust stands a good chance of taking the necessary steps to safeguard the interests of all staff and protect the organisation.

Note: This policy is not the normal Grievance Procedure. If you have a complaint about your own personal circumstances then you should use the normal Grievance Procedure. If you have concerns about malpractice within the organisation then you should use the procedure outlined in this policy. Neither this policy and procedure nor any part of it is intended to have contractual effect.

Procedure

Public Interest Disclosure Act

The main purpose of the Public Interest Disclosure Act 1998 (PIDA) is to provide protection against victimisation or dismissal for workers who “blow the whistle” on criminal behaviour or other defined wrongdoing. It applies to workers who follow procedures laid down in the legislation in disclosing the following categories of malpractice:

- Poor clinical practice
- The endangering of an individual’s health and safety
- A criminal offence
- Fraud (bribery, theft, corruption or embezzlement)
- Abuse of authority
- A failure to comply with a legal obligation
- A qualifying disclosure to the Charity Commission
- A miscarriage of justice
- The endangering of an individual’s health and safety
- Damage to the environment
- Deliberate concealment of information relating to any of the above

Reporting Procedure

Employees have an obligation to raise any concerns through the appropriate channels by reporting any incident, event, action or behaviour which contravenes Trust, legal or regulatory policies. The Trust wants to encourage staff to talk to an appropriate senior person and this does not need to be a manager from the employee’s own department. The key here is to encourage the employee to talk openly and without fear of retribution.

If they are comfortable in doing so, employees should inform the Chief Executive immediately if they become aware that any of the actions above is happening (or has happened, or is likely to happen). Any report will be logged with the Chief Executive to enable a full investigation to take place.

If an employee feels it is more appropriate, or they are more comfortable with an independent person, they are encouraged to approach the **Freedom to Speak Up Guardian** who will offer advice and guidance on the procedure to be followed to ensure the issue is dealt with effectively and efficiently. Details of the FSUG’s role are outlined at the end of this policy.

Anyone who is suspicious of conduct which may prove harmful to the Trust, and who subsequently reports their concerns can ask for their comments to be treated in confidence and such wishes will be respected.

Management Responsibility

Managers notified of a concern have a responsibility to:

- Inform the Chief Executive immediately OR
- Inform the FSUG if it is more appropriate
- Ensure that concerns raised are taken seriously

Protection against harassment, victimisation and dismissal

The Trust gives its assurance that no worker who makes a bona fide report under this procedure will be subjected to any detriment by the Trust as a result, in accordance with section 47B of the Employment Rights Act 1996. In the event that you believe you are being subjected to a detriment by any person within the Trust as a result of your decision to invoke the procedure you must inform the Chief Executive or the FSUG immediately and appropriate action will be taken to protect you from any reprisals.

If it should become clear that false allegations have been made for purely malicious reasons or to pursue a personal grudge against another colleague or manager, this could constitute misconduct and in appropriate cases will be dealt with in accordance with the terms of the Trust's disciplinary procedure.

Raising a concern

Any employee who wishes to raise a concern can do so by contacting the Chief Executive in person, by phone or in writing by completing a Confidential report form attached to this policy. Alternatively, they are encouraged to contact the FSUG. Your concern will be acknowledged and you will be advised when you can expect a response. The findings of any investigation will be shared with you provided there are no legal obligations preventing this. Your comments and concerns will also be treated in strictest confidence unless they form part of a criminal investigation when it may become necessary to involve other professional bodies. Further information is outlined in section below covering the role and duties of the FSUG.

The Trust would expect that in almost all cases, raising your concerns internally would be the most appropriate action for you to take. However, if you feel you cannot raise your concerns internally, and you honestly and reasonably believe the information and any allegations are true, you should consider raising the matter with the appropriate recognised regulator. Details of the relevant regulator can be obtained from Public Concern at Work (PCAW), an independent charity which aims to promote compliance with the law and good practice (www.pcaw.co.uk).

If you have any queries about raising your concerns which you feel you cannot ask internally, PCAW also operates a helpline where you can confidentially discuss whether and how best to raise your concerns, details of which are available on the website. If you contact the helpline please ensure they are aware of the contents of this policy.

This policy is intended to deal with concerns of a very serious nature, for example where there has been an act or suspicion of an act that breaks the law or clinical practices. If employees have other concerns regarding their day to day duties, they should refer to the Trust's grievance procedures.

Freedom to Speak up Guardian – your guide to raising and responding to concerns

We firmly believe that our organisational goals, commitment to quality care and demonstration of our core values all work together to make Naomi House & Jacksplace a caring, responsive, professional and supportive place to work. We feel our staff and volunteers conduct themselves with integrity, working hard to meet the needs of the people we care for and respecting one another. All our staff, in every department are proud to be part of an organisation that aims to support families through good days, difficult days and last days.

We acknowledge, however, that in every walk of life, there may be some individuals who do not act in the best interests of their organisation. That could result in some action that is to the detriment of colleagues or to people making use of services, and we want to ensure that if any malpractice is suspected, we have clear and appropriate channels of response.

For some years we have had a policy in place that covers this - it's called Reporting Concerns – and it outlines how we deal with cases of "Whistleblowing", where someone suspects and reports some kind of wrong doing. In our environment, patient safety is of paramount importance, and if any member of staff suspects any poor practice, we urge them to report it. But we also want to encourage staff to report other wrong doing such as fraud or blatant disregard for health and safety, for example. If any colleague suspects any inappropriate conduct we will deal with it in a confidential and sensitive way and we will also treat the reporter with dignity and respect.

Our Reporting Concerns policy is based around the Public Interest Disclosure Act (PIDA) which grants protection to employees, including certain workers, contractors, trainees and agency staff, who make a disclosure about issues that are in the interest of the wider public. The key definition for the PIDA is the term "in the wider public interest". This differs to issues relating to an employee's personal terms of employment (which is described below) which would be covered under the organisation's grievance procedures. The Act protects employees by stating that employers should not victimise staff should they raise a concern internally or to a prescribed regulator.

So, if a colleague suspects some form of malpractice, what do they do? They can of course talk to a manager or a member of the Senior Management Team, but what if it is a senior person who is suspected of doing something wrong, something dangerous or illegal? This is why we have introduced a new internal post of the Freedom to Speak Up Guardian. This person is there to help and protect staff who "speak up" or "blow the whistle". The FSUG will encourage and support people to speak up. They will also therefore help the organisation maintain its standards, its values and its reputation.

Freedom to Speak Up Guardian

The Freedom to Speak Up Guardian (FSUG) is a role that has been developed following the healthcare sector's Freedom to Speak Up review, led by Sir Robert Francis QC. This recognised the progress made in the NHS since the report into the failings at Mid Staffordshire Healthcare Trust. FSUGs have responsibility for supporting the process of raising concerns. They are tasked with supporting staff to raise and handle issues effectively. They also have responsibility for reporting to the board and senior management teams on the effectiveness of local arrangements, identifying and making recommendations for improvement, where necessary. Where there is serious misdirection or failure by the organisation to deal with issues, the FSUGs have the ability to escalate issues to the relevant regulator or other prescribed body. Following the Francis review, all NHS establishments are required to have a FSUG in place by April 2017. Similarly, all care providers are required to do the same. Commercial organisations have followed this practice for many years and you may have heard of Business Ethics Officers in other kinds of businesses.

The role of the FSUG

The FSUG is a voluntary role undertaken by a management colleague, or a colleague with significant understanding of the organisation. They can work in any department but they must have a good understanding of how the organisation works, and a genuine interest in all departments. They need to be able to convey trust and confidentiality and they need to be able to make sound judgement, about whether or not an issue a speaking up issue, and so how to deal with it. FSUGs do not replace line management or the HR function: if a person has an issue that concerns their work, terms and conditions or treatment, the FSUG will signpost them to other internal procedures. They are there to listen to and if necessary investigate any concern that could be seen as something "in the public interest" such as allegations of:

Poor clinical practice

Cases of fraud (theft, bribery, corruption or embezzlement)
Abuse of authority
A deliberate attempt to cover up any of the above

The FSUG is not there to deal with grievances, so will not investigate issues which relate to an individual such as:

Pay and conditions of work
Terms of employment
Allegations of unfair treatment at work
Bullying or harassment
Disagreement between co-workers

A full outline of the FSUG role specification is attached at the end of this guide.

The FFUG is a role that someone takes on alongside their day job, and the amount of time they need to dedicate to this work may vary. If an issue is raised the FSUG will have time to investigate the matter thoroughly and they will also be encouraged to use their time for education and awareness.

There are national and local FSUGs and our Guardian will be able to access guides, training and resources to help them ensure that we maintain an open, transparent safe and supported service right across the organisation. The FSUG will meet regularly with the Chief Executive to discuss any themes and improvements and any reports produced will also be provided to the Board of Trustees. They will also help the SMT with policy development including updating our current policy on Reporting Concerns, and helping to communicate this important initiative and processes to staff.

The FSUG will be appointed by the Chief Exec and will hold the post for three years.

Role Specification for the Freedom to Speak Up Guardian (FSUG)

As an independent resource, the FSUG will work alongside the Board and the SMT to help support the organisation to become a more open and transparent place to work. In particular they will:

- Work with the Chief Exec, SMT and the Board to help create an open culture which is based on listening and learning and not blaming
- Develop mechanisms to empower and encourage staff to speak up safely and ensure that staff are not disadvantaged for doing so
- Participate in education/awareness programmes for staff so they understand how and when to raise concerns
- Ensure they are known to staff in all areas and ensure they are contactable
- Independently review any complaints from staff about the way they have been treated as a result of raising a concern, and escalate this as appropriate
- Ensure that staff who speak up are treated fairly throughout the investigation, ensuring effective open communication
- Ensure that information about those who speak up is kept confidential (subject to requirements around safeguarding and illegality)
- Report findings to the Board within agreed timeframe/frequency
- Participate in Guardian network events as appropriate

The FSUG should have the following characteristics and attributes:

- Thorough understanding of the organisation, its structure, aims and values
- Experience in supporting staff and demonstrating the values of the organisation
- Good facilitation skills
- An approachable manner, trusted and non-judgemental
- Respectful of boundaries
- Highly confidential, responsive and resilient
- Able to communicate at all levels

Confidential Report Form – PLEASE SEND TO THE CHIEF EXEC, FSUG, OR A SENIOR MANAGER AS YOU SEE APPROPRIATE

In accordance with the Public Interest Disclosure Act, 1998, the Trust will protect the rights of any individual who reports suspicious practices.

Any member of staff who suspects a colleague of malpractice and raises concerns about such malpractice will be treated with the utmost confidentiality and respect.

To:

From:

Date:

Please describe the issue you are concerned about

How can I contact you to investigate this matter further (please note this may be away from the office premises if you wish)

Appendix 5

NAOMI HOUSE POLICY

Name of Policy	Lone Worker policy
Reason for the Policy	To ensure safe working for staff who work alone
What the Policy will Achieve	Outline guidelines for personal safety
Who Needs to Know About it	All Trust staff & Volunteers
Date Approved	November 2009
Version No.	2.2
Approving Committee	SMT
Date of Implementation	April 2018
Date of Formal Review	April 2020
Author / Reviewer	June Morton

Lone worker Policy

Introduction

The purpose of this Policy is to ensure that where services are provided by employees who can be classed as “lone workers” the risks associated with lone working are assessed and measures implemented and maintained to manage those risks.

Wessex Children’s Hospice Trust recognises and accepts its responsibilities in accordance with the Health and Safety at Work Act 1974.

The Trust is committed to ensuring, so far as is reasonably practicable, the personal safety of its employees in their working environments.

Scope of the Policy

This Policy applies to all workers, employees, contractors and volunteers.

Definitions

Lone Working is defined as:

Any situation in which someone works alone without supervision or without a colleague nearby, in any location, on or away from Trust premises.

Situations when someone is working out of sight or earshot of another colleague for a reasonable duration, likely an hour plus.

A number of staff will be lone workers at some point in the course of their duties, typical examples of Trust employees who will be lone workers include:

- Hospice Outreach Team Members
- Care team members undertaking home visits
- Fund raisers
- Receptionists
- Those who open (or re-open) and close premises either early in the morning or late at night
- Shop staff especially at the start or close of the day

This list is by no means exhaustive but is given as a guide to the staff who could be deemed to be lone workers. Working on your own in private office when colleagues are not in attendance will not usually constitute loan working but it may be prudent to be aware of the guidelines below. Staff who are on their own in an office should always exercise common sense but if they are ever in an uncomfortable situation they should contact another colleague.

Responsibilities

The Management is responsible for:

- Ensuring that risk assessments are completed within their area of responsibility.
- Developing local arrangements to reduce the risks.
- Putting processes in place to deal with any emergency situation e.g. in the event that a member of staff cannot be contacted, or phones in to report they are in immediate danger.
- Implementing any necessary remedial action identified by incidents, audits or inspections.

- Allocating sufficient resources/funds for procurement of equipment or changes to working practices where it will reduce the risk of injury or ill health.

The Senior Management Team will periodically review and monitor the status of the risk assessments in place.
Line Managers have responsibility to:

- Review operations to identify situations where employees may be exposed to foreseeable risks etc, verbal abuse, physical assault or a work related safety hazard
- Undertake and record risk assessments and review their effectiveness at intervals not exceeding one year or when a significant change in circumstances occurs and following any incident
- Communicate the significant findings of the risk assessments and monitor compliance with the recommendations and control measures
- Establish clear procedures as to what can and cannot be done when working alone and where appropriate when to stop and seek advice

Employees have responsibilities to:

- Comply with the risk assessment recommendations and report any problems encountered.
- Take reasonable care of themselves and other people affected by their work and to co-operate with their employers in meeting their obligations. Staff should ensure that they do not put themselves at risk – if in doubt, avoid or withdraw from a situation.
- Comply with any information, instruction and training which is provided to minimise the risks to their health and safety.
- Report to their Line Manager any personal conditions which may affect their capability to undertake certain activities.
- Report and document any accidents, incidents, injuries or ill health which may arise.

Risk Assessment

Health and safety legislation does not prohibit lone working. However, it does stress that, where lone worker activities are carried out, risk assessments must be undertaken.

Risk assessments should be reviewed and updated if there are any significant changes in circumstances to which the risk assessment relates; it is recommended that all risk assessments should be reviewed at least annually.

Training

Appropriate training needs to be identified, developed, implemented and monitored to meet differing employee needs as identified through the risk assessment.

Use of Mobile Phones

Where lone working staff are issued with mobile phones they must be given sufficient information and instruction in their use and they must familiarise themselves with the use of the phone, including features such as speed dial facilities.

All staff using mobile phones should establish the numbers they need to call should they need to contact a colleague or the emergency services. Arrangements in place to eliminate, reduce or control risks from lone working must be recorded.

Appendix 1

Lone Working – Safety Guidance

- Ensure that there is unimpeded access/egress to and from the building/room.
- Only give access to others if you are sure that you know who they are.
- Arrange for someone to ring you at a predetermined time to check that you are safe.
- Check on means of escape from the building in an emergency, e.g. fire doors
- Check your access to a telephone.
- Avoid meeting people in isolated locations. If you are suspicious in any way, refuse the meeting and insist that the person attends at a more appropriate location.
- If you believe a person could present difficulties, try to see them at a location where others will be present rather than at a more remote venue. Tell people where you are going to be and ask that someone phones you/locates you at intervals to check that you are not in any danger.
- If you become concerned about the potential behaviour of a client arrange future meetings in line with the above points. Always record your concerns, for your own safety and for the safety of others who may see the client in the future. Share concerns with your Line Manager.
- Make a point of telling colleagues so that they are pre-warned of potential problems.
- Keep valuables – handbags, cases, equipment etc. out of sight.
- **If you are assaulted or threatened contact the Police immediately on 999.**
- If you are verbally abused or receive indecent telephone calls report the matter immediately to your Line Manager. In all instances complete an incident report form.
- Do not give your personal details to clients or business associates. Only issue your work phone/mobile number and your work e-mail address.

