Sunflowers Care Limited

Sunflowers

Inspection report

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Date of inspection visit:
18 February 2019
19 February 2019

Date of publication:
28 June 2019

Ratings

Overall rating for this service	Outstanding ☆

Is the service safe?	**Outstanding** ☆
Is the service effective?	**Good** ●
Is the service caring?	**Outstanding** ☆
Is the service responsive?	**Outstanding** ☆
Is the service well-led?	**Outstanding** ☆

Summary of findings

Overall summary

Sunflowers is registered to provide treatment of disease, disorder or injury for up to four children and young people who may use the service. At the time of our inspection there were three children using the service which included respite care. The service is a two storey premises located in the village of Cottenham close to local shops, amenities and other facilities. It is well supported by the local community and interaction is encouraged between the community and service users at the home.

This announced inspection took place on the 18 and 19 February 2019.

The service had two registered managers, both registered paediatric nurses with an extensive background in providing care and support to children and young people living with complex care needs and the effects of brain injury. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Staff had been highly trained in recognising any potential harm and they were exceptionally knowledgeable about how to help protect children and young people from any actual, or potential, incident of harm. A sufficient number of skilled, safely recruited and competent staff were in post day and night.

Children and young people's medicines, including medicines prescribed to be given 'when required' were safely administered by those staff who had been trained and deemed competent. Children and young people's medicines were managed and disposed of safely. The recording of medicine administration was accurate and easy to understand using documentation adapted to be safe and practicable to use.

Staff were supported in their role with an effective induction, training and on-going clinical supervision, safeguarding supervision in some circumstances over-and-above recommendations and associated mentoring.

Appropriate risk management strategies were in place to help ensure people were kept as safe as reasonably practicable. Systems were also in place to support people in the event of an emergency such as need to evacuate the premises.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The registered managers, nursing, senior and care staff were knowledgeable about if and when a decision needed to be made in any person's best interests.

People were supported by, and they had to access to, a wide range of health care services. Children and young people's nutritional support needs were met and they were effectively supported to maintain a safe

level of hydration and nutrition. Children and young people who were at risk of malnutrition were supported in a safe way.

Children and young people's care came first and foremost and this care was provided by staff with compassion and respect.

Staff undertook this role with full consideration of children and young people's needs and personal dignity. Children, young people and their relatives, were involved in the planning and delivery of the care that was provided. Advocacy arrangements were in place should any child or young person require this support.

Children and young people's care plans contained detailed and sufficient up to date guidance. This was to help ensure that their care was as individualised as it could possibly be. Reviews of care plans were effective in identifying in a timely manner if and when changes were required. 'All About Me' plans and personal scrapbooks helped staff and visitors relate to each child and understand their individual likes and preferences. Children and young people were supported to be given the best opportunities to be involved in and living as meaningful lives as potentially possible as did their peers in the community. They were supported with a wide range of hobbies, interests, social awareness, interaction and stimulation. There were no boundaries as to the provision of equipment that could practicably be used to support children and young people lead positive and fruitful lives.

A complaints, suggestions and compliments process was in place and actions were taken to implement changes or sustain good practice although no complaints had been made during the 12 months prior to this inspection. Children, young people, staff and visitors were encouraged to provide their feedback and views on the quality of care provided in a variety of ways and service provision was seen to be altered according to those views.

Parents, carers and external multi-disciplinary professionals were extremely complimentary about the way the home was run by the two registered managers and also how staff dedicated themselves to the support of children and young people in their care, positively promoting those children as individuals who could, where possible, lead effective and happy lives alongside their peers in the community.

A range of effective audit and quality assurance procedures were in place. This was to help identify what worked well and any area that did not work as well as planned and where necessary service provision was be adjusted accordingly.

The registered managers fostered an open and honest culture within the staff team. Best practice was seen as being part of the day-to-day care people received. Innovation was considered and acted upon with a tangible benefit so that children and young people could live ordinary lives in extraordinary circumstances. The registered managers enabled those children and young people in their care to access the local community in range of ways to suit their wishes and capabilities.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Outstanding ☆

The service was safe.

Children and young people were safely supported by staff who were well trained and supervised to ensure that they knew how to protect children, young people and their families from harm and how to report this should the need arise.

A sufficient number of safely recruited, qualified and competent staff were in post and available at the home at any given time when children were in residence. Risks were managed to help ensure children, young people and visiting families were kept as safe as reasonably practicable.

Medicines were safely stored, managed and administered. Medicines administered or not required were recorded appropriately.

Risk assessments were updated at least annually and were relevant and up-to-date.

Is the service effective?

Good ●

The service was effective.

Children and young people were supported by staff who had been trained and were competent to ensure children and young people were kept safe.

Staff understood how to apply the various legislation relating to children's consent and where decisions had to me made in their best interests.

Children and young people's health and nutritional needs were met including those who required a liquid or soft food diet or nutrition by more invasive procedures.

Managers and staff members worked closely with multi-agency and multi-disciplinary partners effectively.

Is the service caring?

Outstanding ☆

The service was caring.

Children and young people were encouraged to be as independent as they wanted and could be.

Children and young people were cared for by staff who respected their rights, independence and how each child or young person communicated.

Families and carers personal circumstances were considered as part of children and young people's overall care package.

Children and young people's care records were detailed, up-to-date and they were kept confidential. They referred directly to other statutory records and could be easily cross referenced.

Is the service responsive?

Outstanding ☆

The service was responsive.

Children and young people's individualised care needs were identified, responded to and made a tangible, real difference to each child's life.

A wide range of hobbies and social stimulation was provided to children and young people in a format of their own choice.

Children and young people's, relatives' and staff's concerns were investigated and acted upon. Compliments were used to identify what worked well and further inform service design.

Is the service well-led?

Outstanding ☆

The service was well-led.

Children, young people, relatives and staff were listened to and they were actively involved in identifying and developing improvements in and to the service.

The registered managers fostered an open and honest culture with children, young people, relatives and staff.

Effective quality assurance and audit processes and procedures were in place and these were used to help drive improvements. Innovation and best practice was seen as being part of children and young people's day to day care.

Staff employment reflected the needs of children and young people at the home.

Sunflowers

Detailed findings

Background to this inspection

This announced inspection took place on 18 and 19 February 2019 and was undertaken by one inspector. We gave the provider 48 hours' notice as some children and young people had anxieties which could be triggered by new visitors they were not aware of and we needed them to be aware that we would be visiting. We also asked the provider to ask parents if they would be available to meet with us to discuss the care provided to their children and young people.

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

Our last comprehensive inspection took place on 10 August 2016 when the service was rated as Good. During this inspection we found evidence to support and improve the rating to Outstanding overall.

Before the inspection the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what it does well and improvements they plan to make. The registered provider returned the PIR and we took this into account when we made judgements in this report. We also looked at the number and type of notifications submitted to the Care Quality Commission. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with two relatives, both registered managers, three nurses, two health care assistants and two other support staff. We also spoke with a GP who was visiting a child at the home and have since spoken with a Community Consultant Paediatrician.