Home Visits/Travelling

Both managers and staff have a responsibility to ensure working arrangements are as safe as possible. A key factor in this is the manager (or other staff) knowing where staff plan to be and for there to be the means for two way communication whenever possible. A list of planned visits with estimated times, should be available to the manager. When undertaking a visit, ensure that your colleagues have the appropriate contact details (i.e., donor, family's home number, business office number etc).

Home Visits

- Have an arrangement with a colleague. Make a pre-arranged contact at the end of your visits or day and have a plan of what to do if the contact is not made. Make sure your manager and colleagues know these arrangements to avoid confusion.
- Find out as much as you can about clients before you visit
- With new/unknown people, try to visit in daylight or with someone else. Telephone the people prior to the visit to confirm your visit and to ensure that they will be there
- If, on arrival at a the location, you meet with a situation that you did not expect and which gives you cause for concern make an excuse to leave the premises and leave immediately. Once you have safely left the premises inform your line manager of your actions. You should never enter any premises if you are suspicious
- If a visit takes significantly longer than planned, make contact with your Line Manager, to update them on your revised plan and timetable.
- Avoid being alone in a lift with any person(s) you are unsure of.

Travelling

- Plan your route. Avoid having to stop to check maps etc. Carry an A-Z for the area • If you feel threatened by either the environment or situation should lock your car door
- Keep valuables etc. out of sight preferably in the boot of your car.
- Try to park in open, well-lit places.

- Reverse into parking bays wherever possible. This will ensure that you have an easy and direct exit in an emergency.
- Ensure you have enough fuel for your journey.
- If you suspect you are being followed, drive around the block or a roundabout a couple of times. If you are still suspicious, drive to a busy place or a police station. Try to note the number of the vehicle you believe is following you. Report the matter to the police if necessary and to your manager.
- If someone approaches you when you have stopped, lock all the doors of the vehicle. Open your window a fraction to facilitate conversation. Only accept help (or offer to help if someone asks you for assistance) if you are sure the situation is genuine. If you have a mobile phone offer assistance whilst remaining in your car. Once your vehicle is in motion, unlock the car doors.
- When returning to your car, have the key ready and enter quickly. Lock the doors as routine, but unlock them when the vehicle is in motion.
- Avoid walking in isolated or poorly lit places or in subways whenever possible carry a personal attack alarm; check that it is working beforehand. Have an arrangement with a colleague to make contact at a predetermined time.

Shop colleagues

For cash in transit:

- Try to avoid situations where you have to take cash to a bank or collect cash at an event on your own. If this is unavoidable, try to disguise the fact that you have money with you, or vary your time/route.

- If you are challenged when holding cash, either at a fundraising event or in a Naomi House shop, do not under any circumstances put yourself at risk. If someone threatening makes a demand, hand over the cash without a struggle. If anyone tries to take money or any goods from the shop – let them.

In the shop

- If you feel in any way threatened or at risk in the shop, close up without hesitation Funds, goods and property can be replaced: valuable friends and colleagues cannot.

- Do not undertake any potentially dangerous activities while on your own, such as climbing ladders, moving heavy stock or fixtures around or using the steamer.

- Carry your mobile. That way if you have an accident you can phone for help.

- Arrange for someone to call you at the end of the day. That way if anything untoward has happened, they would be suspicious if they did not reach you and would hopefully raise the alarm.

Appendix 2

Lone Working Checklist for Home Visiting

Check	Yes	No	Comments/Action Required
Caseload			
Do you clearly record your itinerary with manager/colleague or at base?			
Do you make and agree appointments?			

Do you clearly communicate any changes in your itinerary?			
Do you have plans in place to keep in contact with colleagues/base?			
Do you make contact at end of working day/shift?			
Communication			
Do you have a mobile phone?			
Is it kept charged?			
Is it programmed with contact numbers?			
Does your line manager/ colleagues have your number?			
Do you have emergency numbers recorded in phone?			
Security & Transport			
Do you have a clear understanding of the type and nature of area you are visiting?			
Do you park in a well lit area?			
Do you always consider the risk from potential hiding points e.g. hedges?			
Do you always lock your car?			
Do you leave anything on sight within it e.g. bags?			
Is your car serviced, roadworthy and with enough fuel?			
Do you have an emergency breakdown contact?			
If you have been issued with an attack alarm – do you check it regularly?			
In the Home			
Do you always identify a means of escape as your first priority?			
Have you had lone worker training			

Name ……….…….…….…… Job Title ……………..………………… Signed ....

Appendix 6

JACKSPLACE POLICY

Name of Policy	Safeguarding Adults
Reason for the Policy	To ensure all staff have an awareness of their responsibility and duty in safeguarding vulnerable adults and how to manage risks associated with protecting vulnerable adults.
Who Needs to Know About it	All Care Team Members
Date of Approval and Implementation	14th August 2017
Version No.	4.0
Approving Committee	Clinical Committee
Date of Formal Review	November 2018
Author / Reviewer	Jackie Collins (Governance Lead Nurse) Sue Wilkins (Family Support Manager and Safeguarding Lead)

Safeguarding Adults

1.0 Policy Statement

Naomi House recognises the need to protect and safeguard young people. The policy applies to all staff and volunteers and promotes a framework identifying principles and best practise.

The guiding principles are:

- To promote the wellbeing of young people whilst taking into account their wishes
- To establish a safe environment for young people and staff
- To ensure that no young person who lacks capacity is detained without authorisation under the Deprivation of Liberty Safeguards (DOLS)
- To recruit staff and volunteers with appropriate checks in advance of employment
- To support the training needs of staff and volunteers
- To ensure a named person is identified for safeguarding adults
- To offer support to young people, families and staff at the time of concerns being raised taking into account the wishes of the young person if they have capacity or their "best interests" when the young person lacks capacity
- To ensure systems and procedures are in place to accurately support disclosure of abuse and provide step by step guidance in regards to process and responsibility
- To work with young people and families so they are aware of and understand our policy
- To work in partnership with other agencies

2.0 Related Policies and Standard Operating Procedures (SOPs):

- Recruitment Policy and Procedure
- Safeguarding Children Policy and SOP
- Safeguarding Adults SOP
- Risk Management Policy and SOP
- Clinical Complaints Policy and SOP
- Privacy and Dignity Policy and SOP
- Lone worker policy
- Data Protection Policy
- Reporting Concerns Policy
- DOLS Policy and SOP

3.0 Responsibilities

Trustees

Ensure appropriate structures to support safeguarding exist across the organisation. Will be subject to the same DBS checks and 3 year on line training as all employed staff and volunteers

Chief Executive

The Chief Executive is responsible for ensuring that the relevant Policies and Procedures are in place and reports to the Board of Trustees.

Director of Care

The Director of Care is responsible for ensuring the Policies and Procedures are followed and are available to all staff.

The Designated Safeguarding Person

This is an identified member of the Care Management Team who has an overarching role in safeguarding and will:

- undertake biennial training for their role in addition to annual mandatory training
- report any safeguarding issues to the board of trustees and Healthcare Governance meetings on a quarterly basis
- liaise with PE team regarding the mandatory safeguarding training for all staff to ensure appropriate to required levels
- Feedback to staff about results of any investigations undertaken and any follow up action required

Head of Adult Services/Adult Safeguarding Lead

The Head of Adult Services is the Adult Safeguarding Lead and will:

- ensure that any young person over 16 who lacks capacity has an acid test completed and for over 18s an application is submitted for authorisation to deprive them of their liberty in line with current guidelines (see DOLS policy and SOP)
- ensure all members of staff are aware of how to raise safeguarding concerns and understand the symptoms of abuse and neglect
- Liaise with the Adult Services
- monitor adults who are subject to safeguarding plans
- maintain accurate and confidential records
- undertake biennial training for their role in addition to annual mandatory training

Care Management

Care Management, as part of their on call duties, will:

- have an overall awareness of any safeguarding issues
- respond to any concerns with advice
- liaise with the Designated Safeguarding Person and appropriate Safeguarding Lead

Clinical Team Leaders

Clinical Team Leaders, as part of their on call duties, will:

- Report any concerns to care management
- Be aware of any ongoing concerns
- Take action to safeguard any adult should the need arise such as contacting the police or Adult Services out of hours
- Document all actions and concerns
- Liaise with and support staff involved

Shift Coordinator

The shift coordinator will:

- Contact the Clinical Team Leader on call with any concerns about safeguarding

- Maintain appropriate levels of confidentiality on a “need to know” basis

All Staff

All staff should:

- be aware of signs and symptoms of abuse and neglect
- raise any safeguarding concerns with their line manager in the first instance
- be aware of who the Designated Safeguarding Person, Adult and Child Safeguarding Leads are
- participate in mandatory training in safeguarding
- document all safeguarding concerns accurately
- promote a culture of listening and engaging in dialogue with young people, seeking their views in ways appropriate to their age and understanding
- work in partnership with other agencies
- offer support to young people, families and other staff at time of disclosure
- work with young people and families so they are aware of and understand our policy
- feedback any existing and ongoing safeguarding concerns to the Designated Safeguarding Person

4.0 Implementation and Training

- Naomi House staff should ensure that advice, support and guidance are provided to all young people whilst respecting their right to confidentiality. However, if there is a lifethreatening or significant risk of harm to any young person then the member of staff should always follow procedures as the safety of the young person takes absolute priority over confidentiality. Therefore staff should advise all young people that information pertaining to safeguarding issues may have to be shared with specific others in accordance with this policy and legal requirements.
- Abuse of young people can take place in any environment. All staff, including volunteers, must have an Enhanced Disclosure and Barring Service (DBS) form completed and this will be requested every 3 years. Further checks are made during the interview process and new staff will be monitored during their 6 month probationary period. However, if there are any concerns about a member of staff at any stage during their employment these should be reported immediately.
- All staff working in Naomi House and Jacksplace (including volunteers) must be aware that abuse in all forms exists, and have a responsibility to protect any young person by acting according to procedure.
- Training will be provided for all staff and volunteers on an annual basis and appropriate training records are kept by the Practice Education Team.
- In addition to annual training there is an online programme that staff, volunteers and Trustees need to complete on a 3 yearly basis. All those with direct contact with young people will complete levels 1, 2 and 3 whilst all other staff will complete levels 1 and 2.

5.0 Audit

- An annual audit of safeguarding documentation such as body stamps and capacity assessments will be completed.
- Any safeguarding issues will be reported to Healthcare Governance on a quarterly basis.

6.0 References

- The National Service Framework for Children, Young people and Maternity services, standard 5 (DH 2004)

- Mental Capacity Act 2005 Deprivation of Liberty Safeguards 2008 available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf
- Working Together to Safeguard Children - Department of Health (2015)
- 4 Local Safeguarding Children Boards (4LSCB) on line procedures available at: http://4lscb.proceduresonline.com/hampshire/index.html
- Care and Support Statutory Guidance Issued under the Care Act 2014 Department of Health available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf

Appendix 6a

WESSEX CHILDREN'S HOSPICE TRUST
STANDARD OPERATING PROCEDURE (SOP)

Name of SOP	Safeguarding Vulnerable Adults
Reason for the SOP	To ensure all staff have an awareness of their responsibility and duty in safeguarding vulnerable adults and how to manage risks associated with protecting vulnerable adults.
Who Needs to Know About it	All Staff
Date of Approval and Implementation	14th August 2017
Version No.	3.0
Approving Committee	Clinical Committee
Date of Formal Review	August 2020
Author/Reviewer	Jackie Collins (Governance Lead Nurse) Sue Wilkins (Family Support Manager and Safeguarding Lead)

Safeguarding Vulnerable Adults

Rationale for SOP: To actively promote and ensure safer practice in the management of risks associated with vulnerable adults.

References:

- Safeguarding Adults Multi-Agency Policy, Procedures and Guidance – Southampton, Hampshire, IOW and Portsmouth July 2013 (kept in Dir. Of Care office)
- Protection of Vulnerable Adults Scheme in England & Wales for adults placements schemes, domiciliary care agencies and nursing homes – A Practical Guide – January 2009
- Mental Capacity Act 2005 Deprivation of Liberty Safeguards 2008 available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf
- Care and Support Statutory Guidance Issued under the Care Act 2014 Department of Health available at: https://www.gov.uk/government/publications/care-act-statutoryguidance/care-and-support-statutory-guidance
- Identifying a deprivation of liberty: a practical guide 2015; The Law Society; available at http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/ accessed 07/08/2017

Equipment: None required

Procedure:

1. Recognising abuse

Abuse is a violation of a person's human or civil rights by another person and there are several different types of abuse –

- Physical – kicking, hitting, restraint
- Sexual – rape, sexual assault
- Psychological – emotional, deprivation of contact, humiliation
- Financial or material – theft, fraud
- Neglect – omission of care, withholding of food
- Discriminatory – racism, sexism, disability discrimination NB. Some of these may occur online

2. When an allegation of abuse is made, or abuse is suspected, the member of staff:

- Must not interview either the alleged victim, perpetrator or witnesses to avoid compromising any future investigation as this should be carried out by trained personnel
- Must record the content of the allegation, its circumstances and details of possible witnesses in writing and sign and date the record
- Must report the allegation to the Team Leader on call

3. Allegations should not be discussed in public areas or where the conversation can be overheard by others. The Care Manager / Team Leader will, on all occasions, discuss the allegation with the Adult Safeguarding Lead, Designated Safeguarding Person and the Director of Care.

4. When an allegation is made, the Adult Safeguarding Lead in discussion with the Designated Safeguarding Person will decide, using the Hampshire Safeguarding Adults Board (HSAB) Multi Agency Safeguarding Adults Policy and Guidance (available at: K:\Safeguarding\Safeguarding Adults\Hampshire-Safeguarding-Adults-Board-HSAB-FINAL-VERSION-Multi-Agency-Safeguarding-Adults-Policy-andGuidance-May-2015_HF000009203965.pdf) what level of action regarding reporting and intervention is required (also see Appendix A)

5. The Adult Safeguarding Lead must ascertain whether the young person is able to decide whether to have the matter taken further. They must not promise the young person that what has been disclosed / witnessed will be kept secret or confidential. Their right to confidentiality is not absolute and may be over-ridden where there is concern or evidence that the individual or others may be at risk of harm or that a serious crime may have occurred

6. In making this decision, the Adult Safeguarding Lead must be aware of the vulnerable adult's ability to consent. For many of our service users, valid consent may not have been given because of a number of barriers to consent that exist. These include:-

- the presence of a parental or familial relationship between the persons involved
- the presence of a custodial or caretaking relationship between the persons involved
- the use of a weapon, threat of injury, or use of force by anyone involved
- the presence of a cognitive inability in the victim to understand the basic elements of sexual or other behaviours
- the presence of a power imbalance which precludes consent by the weaker person

7. If the young person gives their consent then the Adult Safeguarding Lead should invoke the Multi-Agency Procedures by contacting Adult Services and the Police as laid out in the HSAB Guidance (Section 2, 52 - Stages of the Safeguarding Process, Page 48) available at: K:\Safeguarding\Safeguarding Adults\HampshireSafeguarding-Adults-Board-HSAB-FINAL-VERSION-Multi-Agency-Safeguarding-Adults-Policy-and-Guidance-May-2015_HF000009203965.pdf

8. If the young person is able to choose and does not wish to have the allegation reported, then the decision must be discussed with a relevant health professional and/or care manager to check whether the young person is able to validly make that decision, and the final decision recorded in their notes. They must also be made aware that their decision may be over-ridden as highlighted above. If the young person is not able to give consent, then decisions need to be made in their best interests and the alleged incident must be reported to Adult Services/Social Services and/or the Police

9. Staff as Witnesses of Alleged Abuse:

- All those in the organisation have a duty to raise concerns about the behaviour by staff or anyone else which may be harmful to those in their care, without prejudice to their own position
- Any staff member who witnesses any incidents of abuse must report this to the Team Leader on call unless this is inappropriate, in which case they must report it to another manager. Staff must co-operate with all enquiries into allegations of abuse with all agencies. This will include making a statement if requested. Failure to fully co-operate may be considered under the disciplinary procedure
- Support will be offered to any staff affected. Managers must confirm to staff who raise the alert, the outcome of the decision to report to Adult Services and/or police

10. Contacting Adult Services / Social Services:

It is the responsibility of the Adult Safeguarding Lead who leads any investigation, to contact Adult Services should they need to seek advice or report any concerns. This may be delegated in their absence to the on call Care Manager.

Hampshire: Tel 0300 555 1386
Out of hours Tel 0300 555 1373

11. Contacting the Police:

Where a crime is suspected, the Adult Safeguarding Lead or Care Manager must contact the Police:
999 in an emergency
Hampshire Police 0845 045 4545

12. Confidentiality and Recording:

The Adult Safeguarding Lead or Care Manager should record all allegations of abuse, action taken, outcome and lessons learnt in the young person's record of care. This will include anonymised details of the allegation and any subsequent actions.

13. Reporting within the Trust

- All allegations must also be recorded on Trust Incident Forms.
- The Care Quality Commission must be informed where necessary
- If/when a decision is made that Wessex Children's Hospice Trust should conduct an internal investigation, an appropriate manager will be identified and will refer to the Disciplinary Procedure, after seeking advice from the Director of Human Resources
- The Designated Safeguarding Person will prepare a full report of any Safeguarding concerns and outcomes to the Director of Care and a summary of this will be shared at Clinical Committee and Healthcare Governance.

14. Timescales:

Timescales for reporting and decision making should be followed in line with the HSAB guidance:

- A decision will be made as to whether a safeguarding enquiry is required within 24 hours of reporting the alert
- Information gathering form the young person will then take place within 72 hours of the initial contact to decide whether the enquiry will proceed
- Should an enquiry be commenced a planning meeting will take place within 7 working days
- The enquiry should then be completed within 28 days of the planning meeting
- Ongoing review will continue over the next 8 weeks until the matter is resolved For further information see the HSAB guidelines.

15. Disclosure and Barring Service

- The Disclosure and Barring Service (DBS) provides checks for employers on prospective or existing employees on any criminal records and in the case of an enhanced check on the list of those barred from working with children and/or adults
- The Trust will seek enhanced checks on all employees and volunteers and seeks an update check on a three yearly basis (see Recruitment Policy and Procedure) The Trust will report a staff member to the DBS if they have:
  - Been dismissed because they harmed someone
  - Been dismissed or removed from working in regulated activity because they might have harmed someone
  - faced dismissal for either of these reasons, but they resigned first
- Qualified staff may also be reported to their Professional body

16. Repeated Allegations of Abuse:

Where a young person has made repeated allegations of abuse which have each been thoroughly investigated and found to be unfounded, the service user's multi-disciplinary team together with the care manager can agree that making repeated allegations is part of the person's normal repertoire of behaviour. This must lead to the development of a risk management plan and guidelines surrounding similar future allegations. All allegations must be dealt with and recorded as agreed in the risk management plan

17. Informing relatives/advocates:

Unless there is a conflict of interest, a young person should be asked whether they wish their relatives/advocate to be informed of any incidents. Where a young person is able to give their consent and does not wish their relatives/advocate to be informed, then this must be respected and a record made of the discussion with the young person. If the young person is unable to consent, then the Care Manager/Team Leader must act in the person's best interests and make an appropriate decision on how and when to tell the family/carers

18. Deprivation of Liberty Safeguards (DOLS):

Prior to admission, each young person over the age of 16 is assessed in relation to their mental capacity and guidance issued from the Supreme Court, 'the acid test' (The Law society 2015). This will determine the need for a full DOLS assessment and application. The Adult Safeguarding Lead is responsible for submitting DOLS applications to the local authority (see DOLS policy and SOP).

19. Training:

Training in Safeguarding Adults is vital for all staff and is therefore a mandatory requirement.

Training will be monitored through the Care Competency Framework, appraisal process and via records of attendance at training

20. Staff Support:

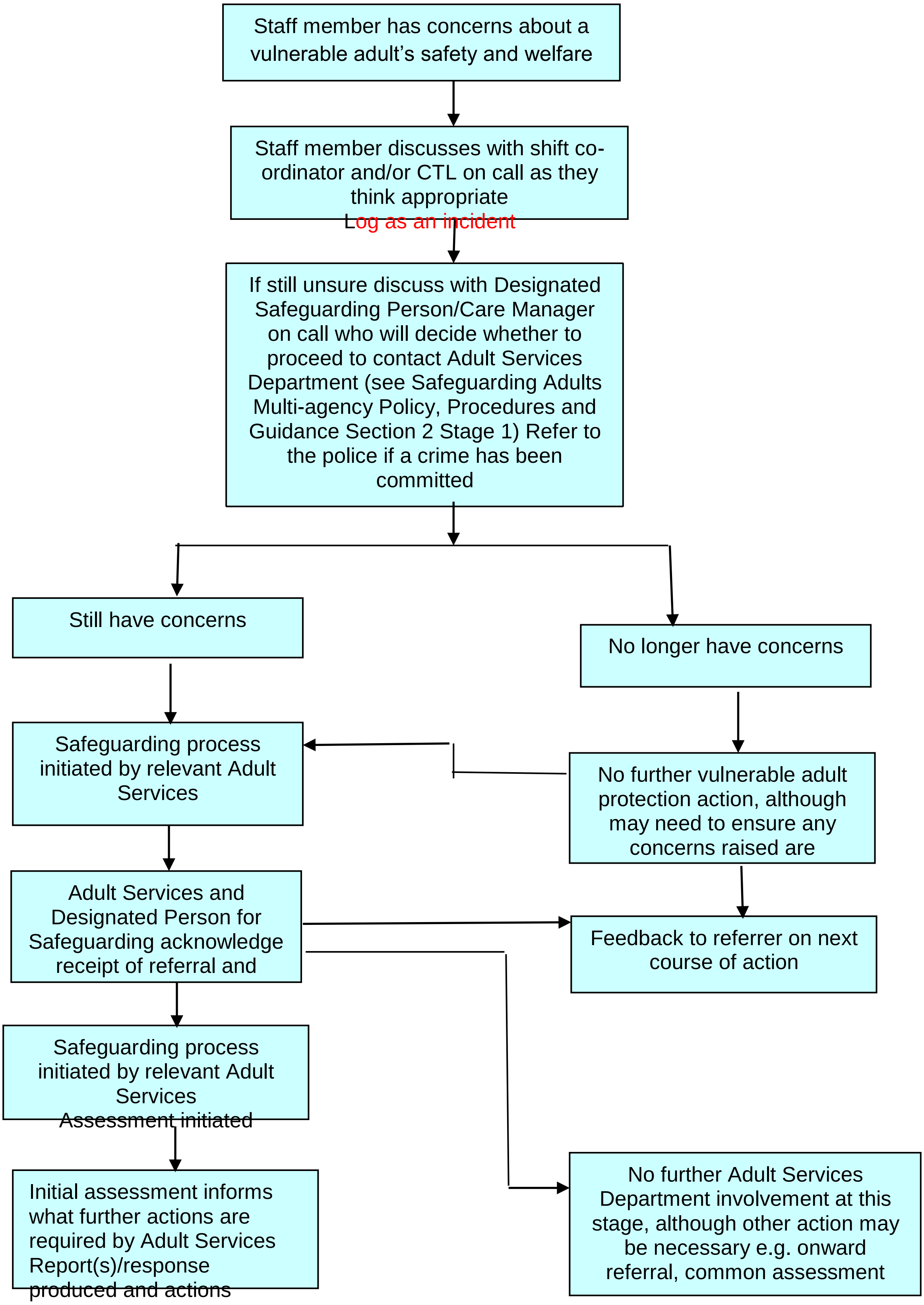
During a Safeguarding Adults investigation – an employee can expect the following information and/or support:

- The employee will be informed in writing that an allegation of abuse has been made against them.
- No details of the allegation will be shared at this stage.
- The employee and any other staff affected will also be notified of any counselling or help available to them.
- They will be given copies of the Trust Safeguarding Adults Policy/SOP and of the Disciplinary Procedure and advised of their right to consult a colleague or Representative of a recognised Trade Union
- Employees will have the right to be accompanied by an appropriately recognised representative or workplace colleague during all investigatory proceedings in which they are required to participate
- They will receive weekly contact from the investigating officer to keep them informed of progress being made with regard to the investigation and other related matters

APPENDIX A

SAFEGUARDING REFERRAL PROCESS

Flow Chart Referral: What to do if you are concerned about a vulnerable adult’s safety



Summary of process for dealing with a concerns about a vulnerable adult

- If it is suspected a vulnerable adult is being maltreated (abuse or neglect) this should be discussed with the Clinical Team Leader / Care Manager on call and/or the Designated Safeguarding Person.
- If the alerting feature or concern is considered to be maltreatment after consultation with the Designated Safeguarding Person or Care Manager this will result in a referral to Adult Services by phone.
- This will be recorded as an incident and an incident form completed.
- The family/carers should be informed where appropriate to do so, unless this would put the vulnerable adult at further risk.
- The referral should then be completed in writing and all actions documented.
- The Designated Safeguarding Person will liaise with Adults Services with regard to the level of investigation, response methods and timescales.
- Any concerns of a criminal nature should be reported to the police
- Agreed investigations or assessments will be carried under the supervision of the Designated Safeguarding Person
- The Designated Safeguarding Person will undertake monitoring and review and record decisions and outcomes.

Contact details for Local Authority

Hampshire	0300 555 1386	
Hampshire Police	0845 045 4545	emergency 999 Non-emergency 101

Appendix 7

NAOMI HOUSE AND JACKSPLACE POLICY

Name of Policy	Safeguarding Children
Reason for the Policy	To ensure all staff have an awareness of their responsibility and duty in relation to safeguarding the children in their care.
Who Needs to Know About it	All staff
Date of Approval and Implementation	14th August 2017
Version No.	4.0
Approving Committee	Clinical Committee
Date of Formal Review	August 2020
Author / Reviewer	Jackie Collins (Governance Lead Nurse) Sue Wilkins (Family Support Manager)

CQC Domain – Safe

1.0 Policy Statement

Ensuring personal safety is an important part of caring. Naomi House recognises the need to protect and safeguard all children aged 0 to their 18th birthday. The policy applies to all staff and volunteers and promotes a framework identifying principles and best practise in line with statutory guidance.

The guiding principles are:

- To value each child
- To establish a safe environment for children and staff
- To ensure that no young person aged 16-18 who lacks capacity is detained without authorisation under the Deprivation of Liberty Safeguards (DOLS)
- To recruit staff and volunteers with appropriate checks in advance of employment
- To support the training needs of staff and volunteers
- To ensure a named person is identified for safeguarding issues
- To offer support to children, parents and staff at time of disclosure or recognition of concerns.
- To ensure systems and procedures are in place to accurately support disclosure of abuse and provide a step by step guidance in regards to process and responsibility
- To work with parents so they are aware of and understand our policy
- To work in partnership with other agencies

2.0 Related Policies and Standard Operating Procedures (SOPs):

- Recruitment Policy and Procedure
- Safeguarding Children SOP
- Safeguarding Adults Policy and SOP
- Risk Management Policy and SOP
- Clinical Complaints Policy and SOP
- Privacy and Dignity Policy and SOP
- Lone worker policy
- Data Protection Policy
- Reporting Concerns Policy
- DOLS Policy and SOP
- Restraint Policy

3.0 Responsibilities

Trustees

Ensure appropriate structures to support safeguarding exist across the organisation. Will be subject to the same DBS checks and 3 year on line training as all employed staff and volunteers

Chief Executive

The Chief Executive is responsible for ensuring that the relevant Policies and Procedures are in place and reports to the Board of Trustees.

Director of Care

The Director of Care is responsible for ensuring the Policies and Procedures are followed and are available to all staff.

The Designated Safeguarding Person

This is an identified member of the Care Management Team who has an overarching role in safeguarding and will:

- undertake biennial training for their role in addition to annual mandatory training
- report any safeguarding issues to the board of trustees and Healthcare Governance meetings on a quarterly basis
- liaise with PE team regarding the mandatory safeguarding training for all staff to ensure appropriate to required levels
- Feedback to staff about results of any investigations undertaken and any follow up action required

Head of Adult Services/Adult Safeguarding Lead

The Head of Adult Services is the Adult Safeguarding Lead and will:

- ensure that any young person aged 16-18 years who lacks capacity has an acid test completed and plan care in line with DOLS SOP
- undertake biennial training for their role in addition to annual mandatory training

Head of Paediatric Services/Child Safeguarding Lead

The Head of Paediatric Services is the Child Safeguarding Lead and will:

- ensure all members of staff are aware of how to raise safeguarding concerns and understand the symptoms of child abuse and neglect
- Liaise with the relevant local authority Children's Services Department
- monitor children who are subject to child protection plans
- maintain accurate and confidential child protection records
- undertake biennial training for their role in addition to annual mandatory training

Care Management

Care Management, as part of their on call duties, will:

- have an overall awareness of any safeguarding issues
- respond to any concerns with advice
- liaise with the Designated Safeguarding Person and appropriate Safeguarding Lead

Clinical Team Leaders

Clinical Team Leaders, as part of their on call duties, will:

- Report any concerns to care management
- Be aware of any ongoing concerns
- Take action to safeguard any child should the need arise such as contacting the police, Children's Services Department out of hours
- Document all actions and concerns
- Liaise with and support staff involved

Shift Coordinator

The shift coordinator will:

- Contact the Clinical Team Leader on call with any concerns about safeguarding
- Maintain appropriate levels of confidentiality on a “need to know” basis

All Staff

All staff should:

- be aware of signs and symptoms of child abuse and neglect
- raise any safeguarding concerns with their line manager in the first instance
- be aware of who the Designated Safeguarding Person, Child and Adult Safeguarding Leads are
- attend annual mandatory training in safeguarding
- document all safeguarding concerns accurately
- promote a culture of listening and engaging in dialogue with children, seeking their views in ways appropriate to their age and understanding
- work in partnership with other agencies
- offer support to children, parents and other staff at time of disclosure
- work with parents so they are aware of and understand our policy
- feedback any existing and ongoing safeguarding concerns to the Designated Safeguarding Person

4.0 Implementation and Training

- Naomi House staff should ensure that advice, support and guidance are provided to all children and young people whilst respecting their right to confidentiality. However, if there is a life-threatening or significant risk of harm to any child or young person then the member of staff should always follow procedures as child protection takes absolute priority over confidentiality. Therefore staff should advise all young people and children that information pertaining to child protection issues may have to be shared with specific others in accordance with this policy and legal requirements.
- Abuse of children and young persons can take place in any environment. All staff, including volunteers, must have an Enhanced Disclosure and Barring Service (DBS) form completed and this will be requested every 3 years. Further checks are made during the interview process and new staff will be monitored during their 6 month probationary period. However, if there are any concerns about a member of staff at any stage during their employment these should be reported immediately.
- All staff working in Naomi House (including volunteers) must be aware that child abuse in all forms exists, and have a responsibility to protect any child or young person by acting according to procedure.
- Training will be provided for all staff and volunteers on an annual basis and appropriate training records are kept by the Practice Education Team.
- In addition to annual training there is an online programme that staff, volunteers and Trustees need to complete on a 3 yearly basis. All those with direct contact with children will complete levels 1, 2 and 3 whilst all other staff will complete levels 1 and 2.

5.0 Audit

- An annual audit of safeguarding documentation such as body stamps and competency assessments will be completed.

- Any safeguarding issues will be reported to Healthcare Governance on a quarterly basis.