We observed children and young people's care to assist us in understanding the quality of care they received. This was because children and younger people who used the service were not able to communicate with us and all had complex care and support needs. We also examined two young people's records (with relative's permission) and their education, health and care plans. This was to check that care being provided by Sunflowers was aligned to the person's education, health and care plan as agreed by the

young person and their family.

Outstanding ☆

Is the service safe?

Our findings

Sunflowers aimed to provide one-to-one care to all children and young people who used services at the home and we saw that there was always at least one experienced and appropriately qualified nurse on duty during each shift. Each of the children at the home was allocated a key worker who held additional responsibilities to ensure that the unique needs and preferences of the child in their care were met in an effective way. By also employing their own team of 'bank' nurses and health care support workers, the home ensured consistency of staff which was an important element in the provision of effective and personal care and support. We saw that a flexible approach to working shift patterns targeted key times where extra staff were required, such as when children returned from education activities away from the home or when there were children in residence who required additional care and support at night.

We spoke with the parent of one young person who had received care and support at the home. They told us that they were confident that staff were competent, supported and appropriately qualified to protect their child. They went on to tell us, "My (child) was once cared for in a different environment. I used to check my mobile every two minutes and have the volume turned up to maximum at night in case I missed a call. Now they are here though I never have to do that anymore. I know they are safe all the time. Sunflowers is a God send."

Staff we spoke with at Sunflowers told us that keeping children, young people and their families safe was paramount in all that they did at the home and this was evidenced in documents and records we examined during our inspection. For example, we saw evidence of, and also heard about, specific safeguarding training provided to staff at the home in accordance with the 'safeguarding children and young people: roles and competences for health care staff Intercollegiate Document,' updated and published by the Royal College of paediatrics and Child Health in January 2019. This document recommended that all clinical staff working with children, young people and/or their parents/carers should be trained to level three safeguarding children.

We saw how this training was historically provided online at the home. However, managers recognised that this form of training was not as beneficial as 'face-to-face' training, and so level three safeguarding children training was provided by a 'face-to-face' trainer in a multi-disciplinary setting. This ensured clinical staff were better able to identify and report safeguarding concerns from 'real life' case discussions and evaluation. They also learned from multi-disciplinary practitioners in settings other than those at Sunflowers, including, for example, national learning taken from serious case reviews into avoidable child deaths.

We also saw that all staff at Sunflowers had undertaken or were scheduled to undertake training in this format, not just clinical staff as recommended by the Intercollegiate Document. This investment went beyond statutory recommendations which ensured all staff at the home were trained and supported to identify situations that might have placed vulnerable children, young people and their families at risk. Staff members we spoke with told us that they felt empowered by safeguarding training as provided to them and that they were confident to recognise risk and report and act accordingly should such risk be identified to

those very vulnerable children and young people in their care.

Staff at Sunflowers had a good understanding of policies and procedures in place at the home to help protect vulnerable children and young people from different types of harm. We examined those policies and saw that they were detailed, up-to-date and relevant to the complex needs of children resident at the home.

When a child's condition or care needs changed, or when a child or young person was new to the service, we saw that staff had been provided with appropriately detailed training regarding the child's specific needs and vulnerabilities so that they could safely meet the needs of those children in their care prior to those children attending the home.

We examined children's care plans and saw that individual risk was considered according to each child's care needs. We saw how staff had been made aware by those individually tailored care plans to ensure the safety of the child in their care. This included, for example, where a child required specific handling methods due to limited mobility. We also saw that each child had assistive technology and equipment provided for their use and that this equipment was clearly marked to reduce the risk of the wrong equipment being used by other children at the home.

Staffing levels at the home were seen to be sufficient to meet the needs of children residing there both day and night. Each child's care plan demonstrated the quality and amount of care needed to keep them safe and managers ensured an appropriate number of suitably qualified staff were on duty at any given time, including at weekends and also at night.

We examined evidence of staff attending safeguarding supervision over and above standard clinical supervision, and staff members we spoke with told us how safeguarding supervision helped them to maintain a safe environment for children in their care. Staff we spoke with had a good understanding of the procedures to help protect children and younger people from different types of harm and how these were put into practice. We spoke with staff members at the home who could all describe examples of how to recognise a potential safeguarding concern, particularly important in relation to children who are verbally non-communicative. This included a child acting in a way which was unusual, such as not engaging in a favourite activity or being tearful and withdrawn. Staff were able to clearly articulate how to report concerns should they need to such as discussing potential concerns with managers at the home or, for example, with children's social services.

We saw that where staff members attend safeguarding supervision during a scheduled rest day or during annual leave then the registered managers would ensure they were paid for the attendance. This helped to ensure staff received appropriate safeguarding supervision and case reflection to better protect vulnerable children.

When asked, managers at Sunflowers respond to requests from children's social care for information that might inform the decision-making processes at child protection and child in need meetings. We examined reports submitted to inform those decision-making meetings and saw that they were accurate, detailed and evidenced well the child or young person's needs, likes, wishes and personal circumstances. This meant that important decisions made by social services were well informed by staff at Sunflowers who had close professional relationships with the children in their care and their families. Staff responded to appropriate requests for information by social services in a detailed and timely manner. Although such safeguarding processes were seen to be for circumstances outside of the home, managers we spoke with were aware of their responsibilities to notify CQC should circumstances require it, such as if a safeguarding concern was identified within the home or if a child was injured by accident.

Information about how to recognise and report incidents of harm or risk was publicly available throughout the home that staff and visitors could access should they need to. This information was also available in child friendly, easy to read formats and included ways people could inform staff if they felt vulnerable for example. One relative we spoke with told us, "If I ever need anything I just have to ask for it. I can call at any time and I will always get an honest answer. I know, and have always known that my (child) is safer here than anywhere else. Another relative told us, "There is always someone with the children, those kids are never on their own. For example, if they (the child) drop something, someone is there in an instant to pick it up for them and check that they are OK. There are always plenty of staff on duty. Even the managers work shifts, not because they have to, but because they want to. They are children's nurses and you can't take that away from them. They love our children and want to keep them safe."

Staff we spoke with were aware of the Sunflower's whistleblowing policy and told us of examples of when they might have to advise children's social care, the police and CQC, although none had needed to disclose any incident during the last 12 months prior to our inspection. One member of staff told us, "If, for example, I saw another member of staff assault a child here, I wouldn't think twice about calling the police and letting social services know about it. We have all their contact details available and we are encouraged to whistle blow if we need to. If it was one of the managers that I saw doing something wrong to one of our children I feel confident to make a whistleblowing report without having to advise them first. It's second nature to us."

We examined whistleblowing information displayed around the home, including policies and procedures, and saw that they were easy to follow and had been updated within the last 12 months.

Managers, in association with other staff members, had recognised by audit that Medication Administration Records (MARs) were sometimes complex, and could be difficult to understand due to the nature and amount of medication in use. It had also been recognised that there was also the potential risk of them not being completed accurately due to the complexity of medicines used. A decision was taken to develop a new format MAR that would make it easier for nursing staff using the records to maintain them accurately and also that they included important, relevant information regarding the child so that the risk of mistakes was lessened.

We examined MARs in use and saw that, for example, staff signature fields were now circular. This meant that this area of the MAR was 'less congested' and there was reduced risk of signatures overlapping each other and becoming illegible. We also saw that the improved quality of paper used in the manufacture of the MAR sheets meant that the actual record remained in good condition for longer than previously. Cabinets in which medicines were stored (other than a fridge for example) were also temperature checked on a daily basis with the temperature recorded on the MAR sheet. This ensured those medicines that did not require refrigeration did not reach a higher temperature that might have rendered them ineffective. We also saw that fridge temperatures were checked and recorded on a daily basis.

Medicine administration and management was seen to be in line with current National Institute for Health and Care Excellence (NICE) guidance, managing medicines in care homes March 2014. Medicines were stored in locked cabinets until needed and staff we spoke with were able to demonstrate how some medicines had to be administered in a specific way according to the sometimes complex needs of the children in their care. This included, for example, where children needed to be fed in a non-oral way through a percutaneous endoscopic gastrostomy (PEG). We also saw that when required, medicines were disposed of in a safe way.

We spoke with a Consultant Community Paediatrician who maintained oversight of the health of children at Sunflowers. We examined evidence of, and were told by the Consultant Paediatrician, "I have recently

undertaken an annual review of the prescribed medication for the children at Sunflowers and I went through this with the CCG inspection team and the local GP who provides primary care support at the home. This helps to assure that the often-complex medical needs of those children receiving care and support at Sunflowers remains appropriate and safe. I was impressed by the new format MAR sheets, as were we all, including the overall way that medicines are managed at the home."

The Paediatrician went on to tell us, "I have excellent working relationships with the respiratory specialists and neurologists who also actively support Sunflowers." This meant that those specialists remained 'up-to-date' on the specific care needs of children at the home and so could input into their care and support as necessary to ensure those children had been kept safe.

Children and their parents were effectively supported during the process of children transitioning from receiving care at Sunflowers to returning to their home environment. We examined one case where a parent had expressed concerns that they may have become personally 'de-skilled' since their child had been receiving care and support at the Sunflowers, making the home environment less safe for them. With this in mind, staff at the home planned to ensure procedures were in place for the family and those who were to provide care in the home environment to keep the child safe. Staff travelled some distance to the family home and also liaised with domiciliary care partners in person to ensure ongoing care provision was safe and appropriate, just as it had been provided at Sunflowers.

Making arrangements for transition at an early stage is an important part of ensuring vulnerable children and young people are kept safe. Transition is also a stage that can cause distress and concern, not only for the young people, but also their families. Detailed forward planning helps to reduce such stress and make transition more safe.

Infection control protocols were available for both staff members and children and families to access throughout the home. We also saw that specific procedures regarding individual children in residence were contained within their individual care plans and that these were up-to-date and easy to understand. These included, for example, infection control procedures to follow when changing dressings or sanitary aids.

The kitchen area at the home could be accessed by staff and family members to prepare food for themselves and for children in residence. We noted that kitchen surfaces, the sink area, cooking areas and the inside of storage cupboards were clean and tidy. There was laminated guidance which clearly advised both staff and families about how to prevent infection and cross contamination with further reference to more detailed policy and guidance. We observed staff using the area to prepare food for children in residence and saw that protocols for food preparation and equipment cleaning were followed, including making use of personal protective equipment (PPE) such as disposable gloves.

Staff and families had access to appropriate PPE when preparing food and also when cleaning at the home. Again, we saw that appropriate and up-to-date guidance was available to all person's using cleaning equipment at the home, including, for example, appropriately marked and coloured mops and buckets to differentiate between general cleaning and when clearing spills and bodily fluids. We examined equipment used for cleaning purposes and saw that it was stored safely and locked away out of the reach of children and young people.

We spent time walking around the home observing staff providing care and support to children in residence. We saw that although each child had a very personalised room according to their wishes, evacuation routes remained uncluttered and easily accessible. The fitted lift access for example, was clear and well marked as to when and how staff should use it safely. Stairs had child gates fitted and we saw that each time a member

of staff used the stairs then the gates were closed and secured appropriately behind them. We also saw that risk assessments for each potential hazard at the home were reviewed annually or earlier and, if necessary, updated accordingly.

We found that the provider's systems and procedures helped ensure that only those staff deemed suitable were offered employment with the service. This was evidenced to us by the records that were in place and by what staff told us. We found that checks that had been satisfactorily undertaken included recent photographic identity and proof of their previous employment history. This was as well as checks that ensured nurse's registration with the Nursing and Midwifery Council was current. Other checks included a Disclosure and Barring Service check which had been carried out to ensure that the service had only employed those staff who were suitable to provide care and support to vulnerable children and young people.

The recent appointment of a healthcare support worker with responsibility for risk audit, first aid and fire safety, recognised the importance of such responsibilities. The role was supported by a member of the nursing team who also had linked responsibility for risk assessment. One of the key tasks of the role was to undertake a continuous audit programme to identify areas of good practice and areas where improvement could be made. Every three months a 'safety cross audit' was undertaken which consisted of four key areas including pressure area risk, completion of checklists and accidental de-cannulation. Where it was identified that improvements could be made, then the senior management team collectively proposed an action plan which, once agreed, was implemented and subject to further re-audit to test its effectiveness.

We saw that there were comprehensive systems in place to ensure that all equipment used at the home was serviced according to manufacturer instructions and remained safe and fit for the purpose for which it was intended. This included, for example, the fitted specialist lift which enabled safe access between floors (supervised by staff) for children and young people who were wheelchair users or otherwise immobile. Fire procedures had been recently been updated and a commissioned independent fire safety legislation audit had demonstrated that the home was compliant with all of the requirements of fire safety legislation. We saw that each young person resident at the home had a bespoke safety checklist which all staff members providing care and support completed at the start of each shift. This ensured that equipment used to support the child was in good order and further that the environment in which they were placed was also safe.

Each young person resident at Sunflowers had two designated key-workers assigned to them who each had responsibility to ensure records, care plans and risk assessments were up-to-date and relevant. This also meant that there would always be a designated member of staff on duty at key times of the day and night to ensure children in their care are kept safe.

There was a newly introduced Central Alerting System (CAS) policy in place accompanied by a CAS database which includes details of all responses to CAS alerts which were then added to the agenda of weekly management team meetings for discussion and action. Alerts were supported by action plans and subsequent monitoring of actions to reduce the risk of repetition. We saw, for example, how an incident report highlighted the risk of suction pressures being incorrectly set on a suction machine. There was risk therefore that this might cause discomfort to the young person using the equipment. As a result, National guidelines were consulted and expert opinion sought which resulted in the suction protocol being updated, the child's care plan amended and suction pressures added to the daily safety checklist. Further checks ensured that those changes were embedded into the child's ongoing care regime.