6.0 References

- United Nations Convention on the Rights of the Child – Article 19 (1989) Every Child Matters (DH 2003)
- The Children Act (2004) available at: http://www.legislation.gov.uk/ukpga/2004/31/contents
- the National Service Framework for Children, Young people and Maternity services, standard 5 (DH 2004)
- Working Together to Safeguard Children - Department of Health (2015)
- 4 Local Safeguarding Children Boards (4LSCB) on line procedures available at: http://4lscb.proceduresonline.com/hampshire/index.html
- Mental Capacity Act 2005 Deprivation of Liberty Safeguards 2008 available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf

Appendix 7a

WESSEX CHILDREN'S HOSPICE TRUST STANDARD OPERATING PROCEDURE (SOP)

Name of SOP	Safeguarding Children
Reason for the SOP	To support guidelines for best practice and processes in safeguarding children.
Who Needs to Know About it	All staff
Date of Approval and Implementation	19th January 2016
Version No.	4.0
Approving Committee	Clinical Committee
Date of Formal Review	January 2019
Author/Reviewer	Jackie Collins

CQC Domain

Safeguarding Children

Rationale for SOP: To actively promote and safeguard the welfare of all children and young people aged 0 to their 18th birthday.

References:

- United Nations Convention on the Rights of the Child – Article 19 (1989) ☐
  Every Child Matters (DH 2003)
- The Children Act (2004) available at: http://www.legislation.gov.uk/ukpga/2004/31/contents
- the National Service Framework for Children, Young people and Maternity services, standard 5 (DH 2004)
- Working Together to Safeguard Children - Department of Health (2015)
- 4 Local Safeguarding Children Boards (4LSCB) on line procedures available at: http://4lscb.proceduresonline.com/hampshire/index.html
- Mental Capacity Act 2005 Deprivation of Liberty Safeguards 2008 available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf

Equipment:

Procedure :

1. **Recognising abuse** Abuse is a violation of a person's human or civil rights by another person and there are several different types of abuse –
    - Physical – kicking, hitting, restraint
    - Sexual – rape, sexual assault
    - Psychological – emotional, deprivation of contact, humiliation
    - Financial or material – theft, fraud
    - Neglect – omission of care, withholding of food
    - Discriminatory – racism, sexism, disability discrimination

Concerns may arise from an actual injury or from observing the child or young person or the attitude of the parent/carer. NB Some abuse may occur on line

2. When an allegation of abuse is made, or abuse is suspected, the member of staff:

- Must not interview either the alleged victim, perpetrator or witnesses to avoid compromising any future investigation as this should be carried out by trained personnel
- Must record the content of the allegation, its circumstances and details of possible witnesses in writing and sign and date the record
- Must report the allegation to the Team Leader on call

3. Allegations should not be discussed in public areas or where the conversation can be overheard by others. The Care Manager / Team Leader will, on all occasions, discuss the allegation with the Child Safeguarding Lead, Designated Safeguarding Person and the Director of Care.

4. When an allegation is made, the Child Safeguarding Lead, in discussion with the Designated Safeguarding Person, will decide what level of action to take, using the Local Safeguarding Children Board (LSCB) guidance available at: http://4lscb.proceduresonline.com/

5. They must ascertain whether the matter should be taken further. They must not promise the child/young person that what has been disclosed / witnessed will be kept secret or confidential. Their right to confidentiality is not absolute and may be over-ridden where there is concern or evidence that the individual or others may be at risk of harm or that a serious crime may have occurred.

6. In making this decision, the Child Safeguarding Lead must be aware of the vulnerable child/young person’s ability to consent. For many of our service users, valid consent may not have been given because of a number of barriers to consent that exist. These include:-

- the presence of a parental or familial relationship between the persons involved
- the presence of a custodial or caretaking relationship between the persons involved
- the use of a weapon, threat of injury, or use of force by anyone involved
- the presence of a cognitive inability in the victim to understand the basic elements of sexual or other behaviours
- the presence of a power imbalance which precludes consent by the weaker person

7. The Child Safeguarding Lead should ensure, where appropriate, the family are kept informed of all procedures unless it is considered that this may compromise the safety of the child/young person or any other individual. Parents/carers are asked to sign the consent form on an annual basis which covers sharing of information with other professionals.

8. Staff as Witnesses of Alleged Abuse:

- All those in the organisation have a duty to raise concerns about the behaviour by staff or anyone else which may be harmful to those in their care, without prejudice to their own position
- Any staff member who witnesses any incidents of abuse must report this to the Team Leader on call unless this is inappropriate, in which case they must report it to another manager. Staff must co-operate with all enquiries into allegations of abuse with all agencies. This will include making a statement if requested. Failure to fully co-operate may be considered under the disciplinary procedure
- Support will be offered to any staff affected. Managers must confirm to staff who raise the alert, the outcome of the decision to report to Children's Services Department and/or police.

8. Contacting Children's Services

It is the responsibility of the Child Safeguarding Lead who leads any investigation, to contact Children's Services should they need to seek advice or report any concerns. This may be delegated in their absence to the on call Care Manager.

Children's Services Hants direct Tel: 0300 555 1384.

9. Contacting the Police

Where a crime is suspected, the Child Safeguarding Lead or Care Manager must contact the Police:

999 in an emergency
Hampshire Police 0845 045 4545

10. Confidentiality and Recording:

The Child Safeguarding Lead or Care Manager should record all allegations of abuse, action taken, outcome and lessons learnt in the child/young person's record of care. This will include anonymised details of the allegation and any subsequent actions.

11. Reporting within the Trust

- All allegations must also be recorded on Trust Incident Forms.
- The Care Quality Commission must be informed where necessary
- If/when a decision is made that Wessex Children's Hospice Trust should conduct an internal investigation, an appropriate manager will be identified and will refer to the Disciplinary Procedure, after seeking advice from the Director of Human Resources
- The Designated Safeguarding Person will prepare a full report of any Safeguarding concerns and outcomes to the Director of Care and a summary of this will be shared at Clinical Committee and Healthcare Governance.

12. Timescales

Timescales for reporting and decision making are in line with LSCB guidelines. Any report via phone will receive immediate advice as to the next step dependant on the type of concern and resulting enquiry. Any report needs to be followed up in writing within 48 hours.

13. Disclosure and Barring Service

- The Disclosure and Barring Service (DBS) provides checks for employers on prospective or existing employees on any criminal records and in the case of an enhanced check on the list of those barred from working with children and/or adults
- The Trust will seek enhanced checks on all employees and volunteers and seeks an update check on a three yearly basis (see Recruitment Policy and Procedure) The Trust will report a staff member to the DBS if they have:
    - Been dismissed because they harmed someone
    - Been dismissed or removed from working in regulated activity because they might have harmed someone
    - faced dismissal for either of these reasons, but they resigned first
- Qualified staff may also be reported to their Professional body

14. Informing relatives/advocates:

Parents or those with parental responsibility should be kept informed at all times of any concerns, investigations and actions unless there is concern that this could result in further harm to the child.

Unless there is a conflict of interest, a young person aged 16- 18 should be asked whether they wish their relatives/advocate to be informed of any incidents. Where a young person is able to give their consent and does not wish their relatives/advocate to be informed, then this must be respected and a record made of the discussion with the young person. If the young person is unable to consent, then the Care Manager/Team Leader must act in the person’s best interests and make an appropriate decision on how and when to tell the family/carers

15. Deprivation of Liberty Safeguards (DOLS):

Prior to admission, each young person over the age of 16 is assessed in relation to their mental capacity and guidance issued from the Supreme Court, ‘the acid test’. This will determine the need for a full DOLS assessment and application. The Adult Safeguarding Lead is responsible for submitting DOLS applications to the local authority (see DOLS policy and SOP)

16. Training:

Training in Safeguarding Children is vital for all staff and is therefore a mandatory requirement.

Training will be monitored through the Care Competency Framework, appraisal process and via records of attendance at training

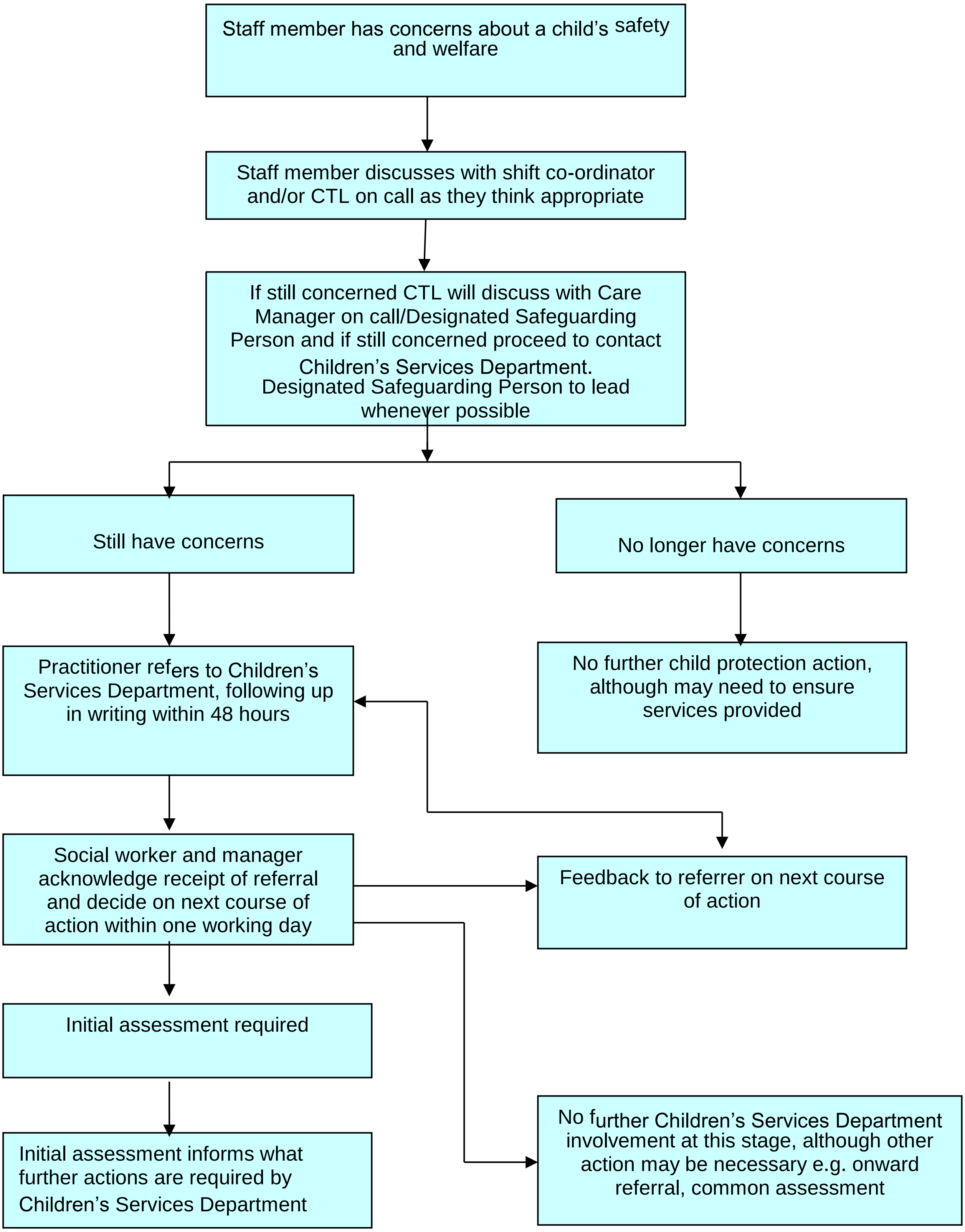
17. Staff Support:

During a Safeguarding investigation – an employee can expect the following information and/or support:

- The employee will be informed in writing that an allegation of abuse has been made against them.
- No details of the allegation will be shared at this stage.
- The employee and any other staff affected will also be notified of any counselling or help available to them.
- They will be given copies of the Trust Safeguarding Adults Policy/SOP and of the Disciplinary Procedure and advised of their right to consult a colleague or Representative of a recognised Trade Union
- Employees will have the right to be accompanied by an appropriately recognised representative or workplace colleague during all investigatory proceedings in which they are required to participate

- They will receive weekly contact from the investigating officer to keep them informed of progress being made with regard to the investigation and other related matters

Appendix A **Flow Chart Referral: What to do if you are concerned about a child's safety**



Be prepared, if required, to attend, or produce a report for a Child Protection Conference (PCP)

Summary of process for dealing with a concerns about a child

- If it is suspected a vulnerable adult is being maltreated (abuse or neglect) this should be discussed with the Clinical Team Leader / Care Manager on call and/or the Designated Safeguarding Person.
- If the alerting feature or concern is considered to be maltreatment after consultation with the Designated Safeguarding Person or Care Manager this will result in a referral to the appropriate Children's Services by phone.
- This will be recorded as an incident and an incident form completed.
- The family/carers should be informed where appropriate to do so, unless this would put the child at further risk.
- The referral should then be completed in writing within 48 hours and all actions documented.
- The Designated Safeguarding Person will liaise with Children's Services with regard to the level of investigation, response methods and timescales.
- Any concerns of a criminal nature should be reported to the police
- Agreed investigations or assessments will be carried under the supervision of the Designated Safeguarding Person
- The Designated Safeguarding Person will undertake monitoring and review and record decisions and outcomes.

Contact details for Local Authority

	In hours
Southampton	023 8083 3336
Hampshire	0300 555 1384
Isle of Wight	01983 814545
Portsmouth	0845 671 0271

Hampshire Police
- 0845 045 4545
- Emergency 999
- Non-emergency 101

Appendix 8

NAOMI HOUSE AND JACKSPLACE POLICY

Name of Policy	Infection Prevention and Control Policy
Reason for the Policy	To ensure all staff are aware of the safe management and prevention of infection within the organisation.
Who Needs to Know About it	All staff
Date of Approval and Implementation	13th March 2017
Version No.	4.0
Approving Committee	Clinical Committee
Date of Formal Review	March 2020
Author / Reviewer	Jackie Collins (Governance Lead Nurse)

1.0 Policy Statement

Wessex Children's Hospice Trust recognise the responsibilities for ensuring that all reasonable steps are taken to protect children, young people, their families, staff, agency staff, contractors and other visitors from infections arising from the care of individuals. The children and young people who access the hospice services are particularly vulnerable and may also be carriers of infections which could present a risk to others.
The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (updated July 2015) sets out the minimum requirements that the organisation will be judged against by the CQC.

There are 10 compliance criteria that the organisation is required to demonstrate:

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of particular infections.
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7. Provide or secure adequate isolation facilities.
8. Secure adequate access to laboratory support as appropriate.
9. Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10. Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

These criteria are addressed in more detail within the Standard Operating Procedures listed below.

2.0 Related Policies Standard Operating Procedures (SOPs) and Guidelines

Policies
Clinical Audit
Clinical Care
Consent
Data Protection
Death of a Service User
Health and Safety
Pool
Preventative Maintenance
Privacy and Dignity for Young People
Records Management
Risk Management

SOPs
Antimicrobial prescribing
Aseptic technique
Decontamination
Dressings Change
Hand hygiene
Hydrogen Peroxide Vapour (HPV)
Infection Prevention and Control Risk Assessment
Isolation
Laboratory Specimens Management
Linen Handling
Major outbreaks of communicable infections
Management of invasive devices
Occupational Health and Blood Borne Viruses
Personal Protective Equipment (PPE)
Safe provision of food
Sharps Management
Uniform
Waste Management

Guidelines
Specific infection information guidelines folder
NHS Choices website with current advice regarding infections available at the following link:
http://www.nhs.uk/Conditions/Pages/hub.aspx
End of Life Pathway

3.0 Responsibilities

Clinical Committee

- Reviews and approves all policies
- Monitors any infection prevention and control activities

Director of Care

- Ensures policies and SOPs are in place
- Ensures appropriate training is undertaken by all staff to enable the effective implementation of the policy and SOPs

Infection Control Nurse

- Provide day-to-day advice, monitoring and prompt identification of infection.
- Advise on appropriate measures to deal with infection and provide information to staff.
- Produce, review and monitor new policies, SOPs and guidelines.
- Advise re service developments and purchasing of new equipment.
- Liaise with Maintenance Engineer with regard to new build projects and issues involving infection prevention such as Legionella and Pseudomonas prevention.
- Report all activities to Clinical Committee and provide an annual report.
- Undertake the Infection Control Audits.
- Link with the PE team to oversee the infection control training for all staff.
- Arrange 6 monthly infection control team meetings with representatives across the organisation in order to disseminate information to the care team Liaise with external organisations and professionals.