Some of the equipment in regular use at the home was specific to the particular child it was developed for.

Other equipment, such as the newly fitted lift or ceiling hoist in the lounge area, was used by several children with small adaptations to suit their need. We saw that each piece of equipment, however designed or adapted, was regularly checked by staff at the home and recorded as fit for use and further, that routine and recommended servicing was undertaken according to manufacturer instructions by appropriately trained contractors.

Good

Is the service effective?

Our findings

Most people using the service at Sunflowers had very complex health care needs also aligned to complex social care issues. We found that these needs had been met with a variety of support provided at the home. Support was provided by a range of health and care professionals both employed by the service and also provided by external agencies which included; dieticians, community dentists, a tissue viability nurse, physiotherapists and speech and language therapists. We examined evidence for example, of how the service routinely referred children to community dental services and we saw that a community dentist had commented, "The child's oral needs were being very well looked after." We saw that the advice, guidance and instructions from a variety of external health care professionals had been followed and this was well documented in individual care plans examined during our inspection.

We examined comprehensive, relevant and up-to-date person-centred care plans at the home, designed specifically to the child or young person concerned. We saw that those care plans regarding children in residence at the last CQC inspection had been updated at least once and had also been reviewed regularly. Emergency information, including specific safe evacuation from the premise and emergency contact information, was easy to understand and follow. Individual sections pertaining to some very complex clinical procedures were also described in detail, clearly written and included photographs and images to assist in the implementation of important care procedures. These included, for example; My eating and drinking care plan, my communication care plan, my wound care plan and importantly, my end of life care plan. All individual staff members had provided examples of not only their signatures, but also their printed name, initials and their role at the home. This ensured that staff actions written within the care plan are accountable to those persons undertaking them.

The registered managers at the home ensured that staff personal development, training and support remained paramount. This ensured that they were always in a position to offer safe and effective care and support to the children and young people in their care. Where, for example, a child new to the home required specific forms of support, then those members of staff identified as key workers were provided with, and also undertook, specific training to meet the needs of that child. Registered nurses undertook revalidation (Revalidation is the process that all nurses need to follow to maintain their registration with the Nursing and Midwifery Council (NMC)) when required and they were supported by the registered managers at the home to do this. This further ensured that clinical staff at Sunflowers had the skills and knowledge necessary to provide effective care and support to the vulnerable children and young people in their care.

Where a new member of staff was employed at the home, they were provided with mentorship by managers and other staff. They also maintained and completed a training competency log as part of their induction process. We saw that this included scenarios and questions that had been answered by the member of staff before they were 'signed off' as competent. This method helped to ensure new staff members were both competent and confident to safely care for children and young people living with complex support needs at the home.

Training as part of the formal induction included, for example; Makaton (sign language) training, the use of

oxygen therapy and how to maintain records and other important documentation. Staff members were not 'signed off' off as able to work with children at the home until mentors and senior staff members were assured that those new members of staff were competent to do so.

A professional development nurse role was developed by the registered managers at the home to oversee the training of all staff. A training package was devised and led by the development nurse which incorporated staff input to ensure relevant competencies were up-to-date and relevant to the children in their care, especially in relation to keeping them safe. Care support workers undertook a child specific course as provided by a local college regarding the care needs of children who used services at Sunflowers.

Regular 'team days' were held at the home which included mandatory training, supervision, and team building exercises. The days started at 7.30am and finished at approximately 8.30pm and were highly regarded by staff we spoke with who told us that they were, "useful, informative and important". We saw that all meetings and training events were recorded and stored at the home for future reference and evidence of attendance.

Staff at Sunflowers received mandatory clinical supervision on a regular basis and we examined recorded evidence of this being undertaken. Over and above this, staff also had access to specific safeguarding supervision which was provided on a monthly-basis by an appropriately trained designated lead nurse for safeguarding. Specific safeguarding supervision is an important addition to clinical supervision as it specifically considers risk, both real and current, as well as potential safeguarding risks such as those posed by others when children are away from the home environment. Although not mandatory, managers monitored attendance at safeguarding supervision and would challenge staff members who did not make use of the service offer. This practice helped to ensure staff did not become complacent regarding their roles and responsibilities pertaining to the safety of vulnerable children and young people and further that they effectively put their knowledge into good practice.

Staff members we spoke with told us that they felt supported by the amount of supervision provided to them and further that senior leaders and managers were always available to discuss any concerns, even outside of office hours.

Staff at the home were aware of the importance of informing the Education Health and Care Plan (EHCP) process. The Special Educational Needs and Disability (SEND) reforms of 2014 extended rights and protection to young people by introducing a new EHCP to replace previously used statements of educational needs. The aim of an EHCP was to bring together different support disciplines (education, health and social care) into one document which should be compiled in close conjunction with children and families and help to provide appropriate care and support to the child across those disciplines, potentially up to age 25 should those young people remain in education.

We examined one case of a child from another County whose EHCP had not been reviewed since it's completion in 2016. EHCPs should be reviewed on a 12-monthly basis for all children aged five years and over, but this is not the responsibility of the care home managers or staff. We saw that managers at the home had contacted the local area responsible for compiling the document, reminding them of the out-of-date plan, and further providing them with important information pertaining to the care of the child that could have been included in any revised EHCP. Although the EHCP examined remained 'out-of-date' at the time of our inspection, we did see that Sunflowers had provided detailed care information to inform the EHCP decision making process and were well placed to review and, if necessary, challenge the content of any draft EHCP once it was published. We also examined evidence of the home providing information to inform the original but now out-of-date EHCP of 2016, although no credit was given to the home in the final

document even though the information they had provided formed a large part of the health section input.

We saw that the personal care plan relating to the child in question was wholly appropriate to the child's needs and provided clear and detailed information to staff providing care over and above the information contained within the EHCP dated 2016. This meant that staff at Sunflowers were not wholly reliant on the content and recommendations of an EHCP, evidencing well their overarching ethos to provide the best care and support to children resident at the home in an effective way.

We spoke to the parent of one young person at the home about the EHCP process and associated care provision at the home. They told us, "I can't fault the team here and I can't think of anything that they could do any better. The school does (child's) EHCP and health have some input although it seems a bit limited other than what Sunflowers say. I don't think the EHCP process is overall anywhere near as good as the support (child) gets here though. My (child) loves everyone who works here. We are both involved in any decisions made about the type of care they get."

Where a child might require admission to an acute hospital, we saw that individual 'health passports' were available and used. These passports included comprehensive information graded red, amber and green in order of importance to inform hospital staff of the child's specific needs. Information included the child's specific communication skills, detail regarding their medical condition and relevant information pertaining to how care and support should be provided. Such information should not only inform the receiving hospital of the child's needs, but also expedite admission to, for example, an accident and emergency department or ward negating the need for the accompanying member of staff or the child themselves having to repeat their sometimes complex health histories, an important aspect of the 2014 SEND reforms. Although we heard that the passport did not always result in a child receiving support more quickly, we did see that staff members at the home would act as advocates for the children during hospital visits as they had extensive knowledge of the child's needs. This helped to ensure that a child did not receive care and support away from the home which might be inappropriate or detrimental to their health.

The Consultant Community Paediatrician we spoke with told us, "Sunflowers is a unique and wonderful environment in which children with sometimes high medical needs can be nursed and cared for in a home rather than hospital ward or hospice. I provide medical support to the children and staff at Sunflowers which gives me the opportunity to visit when new children arrive at the home or when the medical needs of the children change. I can then ensure the children are seen by the correct specialists, for example, at Addenbrooke's Hospital if this is required or discuss changes to medication with the epilepsy team or GP if hospital intervention is not required, and so meet the needs of those children effectively."

We examined the recently introduced MAR sheets for children staying at the home. We saw that as well as information pertaining to prescribed medications and the recording of their being dispensed, individual children's weights were also checked and recorded regularly. This meant that staff at the home were aware of the importance of children maintaining a body weight conducive to their condition and that their diet was not only appropriate but was also enjoyed by them.

We saw that diets were individually tailored according to children's specific needs. Both staff and families could assist in the preparation of meals according to those needs and parents were, when visiting the home, encouraged to take part in this process should they so wish. We also saw that each child's care plan directed staff about how to maintain a nutritional diet and further how to monitor fluid intake and weight. Where possible, children's individual likes were always included within their diet plan and these were also clearly recorded for reference. We also saw that, where possible, meals were provided in a way that children preferred, including being placed on their own, personalised plates.

Children and young people's care plans and 'all about me' folders clearly demonstrated their individual likes and dislikes in relation to eating and drinking. The 'all about me' folders we examined showed how, for example, an individual child had not enjoyed a meal prepared for them which had resulted in an alternative but suitable meal being provided which still met the dietary needs of the child.

A relative we spoke with at the home told us, "I'm always asked for my opinion on the way that care is given to (my child). If we suggest anything then nearly always they (the managers at the home) listen and make any changes we ask for. They will always do what is best for the kids and cost doesn't seem to be an issue." They went on to tell us, "I know what's in (my child's) care plan and I know it works well. They have never been happier than since they moved here."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least 'restrictive' as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA and other legislation. The registered managers were aware of the process to adhere to should any younger person require care that was in their best interests, such as with decisions about health care. We checked whether the service was working within the principles of the MCA. For people under the age, or mental age, of 18 there was accompanying legislation such as, for example, the Children Act 2004. Most people using the service came under parental or carer control with some children who were looked after coming under Local Authority Corporate Parental Control.

Staff had received training on the Children Act, MCA and Deprivation of Liberty Safeguards (DoLS) for those young people where this was applicable. Staff had a good understanding of those safeguards relating to children and whether any parental decisions required challenging. Staff we spoke with described to us how the five key principles of the MCA applied to children between 16 and 18. For example, respecting children and young people's choices, supporting children to make a choice and letting them make unwise decisions where it was safe for them to do so. Any measures put in place to ensure children and young people were not restricted were done in the least inhibitive way. We saw in children and young people's care plans and daily scrapbooks that children were, when necessary, helped and supported to make decisions for themselves, such as what to wear when going out into the community or where they wanted to go or who to associate with. Staff also had good awareness of individual children's social needs and issues. This included awareness of children's social workers where they were allocated and how they could be contacted should this be necessary, such as when making best interest decisions.

Records examined demonstrated that consent was obtained from children, young people, their parents and/or carers at the time of entering into the home environment on a range of subjects including; general consent, trips and outings, first aid and emergency treatment and consent to the type of care being provided. However, in one record examined we saw that those consents had not been reviewed since 2017. It is important that consent is not assumed as ongoing and that it is regularly reviewed and agreed accordingly. We spoke with the registered managers at the home who agreed to implement new consent review procedures with immediate effect to ensure consent was always appropriate, up-to-date and understood by all persons concerned.

We met with a drama therapist who mostly came to the home once per-week. They told us they had been working with one of the children at the home for three years. They went on to tell us, "I love it here. I love the fact that the children are happy and that all the staff are here for the children. It's a relaxed atmosphere but very professional and caring. I meet the children, I hear about them, I read about them in their 'All About Me'

folders and I like to learn from the children and how they best respond to what I can offer them in a way that promotes their individual well-being." They went on to tell us, "I feel part of the team here. I take part in team meetings and am asked to comment on the way that things are done for the children. I even get supervision from (the safeguarding lead) which ensures all that I do is appropriate and effective to meet the needs of the children."

On early engagement with parents and carers, Sunflowers provided a 'parents pack' which included comprehensive information about the home including; A children's brochure which parents and carers can read with their child, a questionnaire and feedback form to complete in their own time, parent/carer agreements to sign, a leaflet about how to access the child's files kept at the home and other information to aid effective decision making and requests for further information.

Children and their families were consulted and encouraged to input into the way that the home was both designed and decorated. We examined evidence of how a child in residence had, over a period of time, demonstrated a specific desire as to how their room should be decorated. This had been completed just as requested and we were advised by the child's parent that it had a positive effect on the child's well-being because they could see the outcome of their request, despite their complex care needs and inability to make requests verbally. We also saw how families had asked for an update to the previously used shower at the home. A newly fitted sensory bath with ceiling hoist had recently been acquired and parents we spoke with told us that this was highly regarded by the children at the home with one wanting to use it on a daily basis.

A fitted lift was seen to be an effective way in ensuring children and young people had effective access between floors, including those children who used wheelchairs. Other equipment recently acquired and fitted at the home at the request of service users and their families included a new ceiling hoist in the communal lounge area and an interactive floor projector for children to enjoy.

Outstanding ☆

Is the service caring?

Our findings

Staff members we spoke with told us that each care plan for children was written with the individual child's preferences at its core, but also with reference to their immediate family. We saw how, for example, one child communicated in a specific but minimalist way to demonstrate consent or refusal. This meant that staff could clearly understand the child's wishes at the time of care and support being provided and so react to that child's wishes as requested by them.

We also saw that a laminated 'All About Me' folder was provided for each child either resident at, or who had attended the home for care and support. Specific to each child, the 'All About Me' folder gave, for example, detailed information about the child's language ability, who their key workers were, what were their needs in relation to moving and handling and what other preferences they had in relation to day-to-day living. Although more detailed information could be found in the associated care plan, the 'all about me' plan was a colourful, personalised précis of the child's needs in a format that is easy to read and produced in conjunction with the child and their family. It also easily travelled with the child during visits away from the home, such as trips to the seaside, so that those staff members providing care and support could understand the child's specific likes and dislikes in an easy to read précis content.