Medical Team

- In the event of an infection, will request appropriate laboratory tests, report to relevant external agencies, co-operate with investigation, co-operate with the control of outbreaks and incidents.
- Follow national guidelines in relation to antimicrobial prescribing

Infection Control Team

The team is made up of members of care, play, catering, housekeeping and cleaning teams and the objectives of the team are

- To review policies
- To formulate and review risk assessments
- To evaluate audits and develop an action plan
- To promote good practice throughout the wider care team
- To discuss any relevant issues related to infection control
- To inform and develop mandatory training
- To support induction training for new staff

All Care Staff including Volunteers and agency staff

- Act in accordance with current legislation, policies and guidelines
- Attend infection prevention and control training on an annual basis
- Use appropriate resources to minimise cross infection
- Identify and report potential risk situations
- Report any health issue which may affect their ability to work

4.0 Implementation and Training

The key requirements set out for the organisation are:

- To ensure that appropriate resources are made available to support infection control activities.
- To have in place a policy, SOPs and guidelines for management of infection control across the organisation.
- To review and improve infection control arrangements where necessary.
- To ensure that all staff receive relevant training in the prevention and control of infection on an annual basis.
- To record immunisation status on admission and any recent contact with infectious disease.
- To communicate information related to communicable disease to all relevant parties including families, young people, care staff, GPs, CCNs, hospital staff.
- To work with other stakeholders such as Public Health England and CQC, to improve surveillance and strengthen infection prevention measures

5.0 Audit

Infection Prevention and Control audits will be undertaken on an annual basis and the results disseminated to all relevant staff. Hand hygiene audits will occur on a 3 monthly basis. All audit results will be reported at Clinical Committee and Healthcare Governance meetings.

6.0 References

The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance DoH 2015
Epic 3: National Evidence-Based Guidelines for Preventing Healthcare Associated Infections (2014) Journal of Hospital Infection

Infection Control Advice

External Contacts

These contacts will be checked on annual basis and minuted at the infection control team meetings.

Public Health England Hampshire & Isle of Wight Health Protection Team (south East)
Fareham Borough Council Civic Offices
Civic Way
Fareham
PO15 7AZ
Tel: 0344 225 3861 choose option 2 (Hampshire and Isle of Wight)
Out of Hours Tel: 0844 9670082

Matthew Dryden MD FRCPath
Consultant Microbiologist
Infection Clinic,
Medical Unit Office,
Royal Hampshire County Hospital,
Romsey Road,
Winchester,
S022 5DG
&
Rare and Imported Pathogens Dept
PHE, Porton
matthew.dryden@hhft.nhs.uk 07850 749454.

Occupational Health Dept
Block 4 Mailpoint 100
Southampton General Hospital
Tremona Road
Southampton
SO16 6YD
02381 204156 8am to 4pm
occupationalhealth@uhs.nhs.uk

Infection Control Team
Royal Hampshire County Hospital
Romsey Road
Winchester
Tel: 01962 825170 or 01962 824483

Appendix 9

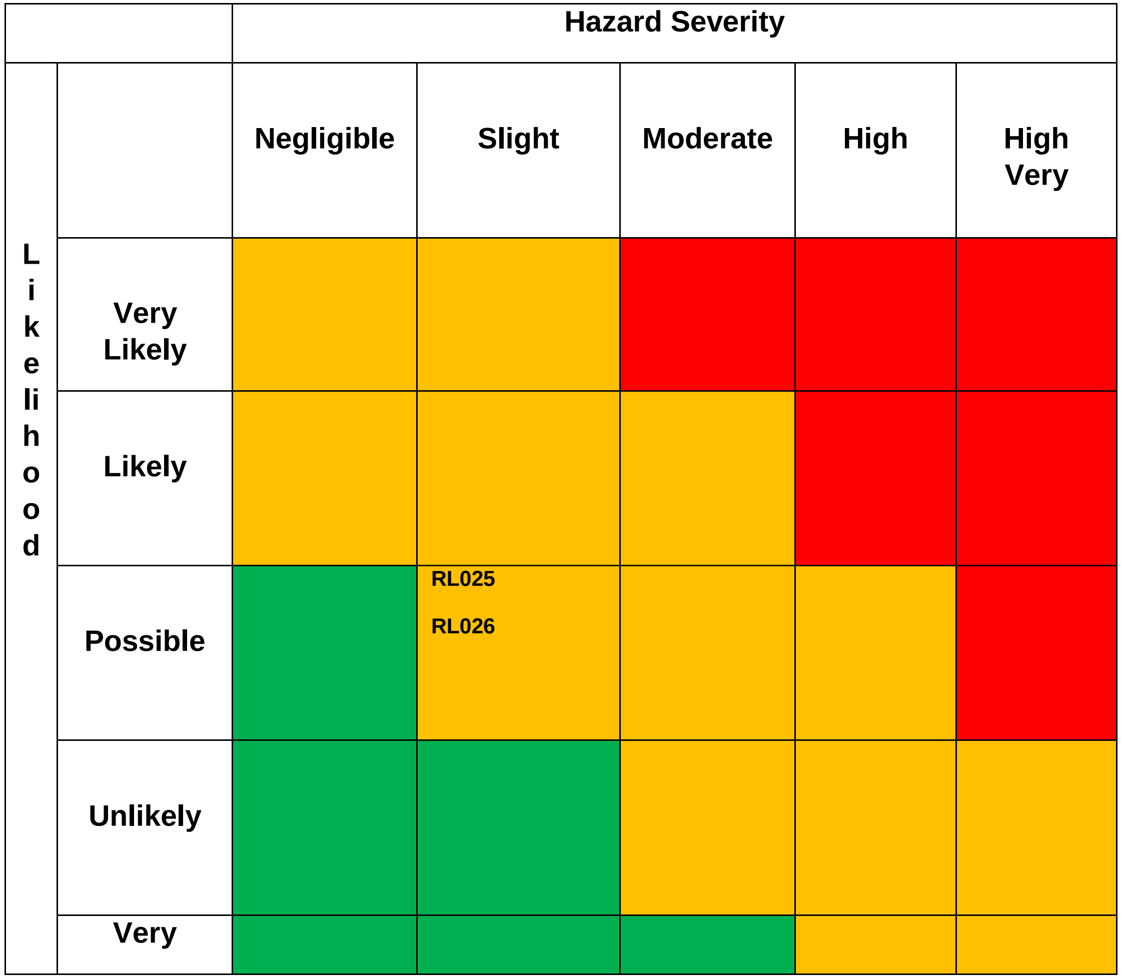
Risk Log 26/03/2018

Risk	Description	Controls	Date Identified	Date Last reviewed	Proposed Resolution Date/ Assurances	Status
RL025 **Increased number of enteral feed related incidents**	Ensure all enteral feeds are administered correctly and safely	There has been some reduction in feed related incidents but the overall trend still requires monitoring (Q4 16/17 8 incidents, Q1 17/18 4 incidents, Q2 6 incidents (2 of which were examples of good process in identifying issue), Q3 7 incidents. Move feeds into milk kitchen so can be checked in good lighting with a separate storage box for each room	25/04/17	28/02/18	Monthly review	Ongoing (Amber)
Update: 22nd March 2018: Discussed at Clinical Committee and Care Governance. No incidents reported in either January or February 2018 therefore agreed to remain on risk log until incidents reviewed at end of quarter 4 2017/18.						
RL026 **Electrical PAT testing for all medical equipment brought in by children and young people**	Ensure all external equipment is PAT tested before being used in house to avoid risk of electrical damage occurring	All internal equipment Is PAT tested on an annual basis there is a significant amount of medical electrical equipment brought in by children and young people for use during their stay which is not necessarily checked of 9 children and YP audited 6 brought in a total of 16 items of electrical equipment of which only 5 items had been PAT tested by an external organisation.	30/1/18	28/02/18	30/03/18	Ongoing (Amber)

Update:

22nd March 2018: Discussed at Clinical Committee and Care Governance. To be discussed with Facilities Manager and agreement made as to the requirements for PAT testing, the feasibility and ongoing risk.

26th March 2018 – response awaited from Facilities Manager.



		Hazard Severity				
		Negligible	Slight	Moderate	High	High Very
Likelihood	Very Likely	🟧	🟧	🟥	🟥	🟥
	Likely	🟧	🟧	🟧	🟥	🟥
	Possible	🟩	🟧 RL025 RL026	🟧	🟧	🟥
	Unlikely	🟩	🟩	🟧	🟧	🟧
	Very	🟩	🟩	🟩	🟧	🟧

	Unlikely	🟩	🟩	🟩	🟨	🟨

🟥	High Risk Red
🟨	Medium Risk Amber
🟩	Low Risk Green

Risk	**Date identified**	**Date resolved**
RL024 **Management of Peritoneal Dialysis**	10/01/16	12/03/2018

Appendix 10

NAOMI HOUSE AND JACKSPLACE POLICY

Name of Policy	Clinical Complaints Policy
Reason for the Policy	To provide guidance to all staff on the procedure for handling complaints and ensure processes are in place for effective response and learning to improve care for children and young people
Who Needs to Know About it	All staff employed by the Wessex Children's Hospice Trust
Date of Approval and Implementation	12th December 2016
Version No.	3.0
Approving Committee	Clinical Committee
Date of Formal Review	December 2019
Author / Reviewer	Jackie Collins (Governance Lead Nurse)

1. Policy Statement

The Wessex Children’s Hospice Trust aims to ensure that high standards of service exist at every level of the organisation. Complaints may be indications of unsatisfactory standards or events and must be investigated promptly.

As part of its vision and values, the Trust is committed to supporting children, young people, their families and acting on their views and experiences. The policy also covers any complaint regarding clinical issues from other sources such as staff, external professionals, visitors etc.

The objectives of the complaints policy are to:

- Endeavour to achieve resolution for complainant.
- Use issues raised to improve service delivery and communication with the children, young people and families who use our services.
- Maintain the highest standards of support and care to children, young people and families.
- Ensure ease of access for people to complain, particularly those who have difficulty in voicing concerns, by providing information on the procedure.
- Ensure fairness to complainant and staff.
- Ensure a rapid, open process.

This policy will ensure any situation is rectified at the earliest opportunity and that the Wessex Children’s Hospice Trust learns from such incidents.

2. Related Policies and Standard Operating Procedures (SOPs)

Equality and Diversity Policy
Records Management Policy and SOP
Risk Management Policy and SOP
Safeguarding Children and Vulnerable Adults Policies and SOPs

3. Roles and Responsibilities

The Board of Trustees

The Board of Trustees has responsibility for the effective management of complaints by monitoring performance of services and investigating any unresolved complaint that has been escalated to the Board.

Chief Executive

- Monitor the number and nature of complaints and action taken to resolve them
- Ensure all complaints are reported to the Board of Trustees
- Respond to any unresolved complaint in writing
- Ensure all appropriate action has been taken in order to resolve complaints
- Escalate complaints to the Board of Trustees if they are not resolved
- Cooperate with any investigation if the complainant refers the complaint to an external organisation

Director of Care

- Has overall responsibility for the complaints process
- Ensure policy and procedures are in place and are implemented effectively
- Follow up any unresolved complaint in order to address it satisfactorily for all concerned

- Report all complaints to the Chief Executive via Healthcare Governance Committee, any unresolved complaints will be escalated to the Board of Trustees
- Ensure any learning identified as a result of the complaint are disseminated to all staff

Care Managers

- Oversee any investigation
- Support the CTLs in completing the investigation process
- Develop strategies regarding any trends in complaints
- Review any written response to a complaint
- Arrange follow up meeting with the complainant to review and conclude the investigation process

Lead Governance Nurse

- Support CTLs in any investigations of complaints
- Prepare reports on the number and nature of complaints on a monthly basis to Clinical Committee and 3 monthly to Healthcare Governance Committee
- Identify any trends and develop action plans as a result

Clinical Team Leaders

- Talk to the complainant as soon as possible ideally in person or over the phone
- If the issue cannot be resolved and the individual wishes to raise a formal complaint commence an investigation
- Inform the Care Management team
- Complete the investigation in conjunction with the Governance Lead Nurse
- Support the care team in implementing any learning outcomes as a result of any investigations

Shift Coordinator

- The Shift coordinator will attempt to resolve the issue at the time
- Raise the concerns with the on call CTL
- Support the CTL in any investigation providing information as necessary
- Ensure an incident form or feedback form has been completed

Care Team

- Should be aware of the complaint process
- Cooperate with any investigation
- Implement learning points as a result of any investigation

4. Implementation and Training

Duty of Candour

In accordance with Duty of Candour – Regulation 20 Section 9 the Trust will abide by the following criteria:

Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

- **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
- **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

All staff will be made aware of the complaint process during the induction period. Detailed information regarding the process is available in the Clinical Complaints SOP.

Should a family or young person raise a concern, staff will reiterate the process at the time to provide clarity.

All complaints will be acknowledged in writing, investigated and monitored through this process with a written response in conclusion.

Incidents that require further investigation, where no complaint has been received, will undergo the same process. In some cases, the family may not be informed if the child or young person is unaffected by the incident.

The Practice Education Team will support all training relating to both the complaints process and any learning outcomes identified as a result of any complaint or incident investigation.

5. Audit

All complaints will be logged on the Complaints and Clinical Investigations Tracker. Monthly and quarterly reports will be prepared and any trends identified. Reports will include actions taken as a conclusion to all investigations.

6. References

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 16: Receiving and acting on complaints. Available at: http://www.cqc.org.uk/content/regulation-16-receiving-and-acting-complaints#guidance-links Accessed on 25/10/16

The Care Act 2014. Available at: http://www.legislation.gov.uk/ukpga/2014/23/contents Accessed on 25/10/16

Appendix 11

NAOMI HOUSE AND JACKSPLACE POLICY

Name of Policy	Meeting Nutritional Needs
Reason for the Policy	To ensure all children and young people's nutritional needs whilst they are under our care
Who Needs to Know About it	All care team, catering staff and food handlers
Date of Approval and Implementation	14th March 2016
Version No.	1.0
Approving Committee	Clinical Committee
Date of Formal Review	March 2019
Author/Reviewer	Jane Bone (Head of Catering) / Jackie Collins (Governance Lead Nurse)

1. Policy Statement

The provision of a healthy, nutritious and balanced diet is essential for the health and wellbeing of all individuals. The children and young people that access our service require guidance, support and care to ensure that they are properly hydrated and nourished. Special diets, food allergies and intolerances are catered for based on each child/young person's individual needs. Special requirements for cultural and religious beliefs are considered wherever reasonably possible.

In line with the Food Safety Act 1990 the organisation has a duty to ensure that all individuals are kept as safe as possible from food poisoning and related food associated illness.