Care plans were linked to the 'all about me' folders which demonstrated by the use of photographs, drawings and other artwork undertaken by the children in residence at the home and written comments made by staff. Those 'all about me' folders examined showed, for example, what mood the child had been in that day and how staff had engaged with the child. One example seen demonstrated that the child had been feeling low in mood. The reasons for this were documented within the folder and staff interventions to support the child at the time demonstrated compassion and empathy provided by the member of staff responsible for their care and support that day. We saw that the child was given appropriate emotional support but also that this was aligned to the fact that the child had their own reason to feel the way they did and that it was appropriate to sometimes feel low in mood but also to obtain support so that that mood did not worsen.

We saw how one young person who used services at the home was a member of a local 'Rainbows Group' of similarly aged young people. Staff at the home facilitated peers from the group coming to the home on a regular basis to visit the young person and involve them in their group meetings. We saw documented evidence that this had a positive effect on the young person including, for example; increased confidence, forging and building friendships and winning achievement awards and associated badges of merit.

We observed staff members providing care and support to individual children at the home. We saw one young person being supported to get ready for a visit into the local community. We saw how the staff member helped the young person to wear suitable outer clothing according to the weather, asking the young person if, for example, the suggested jacket was their one of choice. They also ensured that the young person's adaptive wheelchair was suitably prepared and serviced for the journey and further they also asked the young person if they were comfortable and if they felt safe whilst sitting in the wheelchair. They then double checked with the young person before leaving the premise that they still wanted to go out for the

visit. On their return several hours later we saw that the young person enthusiastically demonstrated their enjoyment at having spent some time away from the home, but we also saw how warmly the staff at the home welcomed the young person back, making them the centre of attention.

We observed staff interactions with children in their care. We saw that, for example, before entering a child's room staff would always knock first and announce their arrival. We saw that staff communicated with children in a way that best met their needs such as by sign language, language associated with facial expression, pictorial cards and, where required, the use of assistive technology. We also saw that staff were keen to ensure the children in their care and their families were afforded privacy when they wanted it. We saw a family visiting a child and we heard them being asked if they wanted to spend some time with their child without staff being present. The family replied that it wasn't necessary and we further observed the family and staff speaking openly and in a friendly way, involving the child in their conversations as they chatted.

The Community Consultant Paediatrician we spoke with told us, "The current children placed Sunflowers have a high level of medical need and some also have complex social issues. I have always found the team at the home to be highly professional in both the medical and holistic care of their children and families. I currently look after a number of children with Cerebral Palsy whose parents have been delighted with the competent and caring service offered as 'respite' in Sunflowers.

We saw and heard how staff at the home were aware of how social issues can impact on a child in their care. Many of the children cared for were also children in care who might have complex backgrounds and families who were known to, or receiving support from, social services. Recognising well the potential impact that such complexities could bring to children and young people who were living with their own sometimes difficult to manage enduring health issues, staff at the home worked closely with families and social services where necessary to ensure that those complexities impacted on children in a minimal way. We saw that staff were aware of children's social workers by name and also that they would, where required, inform and attend child protection and child in need meetings to inform the decision making process at those meetings to ensure the best care was always considered and provided to those vulnerable children at the home.

We spoke with the parent of one child who was resident at the home. They told us, "When (child) was in hospital they were ill a lot, almost constantly. Since they have been here though that has changed. They are very happy, they get a lot of one-to-one time with staff, they love drama therapy and they love their room. The care and support they get has been so important in helping them become who they are and develop to the best of their ability."

We found that children had parents as their representative who acted as an advocate for them if required. Other advocacy had also been provided for example, via the child's social worker. This was to help ensure that care as provided was in the child's best interests. Advocacy is for children who cannot always speak up for themselves and provides a voice for them. The registered managers and staff were aware of when advocacy was required and would, where necessary and appropriate, take on the advocacy role on behalf of children at the home, such as when a visit to a hospital was required and the children were not able to vocalise for themselves. This showed us that children's wishes, needs and preferences would be respected if they were not able to speak up for themselves.

Outstanding ☆

Is the service responsive?

Our findings

Managers at the home used feedback on service provision routinely to inform and improve that service provision. We spoke with one parent who told us, "I have no problem telling (the managers) at the home what I think would work better. It's almost embarrassing though, because everything you say or suggest they do. Anywhere else and you might think it is a bonus if your suggestions are even considered. Here they just get on with it and do it." We examined many examples of where feedback led to service improvements. In one example we saw that a young person had expressed a desire to ride a horse. We then examined photographs of the same young person smiling broadly riding a horse as they had desired. We also saw that the experience was repeated on a regular basis while the young person resided at Sunflowers. Other examples of actions taken following feedback included animal petting sessions being arranged at the home and material improvements and alterations to young people's bedrooms.

The provider told us in their PIR that their wish was to enable children and younger people to, "Live ordinary lives in extraordinary circumstances". Examples we saw of how the provider supported people included how one young person had been an honorary bridesmaid at the service managers wedding, despite the young person being unable to currently leave the home due to their enduring and complex medical needs. The young person was able to take part in the ceremony via social media and enjoyed the celebrations from the home including wearing a new hair style specially for the day and a specially made bridesmaids dress. This example showed how staff at the home had responded to the young person's needs by bring the world to them where they could not currently access it.

We spoke with the parent of one child who was resident at the home. They told us, "When (child) was in hospital they were ill a lot, almost constantly. Since they have been here though that has changed. They are very happy, they get a lot of one-to-one time with staff, they love drama therapy and they love their room. The care and support they get has been so important in helping them become who they are and develop to the best of their ability."

We heard via their submitted PIR, that the home was asked to provide care and support to a young person who required Parenteral Nutrition. Parenteral nutrition (PN) refers to the provision of nutrients by the intravenous route. In partnership with the young person's community nursing team, six nurses at the home were nominated to undergo enhanced PN training and assessment of competence. Protocols and care plans were developed which, along with an appropriately trained nurse being on duty at all times during the young person's stay, ensured that staff responded to the individual specialist needs of the child. We saw that the primary care giver outside of the home appreciated the opportunity to take a 'much needed break' from their carer responsibilities while the child received care and support that met their complex needs.

Children and young people who used services at Sunflowers received care and support to achieve the goals that they wanted to attain. Each young person resident at Sunflowers had a large, colourful personal scrapbook which showed their achievements and gave an account of their day to day activities. This provided a record of achievements and activities undertaken during each person's stay at the home, however long or short that stay. For example, staff took photographs of children during activities and these

images were printed and placed within the scrapbook with a narrative written in a child centred way. The home had two cameras on which to take images. One was kept at the home and connected directly to a printer allowing for instant image transfer and inclusion in the scrapbooks. The other was taken outside of the home to record visits, but on its return, once images are downloaded and printed, then the memory card was erased ensuring maximum privacy should the camera be mislaid or lost when away from the premise. We also saw that the scrapbooks documented when a child was feeling unwell or did not want to associate with others that day.