Families and visitors who are resident during their child/young person's stay will be offered a nutritious, balanced diet according to their individual requirements. Meal times are often a social event with the families sitting together and interacting with each other. Children and young people are able to chat with staff or be part of the activity around the table even if they are not eating themselves and it provides a nurturing atmosphere for families as part of the whole care process. Nutrition can be provided in many ways such as orally, via naso-gastric tube, gastrostomy or jejunostomy and in different formats such as prepared meals, prepacked formula, freshly made up formula or blended diets. Support and information is sought from the child/young person's own dietician where possible to ensure feeding regimes are followed but where this is not the case a risk assessment must be completed for any blended diets to address the need for continuity being in the best interests of the child or young person. (See Blended Diet SOP)

2. Related Policies, Standard Operating Procedures (SOP's)

Health and Safety Policy
Infection Prevention Policy
Alcohol Policy
Equality and Diversity Policy
Referral, Assessment and Review Policy
Risk Management Policy
Safe Provision of Food SOP
Blended Diet SOP

3. Responsibilities

Chief Executive

Has overall responsibility for food safety and quality

Director of Care

- Ensures policies and procedures are in place for food handling
- Policies are implemented and adhered to
- Training is provided for all staff involved in food handling according to the Food Safety Act 1990 requirements

Care Management

- Be aware of any food safety issues and ensure appropriate action is taken

Clinical Team Leaders

- Be the on call contact for any food safety issues and liaise with Care Management, maintenance team and external agencies as required
- Liaise with catering team to address issues and implement actions

Catering Team

- Will plan meals in advance taking into account bookings and staffing levels
- Will liaise with the Care Team regarding individual nutritional needs of children and young people and plan meals according to their preferences where possible
- Will prepare meals at regular times and discuss any time changes with the care team to adapt around activities in and out of house
- Will ensure all health and safety guidelines around food preparation and storage are adhered to
- Will undertake Level 2 Food Safety training every 3 years
- Will undertake ordering and monitoring of all supplies **Shift Coordinator**
- Will liaise with the catering team regarding diets, meal requests, activities in house and changes to bookings
- Will support the care team to ensure adequate time and appropriate environment is available to feed those children or young people who are unable to feed themselves

Care team

- Will select a suitable environment to meet the needs of the individual for meal times
- Will monitor all food and fluid consumption by the child/young person and record appropriately in the record of care
- Will ensure nutritional care plan is shared with the catering team and that they are aware of any allergies and food intolerances
- Choose appropriate equipment for feeding such as spoons, bottles, cups etc
- Report any problems to the shift coordinator and the catering team

4. Implementation and Training

- All catering staff will undergo Level 2 Food Safety training every 3 years
- All catering staff will comply with Safer Food Better Business Guidelines as recommended by Environmental Health Agency
- All kitchens will be inspected by the Environmental Health Agency unannounced
- All care team will undergo annual Infection Prevention Training and Fluids and Nutrition Training

5. Audit

Fridge temperatures are monitored and recorded daily and any variation from the required temperatures are reported to the maintenance team. Food that has not been stored at an appropriate temperature will be disposed of.
Any high risk foods must be probed prior to serving and temperatures recorded to ensure the minimum temperature has been achieved during the cooking process as required by Food Standards Agency.

An annual Infection Prevention audit will be undertaken and any resulting action plan will be shared with the catering and care team. A re-audit will be undertaken if there are any serious concerns to ensure these have been addressed.

6. References

- Gov.uk *Food Safety Act* (1990) Available at: http://www.legislation.gov.uk/ukpga/1990/16/contents Accessed 18/02/2016
- The Food Standards Agency *The Food Safety Act 1990 – A Guide for Food Businesses* (2009) Available at: http://www.food.gov.uk/sites/default/files/multimedia/pdfs/fsactguidefoodbusiness.pdf Accessed 18/02/2016
- The Food Standards Agency *Safer Food Better Business* (2015) Available at: http://www.food.gov.uk/business-industry/caterers/sfbb/carehomes Accessed 18/02/2016

Appendix 12

End of Life Care pathway

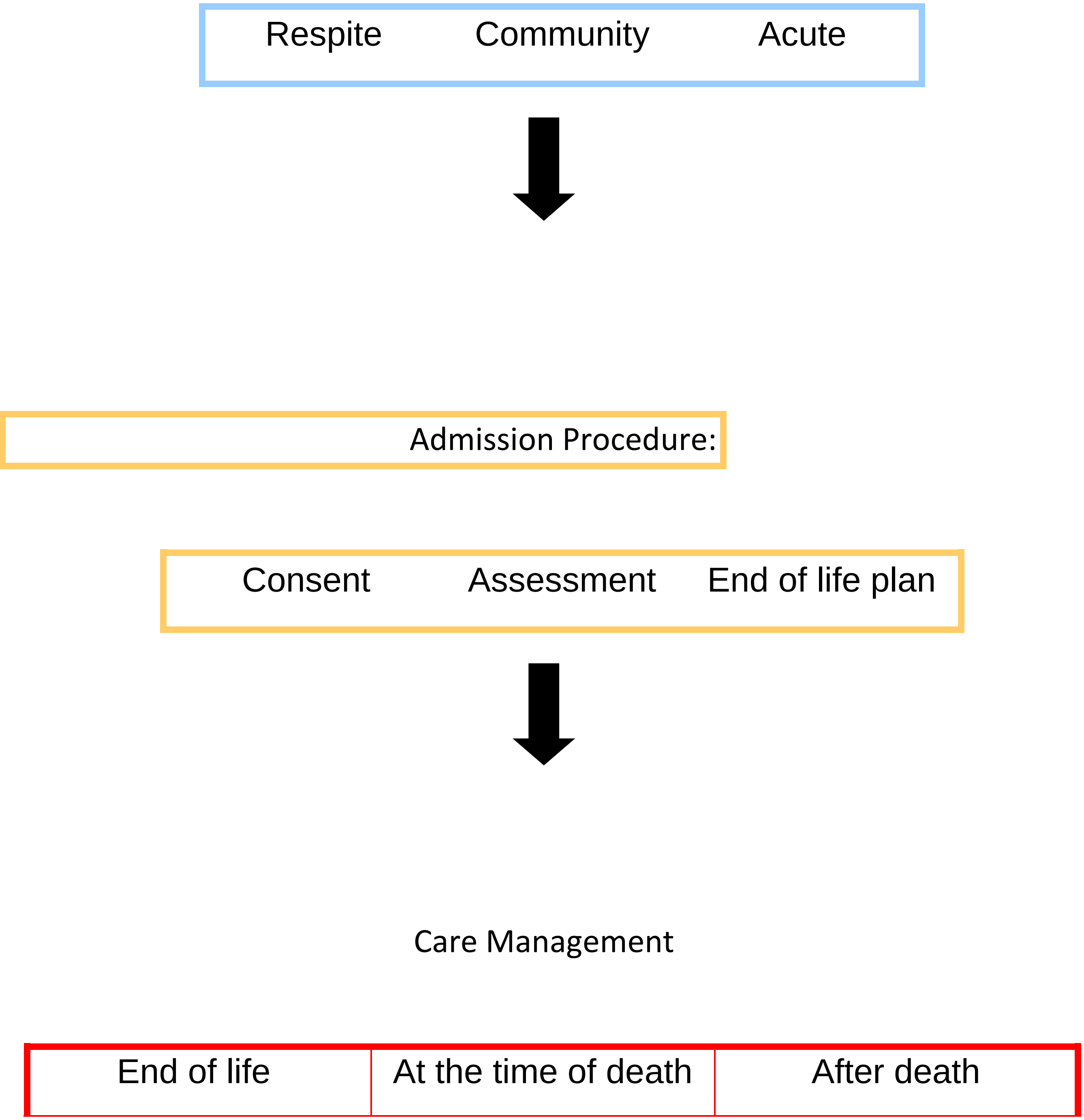
1.

End of Life Pathway

Recognition of

End of Life

Referral from:



Respite Community Acute

Admission Procedure:

Consent Assessment End of life plan

Care Management

End of life	At the time of death	After death

Assessment Continuing review Care of the family Care of siblings Play	Protocol Preparation of Butterfly Care of the Body Moving the child to Butterfly Internal Communication Family support Sibling support	Certification of Death Registration of death Cremation / Burial Butterfly Care of the Body Funeral planning Family support Sibling support

2. Guidance for using End of Life Pathway

2.1 Background

The recognition of Children's Palliative Care has bought with it a number of policies and guidelines for the development of services to promote seamless, quality care and joint working across health, social care and education. Children's palliative care delivery has largely been shaped by the organisation Together for Short Lives but is equally influenced by policies including the National Service Framework for Children, Young People and Maternity Services (DH 2004), Every Child Matters (DH) and the recent Commissioning for Children and Young People's Palliative Care document (DH 2004).

In addition, the emphasis for local services to be coherent in design and delivery with good co-ordination and effective joint working across sectors has been highlighted as an important way forward to secure smooth pathways and transitions of care for children, young people and their families. Integrated Care Pathways focusing on patient centred care aim to address the above and to develop best practice. They can be adapted to individual needs recognising the patient's journey from diagnosis through illness, end of life and death.

To promote an End of Life Pathway for Children and Young People at Naomi House is therefore timely to meet the current healthcare agenda and ultimately improve the care provided for children and families at the end of life.

The End of Life Pathway at Naomi House focuses particularly on phase 3, incorporating the fifth standard, Recognition of End of Life, of the ACT Care Pathway (ACT 2004). The pathway centres on the child and young person's admission to the hospice for end of life care and support for the family during this time and immediately following the death of the child. The criteria for beginning on the pathway is the recognition that the child is at the end of their life. The pathway therefore provides an integral service to the respite and bereavement care provided and acknowledges multi-agency working with the many organisations and services within our locality.

2.2 The Process

A considerable amount of reading and gathering of information was undertaken to inform the first stage of the development of the pathway.

Consultation was wide, involving staff in all departments: administration, the kitchen, play team, our music therapist as well as doctors, nurses and carers on the Care Team.

A particular point was made of drawing on the experience of members of staff who had most recently been involved with caring for families where a child had died. Advice was also sought from the funeral director who works closely with the team.

A working group was established to co-ordinate and plan the progress of the pathway to its first draft.

A developmental group and steering group were then established to further develop the pathway for consultation with stakeholders, a pilot of three months and final draft.

The pathway will be subject to a regular ongoing review.

It is clear that the vital point of the care pathway is that it should be jointly owned by all those involved in its design, implementation and review (ACT p5), and that systems for 'rigorous record keeping' are included (ACT p13).

In addition, it is crucial to create a pathway that is flexible to meet the needs of the child, young person and family and enables families to feel supported and empowered at the most difficult of times.

2.3 Aims

The End of Life Care Pathway will enable delivery of individualised care for the child and family underpinned by the Naomi House care philosophy.

It aims to:

- Actively support the child, young person and their family as they move along the pathway empowering them in the planning, decision making and delivery of care.
- Provide care that is flexible and sensitive to the cultural, spiritual and personal needs of each child and family.
- Provide guidelines, information and support for the child, family, care team and other professionals to enhance quality team working and partnerships.
- Create a clear benchmark in accordance with ACT and ACH quality and standards which can be used as a tool for measuring delivery of end of life care.

2.4 Terms of Reference

Palliative Care – The End of Life Pathway draws on the definition of palliative care promoted by the ACT and RCPCH Development of Children's Palliative Care Services (2003):

"Palliative care is an active and total approach to care, embracing physical, emotional, social and spiritual elements. It focuses on enhancement of quality of life for the child and support for the family and includes the management of distressing symptoms, provision of respite, and care following death and bereavement. It is provided for all children for whom curative treatment is no longer an option and may extend over many years."

Children and Young People – Acknowledgement is made of the differing needs of children and young people dependent on a variety of dimensions including age, experience, culture and upbringing.

Family – All care and support offered acknowledges and promotes diversity of understanding in relation to the term "family" and includes friends, grandparents and those most important to the child.

2.5 Guidance for Use

The End of Life Pathway has been written to guide staff in providing evidence-based care and to support the individual needs of children and young people and their families.

Children and young people enter the pathway at the stage "Recognition of End of Life", and the flow diagram provides a structure to the care delivered at various times. Each section of the pathway offers detailed instruction and information from referral and admission to care before death (at the end of life), at the time of death and after.

The additional “End of Life Pathway Information for Parents”, offers information and guidance for parents about the pathway and care of their child at this difficult time. It does not attempt to address the individual experiences of grief and loss but provides practical information to support their experience.

3. Referral

Referrals for end of life care may come either from families already known to the hospice who have been accepted and are using respite facilities, or from families or professionals recognising children and young people at the end of life from the community or acute services.

3.1 The Referral Process

Families known to the hospice will automatically be granted emergency end of life care. New families referred will be fast tracked to ensure the family receives efficient, seamless care from point of referral to their emergency stay, thus there should be as little delay as possible in the child coming to the hospice. For any fast track referral, the on-call doctor should be notified immediately to discuss the circumstances and approve the fast track for admission.

The green referral forms (accessed from the Care Administration office) are completed by a Clinical Team Leader and close liaison made with the in house Doctor on call. Additional relevant information and details should be sought from other professionals (e.g. Doctor's letters) as soon as possible.

For all referrals for end of life care it is important, if possible, to visit the child / young person and family to assess need and expectation and explain what the hospice is able to offer. Families will move immediately on to the pathway and documentation used specific for end of life care. It is recommended if the child is being referred for end of life from hospital to be involved as soon as possible in any multiprofessional planning meetings.

If the child has already died in the community or hospital (whether or not already known to us) and is being referred for use of the Butterfly Suite, arrangements for transportation must be sensitively made with the family. If the family do not want to transport their child themselves their local funeral director may agree to transfer their child to the hospice.

4. Admission

4.1 Consent

It is important to establish and confirm consent from families in all aspects of care but particularly in gaining medical and health care records at the time of admission. Once the family have arrived it is important to ascertain consent for care and their wishes regarding emergency, end of life care. It is recommended that bespoke emergency care plans are completed and a template for this is available with the end of life care documentation. If the child or young person is able to be included in decision-making and able to give consent it is important to involve them in discussions about the planning and delivery of care.

4.2 Parents Information

All relevant information about Naomi House, the care offered and details of housekeeping and catering should be given to parents at the first opportunity – much of this information is available within the leaflet for parents. Parents may also be given the 'End of Life Pathway – Information for Parents'.

4.3 Assessment

A comprehensive holistic assessment to identify the needs of the child and family will be made including the wishes of the child and family at time of death. This should include details of diagnosis, current medications, clinical care and also address issues such as preferred place of care and preferred place of death. Sensitive communication at this time to explore preferences of care and support will help guide further conversations to ensure individualised care for the child and family. It is good practice, wherever possible, to have two members of the care team supporting the family on admission, one of these being from the family support team.

4.4 End of Life Care Plan and Confidential Handover Form

A bespoke plan of care will be formulated by the doctor on call and nursing team and the appropriate care documentation for end of life completed.

4.5 Emergency Care Plan

Sensitive discussion around completing an Emergency Care Plan is required and this can be carried out by a Clinical Team Leader, Care Manager or the Doctor present on admission. Communication with parents and the child or young person, where possible, should include their preferred care options.

4.6 End of Life Check List

The End of Life Checklist (see Appendix 7) is provided so that all specific information can be recorded and seen in one accessible place at the front of the child's notes. Completing of this form can begin once the referral has been made and the child is recognised as requiring end of life care and will be visiting Naomi House.

5. Care Management

5.1 Care at the end of life

Care of the child

5.1.1 Pain and symptom control

Assessment

A child or young person admitted to Naomi House (NH)/Jacksplace (JP) for end of life care requires a comprehensive holistic assessment. Whether they are known to NH/JP or are being admitted for the first time at the end of life, documentation needs to be completed. An individualised symptom management plan and emergency care plan is to be completed by NH/JP doctors. The nursing care documentation enables individualised care planning and care delivery for the child/young person and their family incorporating their needs and wishes.

All care provided should be inclusive of a culturally sensitive approach encompassing spiritual and emotional aspects of care.

It is helpful for the family to meet key members of the Care Team at this time, e.g. Doctor and Family Support Team if they have not already been introduced.

Continuing review

Symptom management for children and young people at the end of life can be complex and challenging. A multi-professional holistic approach should be delivered throughout and all care must be continually reviewed and evaluated, any changes recorded and care altered accordingly to ensure quality care is provided. The BNF and BNFc, Rainbows Guidance for Symptom Management and the APPM formulary are useful resources.

Rainbows Symptom Control Manual 9th edition

APPM Master Formulary 2015

There are a number of other documents, guidelines and books providing support for symptom management, available as further resources.