One relative we spoke with told us, "The scrapbooks are a great idea. Whenever I visit I look through it and see what (my child) has been up to. Even though their physical needs are so great and they can do so little for themselves it's obvious that they (the staff) don't let this stop them in making sure (my child) gets the most out of life."

We met with one young person who was in receipt of permanent care and support at the home. We saw that they had expressed a desire to have their room decorated in a colour of their choice. Over a period of time, staff at the home had liaised closely with the young person and their family as to what colour they would like the walls of their room painted. This was undertaken by staff who had built up a strong working relationship with, and understanding of, the young person as they had extremely limited communication skills. Their ultimate choice included having 'glitter' included in the paint used to cover the walls for special effect. This was accommodated by managers and staff and we saw that the room was now decorated brightly just as the young person had requested. Likewise, equipment specific to the child's needs had been purchased. This included a special 'boom arm' attachment for the child's TV which means that the TV could be manipulated in a variety of positions ensuring the child continued to be able to enjoy their favourite television programmes and interactive elements whatever their position in bed.

We also noted that managers had invested in further interactive televisions throughout the home and further invested in streaming, digital TV services, including film and series channels. This ensured that children and young people residing at Sunflowers could enjoy mainstream entertainment also followed by their peers in the community.

We examined one young person's care plan and 'all about me' folder and saw that end of life care and support had been considered in a way that would best support the child and their family should the need arise. Although the child was too young to make clear decisions about end of life support, we saw that parents had advocated on the child's behalf to ensure that the child's own needs and, where appropriate, wishes would be considered and acted upon at the point of such care needing to be implemented. The plan included who would be in the best position to provide end of life care, how this would be provided and when each individual element would begin. We spoke with the parent of the child concerned who told us that, although a delicate subject and one they did not want to discuss in detail, they were happy with the plan in place and that it was reviewed regularly with them as advocate for the child.

The children who used services provided at Sunflowers could, as they wished, visit local services within the village location, including a community café. We heard how the local community enjoyed having the children visit them and they welcomed them into their community. We also heard and saw, for example, how one child was often taken into the community using their own adaptive wheelchair and, when passing a local school, was routinely greeted by children there. Managers at Sunflowers also arranged, by previous appointment booked at only one opportunity per year, a premise at a seaside resort where all children and families, even those who no longer used services at the home, could attend and enjoy a day by the sea with entertainment and food befitting the environment. This included, for example, fish and chips and ice creams. Displayed around the home and within 'all about me' folders we saw many example photographs of

children enjoying activities provided at the location and others outside of the home environment.

We saw that Sunflowers have built strong relationships with other areas of the local community. They were, for example, members of the Fen Edge Community Forum. This aided the home and children resident there to keep up-to-date and also participate in local community events including the Fen Edge Festival. They also contributed to the Cottenham Feast where they had a stall selling cakes and other baked goods. This was in response to children and family requests to partake in community activities as much as possible, including taking part in an annual parade through the village.

Sunflowers children's home also provided 'short break' opportunities for children and their families which is an important element of the 2014 SEND reforms. The service is heavily subscribed, but registered managers at the home recognised that short break provision is not routinely available to families and children, and as such they worked to accommodate as many children as possible throughout the year. This meant that families benefited from a break in caring responsibilities which they often found stressful, but also the children and young people in their care could enjoy respite at a location where they were afforded care and support that met their needs and also associate with other children living in similar circumstances.

We saw how staff members and parents had requested, by way of service survey responses, a replacement to the shower which was previously in use at the home. Managers liaised with staff and parents and invested heavily in a new 'sensory bath' unit. The unit required extensive works to strengthen the floor of the bathroom to accommodate the weight of the unit which includes sensory lighting, a spa effect and bubbles. A new ceiling hoist was also fitted to negate the need to use mobile hoists and we saw that each child had specific equipment made for them to aid the process. We saw evidence of how one child made use of the unit on a daily basis because it gave them joy and an opportunity for relaxation. Staff and parent's we spoke with told us of the individual benefits the investment gave to children at the home with one member of staff telling us, "It's an absolute dream for the children. To see and hear them enjoying the new bath tells us so much. It's wonderful and very well used."

Other adaptations at the home included investment in a new ceiling hoist in the lounge area. This meant that children and young people could now be moved around the room without the use of portable, more invasive equipment and as such dignity was maintained more appropriately. We also saw an interactive floor mat and associated projector available for children to enjoy. Projected images to the mat reacted to touch, such as a 'ripples on water' effect.

Children and young people using services at the home were regularly invited to provide feedback about the effectiveness of the support provided to them and further provide ideas on making improvements. We examined evidence of feedback forms being provided in easy read format which means that those children who were unable to communicate verbally could also be involved in service development. We saw evidence of completed feedback forms going on to influence service provision. This included personal items such as the provision of electronic tablets and the colour of individual bedrooms.

Parents and carers, including other visitors to the home, could use the kitchen area (also used by staff members) to make meals and hot drinks for themselves and, where appropriate, their children too. We saw that office areas, when staffed, were open and accessible with visitors welcomed into the home once identification had been confirmed. Visitors signed into the home on entry and again on exit and this procedure was enforced by staff to better staff can respond to any emergency armed with the knowledge of who is in the home at the time.

The Community Consultant Paediatrician we spoke with told us, "Cohesion in the team is excellent, with

clear standards and outcomes for the care of the children. There is a respect for each child and family to be treated as individuals as circumstances will always vary. Some of the social issues are particularly difficult but the team has always embraced those issues to ensure the wellbeing of the child comes first." This meant that staff at the home understood the impact of social issues and reacted to those issues in an understanding and effective way.

The Community Paediatrician went on to tell us, "It is a unique setting and we are very lucky to have this excellent care facility available to children and young people in the region. I always feel very privileged to be invited to be part of the team each time I visit and would wholeheartedly endorse the quality care that is delivered at Sunflowers."

We saw that managers and staff at the home had developed close working relationships with multi-disciplinary partners away from the home in, for example, speech and language services and occupational therapies. In response to individual need, staff had liaised and worked with those partners to obtain equipment and assistive technology as required, including 'high-tech' assistive augmentive technology such as the 'eye gaze' system or 'low-tech' equipment such as specialist spelling boards. We saw examples of children being provided with bespoke equipment which had been adapted, updated or changed according to their ongoing need.

Where young people transition to adult services on leaving care at Sunflowers, we saw that managers and staff at the home were responsive to this often difficult period for young people and their families. Good relationships had been established with equivalent adult services such as adult occupational services to ensure a smooth transition, including the handover of equipment form paediatric services to adult services. This helped to maintain continuity for the young person who had become familiar with that equipment and avoid them either managing without the equipment to which they had become accustomed or waiting to receive alternative equipment.

A complaints, suggestions and compliments process was seen to be in place at Sunflowers and we examined evidence of children and their families making suggestions that were acted on by managers to improve the standards of care at the home. Although no complaints had been made during the previous 12 months prior to the inspection, we saw that children and families had easy access to complaints procedures which were written in a variety of ways to aid understanding, including in easy read format for children.