- Symptom assessment and the management plan should be explained to the family so that they know what symptoms to expect and how they will be managed.

- Medications should be reviewed so that non-essential medications are stopped in discussion with family and any new medications explained and prescribed.
- The potential need for different routes of delivering medications should be explained to the family e.g. buccal or subcutaneous routes.

5.1.2 Quality of life

The time a family has together needs to be optimized with the child/young person wishes central to all conversations. There may already have been discussions, and the team can ask the family their thoughts so that wishes can be facilitated where possible.

There may be friends or pets that the child/young person would like to see, and where possible this can be arranged.

If the family would like to go home or on a special trip, this may be facilitated with the support of the medical, nursing and family support teams.

It is important to ensure the child/young person has ample opportunity to talk about how they feel; this will depend on their understanding of their condition, their age and their parents' involvement.

5.1.3 Organ donation discussion

Where appropriate, organ and tissue donation can be discussed with the family and the child or young person. As the patient receiving end of life care at the hospice will have had a serious medical condition, organ donation may not be suitable but tissue donation could be possible*, such as heart valves or corneas*.

The NH team should address any questions that the child or young person might have and advice can be sought from the Transplant Coordinator at Royal Hampshire County Hospital (Winchester) or Southampton General Hospital.

See tissue donation Appendix 1.

5.1.4 Post mortem discussion

In certain circumstances it may be appropriate to discuss the need for a post mortem examination. Although the child or young person can no longer benefit from the findings, more accurate information about the cause of death may be obtained and the family might find this helpful in the future. In addition, advancing the knowledge of disease processes and the effects of treatment, which may be discovered at post mortem, can be used to help other people with similar conditions.

The child's lead paediatrician should be consulted to clarify the potential benefits, extent and process of the post mortem before the discussion with the parents.

It is important that these discussions happen in plenty of time to organise how a post-mortem is to be facilitated if required.

5.1.5 Resuscitation plan

The Child & Young Person's Advance Care Plan document is widely used in the region. It sets out an agreed plan of care to be followed when a child or young person's condition deteriorates. If the patient does not already have a plan, a senior member of the nursing or medical team can use the CYPACP as a framework for discussing and documenting the agreed wishes of the patient and parents, for when the patient deteriorates.

The CYPACP is designed for use in all environments: home, hospital, school, hospice and for use by the ambulance service. It will apply wherever the patient is cared for. The CYPACP contains both an end of life care plan as well as the resuscitation plan. It remains valid when parents or next of kin cannot be contacted.

Of note, the parents and child should not be asked to sign the DNACPR (Do Not Attempt CardioPulmonary Resuscitation) section. This may place an unnecessary burden on families. It is sufficient for the lead clinical to document and endorse the DNACPR page to confirm this has been discussed and agreed.

Further guidance is available at www.cypacp.nhs.uk.

See Appendix 2 for a template of the care plan and a clinician's guide for using the plan.

5.1.6 Memory making

We have a number of different options to offer families. Some memories NH/JP staff can do and are free to families and others are from a variety of outside companies, which will incur a cost. The Family Support Team and Play Team can assist the Care Team if required.

See Appendix 3 for details of equipment and resources available.

The child and family may have special wishes. They can be from something simple and straightforward, like going for a swim or walk, to involving other organisations for something more complex.

Care of the Family

5.1.7 Practical support

The care and support of parents and siblings is paramount at this time. Families need relevant and appropriate information to make choices and the opportunity to be involved in decisionmaking.

- This may also be an appropriate time to help families consider what their wishes may be for the care of their child after death – any religious or cultural wishes.
- If not previously discussed with them, families may also raise questions about organ donation and post-mortem.

Care for the parents can extend to additional support through the use of complementary therapies. Members of the Care team have complementary therapy skills and qualifications and may be able to provide these therapies in house; if no staff member is available volunteer therapists can be arranged to visit NH/JP.

5.1.8 Sibling involvement

Talking with children about their dying brother or sister may be very difficult. However, letting siblings know what is going on and actively involving them in what is happening can be very supportive and can help them cope better, even if there are no definitive answers or solutions to their questions. Any communication with siblings or questions they may ask need to be responded to in an age appropriate, sensitive and meaningful way and always in line with the parents' wishes (for children under 16) for disclosure of information.

Siblings are good at noticing things but may be mistaken in their interpretation of what they mean. Honest and sensitive communication is therefore important to meet the needs of each child.

Wherever possible clear communication should be encouraged with the whole family. This may be a difficult and challenging time for parents sharing and talking with their well children. They may need guidance and support, before, during and after the conversation. If a parent has asked for a member of the Care Team to talk to their child, keep in close contact with and debrief the parent, so they are fully informed.

There are a number of resources and further information available on support for siblings and how to help parents. The staff resource folder on sibling support includes advice on breaking bad news, explaining death to children and a child's understanding of death and dying.

Play is an extremely valuable means of communication with both children and adults. The Play Team and Family Support Team should be involved as appropriate at all stages to support the child and family. There are a number of books, games and specific activities that can be utilised for the ill child, siblings and parents.

5.1.9 Emotional support

Offering time, along with clear information, will assist a family in making choices that are best for them. There is usually no urgency, and families need time to take in all the information.

Involving the Family Support Team as soon as possible will help to ensure continuity of support throughout end of life, as well as after death.

If there are other children in the family it is likely the parents may be concerned about how to talk with them, and they may look to staff to help or advice with this.

5.1.10 Spiritual, religious and cultural issues

Introduce the Chaplain at the earliest opportunity if the family has not met him/her. He/she will work closely with the Care Team and ensure all appropriate plans are made. It may be that the family will want prayers and other rituals before or at the time of death. However, it is important to stress that the Chaplain is available not just for religious support. Human beings need to make sense of life and to find meaning and purpose. The death of a child or young person raises some of life's biggest questions and most of us struggle when trying to make any sense of what has happened. The Chaplain is available to support the family during this time.

For specific details of spirituality, faith and cultural care please refer to the booklet Together for Short Lives – A Guide to End of Life Care Section 2.3 which gives a definition of spirituality, ethnicity, culture and religion and some information on death and dying in world religions. This booklet is held in the Family Support office at Jacksplace or the care office at Naomi House.

5.1.11 Grandparents and other relatives

There may be grandparents or other relatives who have played a significant part in caring for the child/young person, and it is important to include them in discussions, as the family feels appropriate.

Preferred place of care and death

5.1.12 Place of death

Wherever possible, the child/young person and/or their family will have been able to visit Naomi House/Jackpslace prior to transfer for end of life care, and will therefore be aware of the environment and the possibilities for achieving any particular wishes that they may have: for example, spending time in the garden; sitting under the night sky with their child; having friends and family around, or being alone with their child.

Preferred place of care at the time of death will be part of the discussions held with the family when completing the Advance Care Plan; this will also include discussions regarding place of care after death to explore the family's wishes regarding the use of the Butterfly/Ocean Suite, Funeral Director premises or possibly taking their child home for a period. This should be discussed with the child or young person and family as soon as it can be, giving clear options, along with opportunities for changes of mind.

Consideration should be given to where parents and siblings wish to sleep and every effort should be made to accommodate them safely and comfortably as close to the child/young person as possible, if this is their wish. At least one room in the Family Accommodation should be allocated for the family's use throughout their time at the hospice to ensure they have some private space and facilities available at all times.

5.1.13 Place after death

Check family wishes. Give plenty of time. The main considerations in terms of length of stay in the hospice is likely to be in relation to three things:

- Family wishes
- Condition of body
- Organ donation

It may be possible for the family to care for the child/young person's body at home if they wish. The hospice team can help with advice on how to manage this.

The time staying in the hospice is helpful for friends and family to visit and for family to give some time to their other children (see sibling support), as well as to planning for the next couple of weeks.

It can help children to say goodbye and understand the events that are happening if they are able to be involved in the funeral arrangements and in the service on the day. All involvement should be appropriate to their age and level of development and following the wishes of the family.

Further support for the team and parents in helping children say goodbye, what to expect at a funeral service, experiences of grief and loss and spiritual needs for children is available in our staff resource folder and on the bookshelf in Butterfly and in Ocean Suite lounge.

5.2 Care at the time of death

5.2.1 Family support

If discussions with Family Support have taken place prior to the child/young person dying, these can be re-visited and checked. (See previous section)

If the family has not been able to have conversations and make plans, these will need to take place over the coming hours and days.

The Care Team, alongside the Family Support Team, will work together to ensure the best care for the family.

Parents will often look to the team~~s~~ for help with practical arrangements, support for siblings and memory making. The Family Support Team can provide information on the options available for the bereavement period.

Care and sensitive communication is important for siblings, they should be included and not shielded from the grief and loss felt by others. If they wish to see their brother or sister, attention and support should be offered to manage this in the most positive way with the family.

Siblings may wish to be involved in caring for their brother or sister, making mementos or in the preparations for the funeral.

This time is also useful to ensure the family is offered all there are for making mementos – hand and foot prints; lock of hair and different jewellery. Please see Appendix 3 and work in collaboration with Family Support Team.

For safety reasons we need to know when there will be visitors in the house with the family, therefore all visitors must come in via the main door and sign in at Reception.

Visitors will be offered refreshments but we are unable to provide meals for those who are not resident in house. In certain circumstances the catering team may be asked to provide sandwiches/light refreshments.

5.2.2 Practical issues

What to do when a Child / Young Person Dies

It is not too important to establish death immediately, it is more important for the family to spend those last few moments together.

What to do:

- There is no need to rush to do anything with the child/young person.
- Be sensitive to the needs of the family. They may want to be alone or have company.
- Take a note of the approximate time of death for the death certificate.
- Take a note of who is present.
- The duty doctor will certify the death, and the time of death.
- If the doctor is not present it is helpful for a nurse to confirm death by listening for a heartbeat for a full minute.
- Contact the parents if they are not in-house (see below for protocol).

If the death is expected:

- Telephone the duty doctor, if not present at the death.
- If the death occurs at night the doctor does not need to come in, unless the parents would like them to, but should visit first thing in the morning to certify the death.

If the child was not thought to be at end of life and therefore the death is unexpected, actions taken will depend on the instructions given by parents on the CYPACP or their in house Emergency Care Plan. Please see policy regarding Assessment of Care and Emergency Transfer.

When contacting parents by phone:

- Speak calmly and tell them straight away what has happened. Give them the facts.
- Find out if they are on their own or if there is someone to support them and bring them to the house.
- Explain that there is no need to rush and encourage them to wait for someone to accompany them/bring them to the house.
- Assure them we will not do anything to their child until they arrive.

Internal Communication

Place the large Butterfly/Boat at the front entrance.

Send a short e-mail to Butterfly/Ocean e-mail address – this will inform the Care team and others across the organization who should be notified of the child/young person's death. This only needs to give the child's name and whether the family is at home or being supported in house.

If the death occurred in-house then all appropriate notifications will be made to CQC, CDOP and MBRRACE by the Head of House within 24 hours, or at the start of the week if the death occurred at the weekend.

Commence a set of **Family Notes on blue paper** for the ongoing documentation regarding the family. The child/young person's notes should now only record practical care provided for the child in Butterfly/Ocean, and all other support and care to the family must be documented in the Family Notes. The Family Support team will keep these after the funeral to document ongoing support, such as sibling support and attendance at Remembering Days.

- Commence the End of Life checklist.
- If the patient is subject to Deprivation of Liberty Safeguards (DOLS), check that the coroner has already been informed.

- Inform child/young person's GP as soon as possible. (Check with parents that GP details held on file are current and correct).

- Inform the clinical teams involved with the child/young person as soon as possible.

- Doctor to send letter confirming date and details of death to child/young person's GP and all consultants we know have been involved.

Death Out of House, but using Butterfly or Ocean

There may be requests for the use of Butterfly/Ocean for children/young people who have died in the community or in hospital. This may be for families already known to us, or a new referral of a child/young person who has perhaps died unexpectedly.

All post death referrals for the use of Butterfly/Ocean will be considered on a case-by-case basis, according to the circumstances of the death. We would hope to support families in these circumstances wherever possible, but consideration must be given to the level of support required for both the family and the Care team, particularly in cases of suicide or extreme trauma.

Death Out of House, Not Using Butterfly/Ocean

Send a short e-mail to the Butterfly/Ocean e-mail address – see previous section: Internal Communication.

Place the Dragonfly (Naomi House) /Lighthouse (Jacksplace) at the front entrance

5.3 Care following death

5.3.1 Funeral

See Appendix 4 for detailed information on funeral planning.

- If the child/young person has expressed any wishes about their own funeral, ensure everyone is informed.
- If a funeral director is not requested, the Natural Death Centre can advise on arranging a funeral without a director (www.naturaldeath.org.uk).
- The family should be empowered to be involved with every aspect of the planning process.
  - Encourage parents to enable their other children to express views and be fully involved.
- Staff should be mindful of all that needs to be completed in order to gently keep parents moving towards any deadlines e.g. service sheets.
- Keep the child/young person's file up to date throughout.
- Respect the family's ethnic, cultural and spiritual beliefs at all times and ask the family if there is anything of which we need to be aware or for which we need to make arrangements.

Before the Funeral

It is important to ensure that the death has been registered, and parents have the documentation to give the Funeral Director (death certificate and if appropriate cremation certificate).

On the Day of the Funeral

Ongoing support and care is essential to enable the family to be in control.

The Care Team and Family Support Team can work alongside the funeral director and should act in accordance with the family's wishes.

It is helpful to have one main contact to support the family and co-ordinate the involvement of other staff.

Care team staff wishing to attend the funeral should discuss this with the appropriate Head of House.

Details on arrangements for the day of the funeral are contained within Appendix 4.

5.3.2 Burial or cremation

The funeral cannot go ahead until the funeral director or celebrant has obtained the Certificate for Burial or Cremation.

Following the child's/young person's death, the doctor should complete both the Medical Certificate of Cause of Death (MCCD or Death Certificate) and the Cremation form.

For a cremation:

Form 4 should be completed by the doctor involved in the child/young person's care.

Form 5 must be completed by a second doctor who has not been involved in the child/young person's care. This may be one of the doctors at Naomi House/Jacksplace (if the child/young person died outside of the hospice) or a doctor from Gratton Surgery can be requested to attend and complete the form.

The Death Certificate and Certificate for Cremation will be in the plastic wallet at the front of the child/young person's file. The Family Support Team will help the family with arrangements for registering the child/young person's death. The family should be given the MCCD and a leaflet "Registration and Funeral planning" available in the End of Life resource file (Family Support office at JP / Care office at NH).

For a cremation, ensure arrangements are in place for the completed cremation form to reach the funeral directors in time as they have a legal obligation to deliver it, by hand, to the crematorium at least 24 hours before the service.

If a cremation is planned, contact a second doctor to visit the child/young person and to complete Form 5. The doctor completing Form 5 should speak directly to the doctor completing the MCCD. The doctor will also need to speak to the parents or a nurse who has cared for the child/young person in the last few days of life. The doctor will need to examine the child/young person's body.

N.B. The doctor signing Form 5 must fulfill the following criteria:

- Qualified for at least 5 years.
- NOT have been involved in the child/young person's care at any stage.

(i.e. not another NH/JP doctor if the child/young person died at Naomi House/Jacksplace, nor a doctor from the child/young person's surgery or a consultant from the child's local hospital).

5.3.3 Certification of Death

The doctor is responsible for completing the MCCD. MCCD forms are kept in the green box file in the Notes Cupboard. The doctor should also complete Form 4 of the Cremation Form. These are also kept in the green box file.

The following numbers may be useful:

Registrar	**0300 555 1392**	Mon-Fri 8am-8pm; Sat 9.30am-4pm
Coroner	**01962 667884**	

The doctor should put the MCCD with the tear off slip, into the envelope provided for the parents. It should be immediately placed in a plastic pocket at the front of the Butterfly/Ocean folder. **It will be needed for the registration appointment**. A photocopy of the MCCD should be filed in the notes.

For a burial this is all that is needed. If a burial is confirmed and the doctor has completed Form 4 of the Cremation Form, this should now be shredded.

5.3.4 Registration of Death

An appointment will need to be made.

Usually the death is registered by a relative of the child/young person. However, it can be done by a senior member of staff.

If the siblings are not going to the Register Office, make sure there are adequate arrangements for their care, either with relatives or friends.

The registration process takes approximately half an hour.

The **documents needed** for the appointment are:

- Signed Death Certificate.
- NHS Medical card (if possible).
- If a very young baby's birth has not yet been registered, this will need to be completed in the same appointment.
- In exceptional circumstances the death may have been reported to a Coroner - 01962 667884. The registrar will need additional documentation from the Coroner before registration.

Winchester Registry Office: Castle Hill, The Castle, Winchester, SO23 8UL
Tel 0300 5551392

Office Hours: Monday – Friday 8am-4pm, Saturday 9.30 am-4pm

The parents will be asked:

- Date and place of death.
- Name and surname of child/young person – must be the same as on the birth certificate.
- Date and place of birth.
- Usual address.
- They will not be asked for cause of death, the coroner will take this from the MCCD.

Death Certificates are needed for administrative purposes.

One Death Certificate is free, more can be purchased from the Registrar at a cost of about £5 per copy – prices may vary.

The Registrar will issue a Certificate for Burial or Cremation that must be passed on to the Funeral Director in order for the funeral to take place.

In some circumstances, registry staff may be amenable to coming to the hospice to register the death.

See Appendix 5 for details of register offices in Winchester, Andover, Southampton and Basingstoke.

Removing the body out of England and Wales

There is no restriction on moving bodies within England and Wales, but you need to notify the coroner for the district in which the body is lying if you want to move the body of the deceased to Scotland, Northern Ireland, the Isle of Man or the Channel Island, or overseas.

Further details can be obtained from:

General Register Office - Removing the body out of England or Wales.

5.3.5 Place to be with the body

Parents' Wishes Regarding Butterfly/Ocean

It is vital that the parents retain control and choice in the care of their child. The professionals who care for the child/young person and family should do so with dignity and respect (Riches and Dawson, 2000) affording them time and privacy. As previously stated in 5.1.3 it is important to respect the family's spiritual, religious and cultural beliefs and support them in ensuring rituals are recognised and respected both before and after death (Komaromy, 2008).

Explain that parents may choose:

- What they would like their child to lie on (Moses basket, cot or bed).
- What they would like to have in the room to personalise it for their child; (make a few suggestions such as music, some of the child/young person's personal items from their bedroom, teddy, duvet cover or blanket etc.).

Do Not Overwhelm Parents – Go At Their Pace

When they are ready offer support to:

- Contact key individuals e.g. friends, family, minister of religion - if they haven't already done so.
- Explain that we can field calls and visitors if they wish.
- Explain they can stay in the bedroom for as long as they wish before their child is moved.
- Explain they can spend as much time as they wish in Butterfly/Ocean and the lounge.
- Explain that hand/foot prints and other mementos can be made/taken as and when the family is ready.
- Be prepared to answer questions or direct the family to further support.
- There is no rush to move the child/young person's body, and parents should be enabled to care for their child and make decisions regarding their care after death just as prior to death.

Preparation of Butterfly/Ocean: please see Appendix 6

Parents may wish to wash or bathe their child and dress them; they may wish to be able to do this alone, with support from family or friends or with the Care team; or they may wish Care team members to do this for them. Please remember that some of the child/young person's care may be affected by the family's religious beliefs.

It is best if the child/young person's body is allowed to cool naturally initially, with light clothing and bedding, but this is only a guideline and parents' wishes should be followed if this is difficult for them. It is best to allow the child/young person's body to cool for at least 2 hours before using the cover or mat; this will usually be following transfer to Butterfly/Ocean.

In the unlikely event of a coroner's case and involvement of the CDOP, no tubes, lines, prostheses or devices should be removed until permission from the coroner has been given.

Please check with family before removing any medical equipment: lines, feeding tubes, cannulae etc at this stage; some children/young people will have had these prostheses for some time and family may feel they are part of the child/young person's features, so removing it may seem to take away some of their character. These lines can be removed at a later stage.

When removing nasogastric or gastrostomy tubes, aspirate the stomach before removal to reduce the possibility of leakage. Gastrostomy sites should be covered with a waterproof dressing.

Funeral directors can be asked for advice at any stage regarding the care of the body, and management of prostheses. Most prostheses can be left in-situ for burial / cremation EXCEPT those with batteries. Please check with the funeral director for specific advice.

Moving the Child/Young Person to Butterfly/Ocean

When the family is ready, the child/young person can be moved to Butterfly/Ocean bedroom. If the child is small, then parents may wish to carry them to the room themselves. A larger child should be transferred on their bed.

If the child/young person is being brought to the hospice following death at hospital or home, the Care Team can help the funeral director transfer the child/young person onto the bed.

When the child/young person has been transferred to Butterfly/Ocean, the child/young person's bedroom should only be cleared of medical equipment. Parents may wish to spend time in the room and should not feel rushed to vacate it.

Once the child/young person is settled into Butterfly/Ocean:

- Continue to be sensitive to the needs of the parents – they may wish to be on their own, or have a member of the Care Team with them. Don't be afraid to ask which they would prefer.
- Encourage family to make the Butterfly/Ocean Suite their own space. Ask if there is particular music/stories they would like to have playing for their child. Encourage them to decorate the room with pictures, toys, their child's own bedding etc as they wish.
- Give the parents time.
- They may need guidance on what they are able to do. Encourage them that if they wish they may:
- Cuddle their child.

- Lie on the bed with their child.
- Sleep for a while next to them.
- Pick them up (if small enough) and move them to wherever they would like within reason, i.e. into the garden.

When helping the family in caring for their child or making mementos whilst in Butterfly/Ocean, always remember to wear warm clothing, work at the correct height (bed height etc) and change position frequently if the room is being cooled. In a cold environment, you are at risk of injury to your back, as your own body will be trying to keep warm.

For activities in memory making in Butterfly/Ocean – please see Appendix 3.

Changes to the body

Parents and family of a child/young person who has died are unlikely to be aware of the changes that may take place after death. They may need to be prompted that it is okay to ask questions about these changes, for example discolouration of the skin or leakage. In the absence of information, parents and carers may become alarmed about changes they observe and believe they are abnormal and their child is the only one it has ever happened to. This can be very frightening. Appropriate information, given gently and at an early stage is required.

Please see Appendix 6: Care of the Body for further information regarding changes after death.

Transferring the Body into the Coffin

Ongoing support and care are essential to enable the family to be in control.

The Care team and Family Support team can work alongside the funeral director and should act in accordance with the family’s wishes

The child/young person is usually moved into the coffin on the day before the funeral. The funeral director will usually be present for this transfer, but parents may wish to lift their child into the coffin themselves with support from the Care team, or they may prefer to be present whilst others carry this out.

Care team members should ensure that Funeral directors are aware of the team’s assistance with this transfer, to maintain dignity and respect for the child/young person and family throughout.

Depending on the size and weight of the child/young person, the following factors should be taken into consideration:

- You are not transferring a live body, therefore a slide sheet or Patslide may be used – this task will require at least 3 people to facilitate the move.
- For a larger child / young person a hoist may be necessary to transfer to the coffin.

5.3 Bereavement support

The bereavement support service offers practical, emotional and spiritual support during the child/young person's illness, around the time of death and afterwards. Support aims to be open and sensitive to the individual needs of family members. There is a bereavement support leaflet for families and a wealth of further resources available through the Family Support Team.

5.3.1 Support for parents

The family needs to be aware that the last night they are able to stay is the night before the funeral; this needs to be communicated sensitively at an appropriate time. Before families leave it may be helpful to discuss further support for them:

The Family Support Team offers to call them and/or visit. They will keep in touch as the family wishes in terms of ongoing support.

The family will be offered a stone (for NH) or leaf (for JP) inscribed with their loved one's name.

Support in the community

The Family Support Team will make an assessment of family need before the funeral in order to:

- Discuss their future needs and ongoing support.
- Identify professionals in the community who might help them.
- Possibly identify a key professional who is willing to act as a community link.
- Find out about any local community groups that might be able to offer bereavement support.
- To explain the process of support that NH/JP is able to offer including visits, Remembering Day, sibling days and grandparent days.
- To ensure that families know how to contact us if they should ever need support.

Ongoing support

The Family Support Team at NH and JP offers practical, emotional and spiritual support, around the time of death and afterwards. The team will liaise with the family to arrange appropriate ongoing support and may include trained Bereavement Volunteers in this.

5.3.7 Staff support

Caring for a dying child/young person and supporting families through their child's death is a stressful and emotional time. Emotional support for the team is therefore important and the availability for supervision, **reflection** and debrief should be considered. There are a number of avenues of support available to the team:

- peer support
- one-to-one support with Team Leaders
- supervision with the chaplain ▯ reflective practice sessions ▯ debrief meetings.

Debrief meetings are held after the death of any child/young person known to the service whether they die in house or in the community, and for all children/young people who were referred after death for family support and the use of Butterfly/Ocean.

These meetings are for any member of the Care team who wishes to attend whether involved in the particular child/young person and family's care, or as a learning opportunity. Medical staff and external professionals who were involved in the child/young person's care will also be invited to facilitate learning and development of practice across all settings.

Training and Development

Training opportunities may be supported through team days, mandatory training days, teaching programmes and shadow working with colleagues and senior members of the Care team. All staff should be encouraged to take up these opportunities to develop their knowledge, competence and confidence in this area of their practice.

5.3.8 Staff supervision

All members of staff can access one-to-one support from their Team Leader/Line Manager at any time.

Reflective practice is provided in house for all members of the Care team. This is available on an individual or group basis, to help enhance team working and reduce any sense of isolation. (Bennett and Ilic, 2011)

5.3.9 Organisational support

A central element of good practice is supporting staff through training to develop knowledge, competence and confidence. Staff need to have appropriate training and be professionally competent to be able to achieve high standards in the delivery of care (Bennett and Ilic, 2011)

As stated in the Death of a Service user policy – staff will have access to regular training sessions regarding End of Life care, and will have opportunities to work alongside Practice Educators and senior members of the Care team to gain knowledge and skills to enable development of their practice.

Staff will be encouraged and supported through the appraisal system to consider their individual training needs; they will be given opportunities to access appropriate training to address identified needs.

6. Appendices

Appendix 1	Tissue Donation information
Appendix 2	CYPACP proforma and a clinician’s guide for using the plan
Appendix 3	Memory making
Appendix 4	Funeral arrangements
Appendix 5	Details of Register offices in Hampshire
Appendix 6	Care of the body in the bereavement room
Appendix 7	End of life Checklist and internal communication
	References
Appendix 8	

<u>Appendix 5</u> – Details of Register offices in Hampshire

Winchester Register Office

Castle Hill

High Street

Winchester,

Hampshire

SO23 8UH

Telephone: 0300 5551392

Basingstoke (Hampshire North)

Golding

London Road,

Basingstoke,

Hampshire

RG21 4AN

Telephone: 0300 5551392

Fax: (01256) 350745

Email: basingstoke.registrars@hants.gov.uk

Andover Register Office
Wessex Chambers
South Street,
Andover
SP10 2BN
Telephone: 0300 5551392
Fax: (01264) 366849
Email: andover.registrars@hants.gov.uk

Southampton Register Office

6a Bugle Street

Southampton

SO14 2LX

Telephone: 02380 915327

Email: registrars@southampton.gov.uk **Appendix 8 – References**

Care of the child after death: guidance for children’s hospice services (2011)

Helen Bennett and Marina Ilic. Children’s Hospices UK. DH.

End of Life Planning Series: A Guide to End of Life Care – Care of children and young people before death, at the time of death and after death (2012)

Together for Short Lives.

Care After Death: Guidance for staff responsible for care after death (2015) Hospice UK Guidance for staff responsible for care after death (last offices) (2011)

Developed by the National End of Life Care Programme and National Nurse Consultant Group (Palliative Care)

Appendix 13

Staff Survey 2016 Headline Analysis

Survey conducted end of December 2016, results below are compared to the 2012 survey (where possible) which asked questions of a similar nature. Survey of 2014 does not have comparable topics but an overall satisfaction score is available.

Responses rate

2016		2012
84%	Overall response rate as % of the staff group And of that response:	72%
46%	Care	58%
12.5%	Fundraising	20%
11.5%	Finance, Admin & Facilities	9%
30%	Retail	13%
55%	manage people (NB this = most of shops staff)	
90%	see themselves here in a year	
87%	would attend an annual event	

Responses returned as % of staff by department

70%	Care	66%
88%	Fundraising	95%
100%	Finance, Admin & Facilities	100%
78%	Retail	59%

Length of Service of respondents

25%	0-12 months	14%
26%	1 to 3 years	29%
20%	3 to 5 years	22%
29%	5 + years	35%

Satisfaction

2016		2012
88%	Overall satisfaction	85%
37%	Morale is high	20%
51%	Morale is medium	71%
12%	Morale is low	5%
54%	Morale has improved	40%

Appendix 15

2016	**Specific Questions/theme**	**2012**
	Sustainability: “How can we plan for the future?”	
90%	are positive about our long term strategy and plans	83%
94%	we have the interests of the families at heart	93%
95%	we understand & can deal with pol & econ challenges	94%
80%	we are learning to work smarter	89%
93%	are happy with their pay and conditions	83%
	Quality: “How can we reach and maintain our goals?”	
92%	know what is expected of them	92%
66%	receive regular feedback	92%
98%	feel it’s important to measure and maintain standards (New subject – no match)	
87%	we celebrate success	86%
95%	they take an interest in other departments	74%
	Innovation: “How do we keep ahead of the field?”	
78%	are encouraged to come up with new ideas	74%
83%	know how our work and services will develop in the future	86%
86%	get enough training	88%
85%	feel we can respond to change and that we embrace technology. (New subject – no match)	
	“Leadership: “It’s all of us so how are we doing?”	
73%	feel that their manager keeps them well informed	87%
76%	can talk to their manager	85%
100%	ARE PROUD TO WORK HERE & ENJOY WORKING HERE!	99%
95%	would be happy to support fundraising initiatives	91%
89%	are happy with their work life balance	86%
94%	feel this is a great place to work	98%

18 June 2018

6 May 2014

Laura Bond
Naomi House

NHS
Dorset
Clinical Commissioning Group

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Dear Laura

Re: Quality Account 2018/19

Thank you for asking NHS Dorset Clinical Commissioning Group (CCG) to review and comment on your Quality Accounts for 2018/19. Please find below the CCG's statement for inclusion in the final document:

Dorset Clinical Commissioning Group sees Naomi House and Jack's Place as a key partner in the delivery of end of life and respite care for children and young adult patients from Dorset.

During 2017/18 Naomi House and Jack's Place continued to provide the highest levels of care and support to our service users and their families, working hard to improve their already excellent levels of service by prioritising patient safety, clinical effectiveness, and enhancing patients' and their families' experience.

Naomi House and Jack's Place have an open and welcoming culture which has provided assurance to the CCG that the service they provide meets or exceeds the standards required, and feedback indicates that their support is much appreciated by their patients and families.

Dorset Clinical Commissioning Group is pleased to note that Naomi House opened their Long Term Ventilation (LTV) unit as planned in November 2017. This unit provides a specialist service to assist children and their families in the transition from a specialist clinical environment to the family home. We consider this to be a very important development which will speed up the transfer of these children to a less stressful environment.

Looking forward to 2018/19, Dorset CCG is delighted to have the opportunity to continue working closely with the Hospice as a key partner in helping us to continually improve our services, by providing high quality respite and end of life care to patients and their families.

Please do not hesitate to contact me if you require any further information.

Yours sincerely

VRead

Vanessa Read
Director of Nursing and Quality
NHS Dorset Clinical Commissioning Group