Children at the home experienced every year butterfly larvae being bought into the home. Children could then observe the larvae growing and pupating into butterfly's which were then released into the wild. Likewise, a 'miniature zoo' visited the home so that the children could experience various animals by sight, sound and by handling.

Outstanding ☆

Is the service well-led?

Our findings

Managers at Sunflowers understood and acted in relation to the challenges around caring for children and young people with extensive disabilities and potentially life limiting illnesses. We spoke with the parent of one child using services at Sunflowers. They told us, "The managers here really know their stuff. What they don't do for our kids to make their lives better isn't worth mentioning. It's down to them that we all owe thanks for looking after our children so well."

The service had two registered managers who were both registered nurses with their professional body, the Nursing and Midwifery Council (NMC) with extensive experience in paediatric care. They were supported by a deputy (lead nurse) as well as other nurses, health care assistants, administrative staff and other team members all with experience of working with children living with complex care needs. A more recent appointment was of a service manager with a social care background. Most of the children and young people using the service were linked to a social worker and many referrals to the service were made via social services. This appointment followed recognition by managers of the importance in utilising experience in the field of social care to provide a more holistic service to both children and their families using services at the home.

We spoke with the service manager who explained some of the work they had undertaken since their appointment. This included; development of the 'All About Me' documents aligned to the medical care plans, a re-designed staff appraisal form to better recognise roles and responsibilities according to individual job descriptions and inform additional training requirements and an updated and re-structured induction booklet and workbook to better support new members of staff and ensure they were competent in their individual roles and responsibilities as a part of their ongoing personal development. All of these changes and enhancements meant that children and young people were better protected because managers had identified where changes could be made and had taken the lead to make those changes.

The service manager recognised the importance of General Data Protection Regulation (GDPR) and recent changes in legislation pertaining to the use and retention of personal data. Working closely with IT providers, new policies have been written regarding the safe storage and disposal of information. One of the service managers acts as a Caldecott Guardian. In 1997, a review panel was chaired by Dame Fiona Caldecott and set out six principles that organisations should follow to ensure that information that can identify a patient is protected and only used or shared when it is appropriate to do so. Staff at the home could contact the Caldecott Guardian for advice regarding any concerns about information governance at Sunflowers. This means that the risk of personal information being disclosed without prior authorisation is reduced.

Prior to GDPR legislation coming into force managers at the home had completed an NHS Information Governance Online Toolkit. The Information Governance Toolkit is an online system which allows organisations to assess themselves or be assessed against Information Governance policies and standards. It also allowed members of the public to view participating organisations' Information Governance Toolkit assessments. A decision was also made to better secure emails through an encrypted connection via a

secure portal. This ensured that emails accessed or sent outside of normal office hours for example, were more secure.

Sunflowers had an active presence on social media platforms. However, since GDPR came into force we saw that children and young people resident at the home did not have their images 'posted' on social media to better protect their privacy. However, we also saw that despite this, staff members did allow images of themselves to be included along with events held at and away from the home so that families and other visitors to those sites could stay in touch via those social media platforms.

Managers understood well the additional vulnerabilities of children in care and those children subject to child protection measures arising from matters away from the home, including children in need. Where appropriate, core group meetings took place at the home to ensure continuity for the child and further so that those professionals and family members could witness and understand the child's circumstances in their preferred and comfortable environment. We saw that staff at Sunflowers were encouraged and supported by managers to contribute to core group meetings in relation to children in need or child protection measures. Decisions taken at those meetings were then informed by up-to-date and relevant information regarding to the child's day-to-day living and current circumstances which would impact on the delivery of care and support provided to them.

Staff members told us about the high levels of support they received from managers at the home. One member of staff we spoke with told us, "There is so much training available. If we have a child here with a condition new to us then we are given training to understand it (the condition) and how we can help to manage it." We spoke with a registered nurse who told us, "I have been in the NHS for years now and I have never had access to so much training since I have been working here."

Both of the registered managers at the home were recently shortlisted for a Royal College Of Nursing institute nurse award in the 'Child' category. This award celebrated individual nurses or teams who had used their initiative, insight and skills to improve the health and well-being of children and young people. Although ultimately unsuccessful in obtaining the award, both managers were invited to the awards ceremony in recognition of the work they did to care and support vulnerable children and young people. We also saw that both managers had featured in the publication Nursing Children and Young People, an article that detailed the services provided at Sunflowers.

The Community Consultant Paediatrician we spoke with told us, "The leadership provided by the two managers at Sunflowers is exemplary. All the staff they employ have a huge amount of experience. The children are looked after in a kind and compassionate way by everybody associated with the home. The team are always looking to improve the quality of life and learning for the children."

Policies at Sunflowers were seen to be relevant and updated at least annually or earlier if identified and considered necessary. We also saw displayed on a staff information board the 'policy of the week' which during our inspection was a policy regarding to supervision and staff involvement in both clinical and safeguarding supervision. We spoke with managers at the home who told us that every week a different policy would be displayed and bought to staff members attention. We saw that the previous weeks policy, for example, was in relation to safeguarding roles and responsibilities. The 'policy of the week' process was also an effective way to ensure that policies were relevant and up-to-date. Staff members were encouraged to comment on policies and make suggestions as to their relevance so that their thoughts could be considered and the policy then updated.

We were advised that there was currently a review of the way that policies were formatted at the home, with

the aim to standardise that format so that each policy could be easily understood and filed safely in a more accessible and accountable way.

Managers at the home were proactive in the way that systems were developed and managed at the home. For example, once it had been highlighted that the MAR sheets could be improved, managers began a consultation process with senior nurses who used MAR sheets on a daily basis. This method of collaborative consultation over a period of time ensured that, following a trial and development process, the final product was fit for purpose, safe to use and auditable. Staff members we spoke with told us that managers were approachable and listened and act on staff suggestions. One staff member we spoke with told us, "I spent a long time working in the NHS and have never worked with, not just for, such approachable and reactive managers. We are all part of the same team which makes this (Sunflowers) such a great place to work."

Both registered managers at the home recognised and acted to ensure staff were appropriately trained and supported to care for children and young people in residence. This included the implementation of safeguarding training and supervision that exceeded intercollegiate guidance.

Regular staff meetings and scheduled daily 'handover' meetings between day and night shifts ensured that staff were made aware of any changes or problems that needed to be considered when providing care and support to children in their care. All such considerations and outcomes were seen to be duly recorded in children's care plans.

Where new equipment was being considered for purchase and implementation at the home, the registered managers sought advice from other professionals to ensure the equipment was both safe and appropriate for children and young people to use. For example, when considering buying a new sensory bath following requests made by children, families and staff members, the registered managers sought advice from occupational therapy clinicians to ensure the right choice of equipment was purchased and fitted. This approach ensured that only the most suitable equipment was in use at Sunflowers specific to the particular needs of the children using it.