RNIB Charity

RNIB Pears Centre for Specialist Learning

Inspection report

5 Pears Court, Wheelwright Lane
Ash Green
Coventry
West Midlands
CV7 9RA

Tel: 02476369500

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 14 November 2016 and was unannounced. We informed the registered manager we would return for a second day on 15 November 2016. At our last inspection of this service in November 2013, we found the provider met the requirements of the regulations.

The Royal National Institute of Blind People (RNIB) is a registered charity that offers a range of services to people living with sight loss. RNIB Pears Centre for Specialist Learning; 5 Pears Court provides specialist accommodation, nursing and personal care for up to six children and young adults living with complex health and medical needs who require long term ventilation and / or other complex health requirements.

Five Pears Court is one bungalow of a group of specialist built bungalows at Pears Centre providing care for children and young people up to the age of twenty years. Between the ages of eighteen and twenty years of age, young people are supported to transition to adult services. Five children and young people lived at 5 Pears Court on the day of our inspection visit.

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

Staff put children at the centre of the service and gave person centred care and support appropriate to children and young people's ages. Staff received training in core care practices and specialist clinical training in managing children's complex health care needs. The provider's aim was to have a nurse on every shift, but challenges in recruitment had meant some shifts were not covered by a nurse at the home. Further nurse recruitment was taking place, but while this was happening detailed contingency plans were in place to ensure children and young people's complex care needs continued to be met, including on-call nurse cover. Care staff were trained at level three with advanced care skills which included supporting children and young people on long term ventilation, changing tracheotomy tubes and undertaking oral and nasal suction when needed.

Most risks were assessed and actions were taken to minimise identified risks of harm or injury to people. Risks to children and young people's skin had been assessed but action had not always been taken to implement care plans when people's skin became sore or damaged. Where skin was sore or damaged, risks of further skin damage or deterioration had not always been assessed. Children and young people had their prescribed medicines available to them and staff supported people in administering these safely. Staff received training in the safe handling, administering and recording of people's medicines.

Children and young people had been involved in planning their care as far as possible. Staff were very knowledgeable about children's and young people's needs and were able to effectively support these. Additional training took place to update and refresh staff skills and knowledge. Staff said children and young

people's care plans provided them with the detailed information they needed to support people safely and effectively. Children and young people's nutritional and hydration needs were met and the guidance of dieticians was followed. Staff worked closely with healthcare and other professional therapists involved in children and young people's day to day healthcare and support.

The registered manager and staff understood their responsibility to comply with the requirements of the Mental Capacity Act (2005) and worked within the principles of this. Management had an understanding of the Deprivation of Liberty Safeguards (DoLS).

Staff were kind, respectful and compassionate toward children and young people. Young people were listened to and their views were acted upon. Young people told us they felt they could raise concerns or complaints if they needed to.

The provider had quality monitoring processes which included audits and checks on medicines management, care records and staff practices. However, these were not always effective in identifying where improvements were required. Feedback from children and young people and their relatives was not sought, which meant opportunities to identify where improvement was needed may be missed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff understood their responsibilities to protect children and young people from the risk of abuse and most understood their responsibilities to report any concerns.

Children and young people felt safe living at the home and risks of harm, injury and deterioration in health had been assessed.

Risks to children's' and young people's skin had been assessed but action had not always been taken to implement care plans when young people's skin became sore or damaged.

Staff were suitably skilled and trained to meet children's and young people's complex health care needs. Shifts were planned to safely and effectively meet children's and young people's needs and a contingency plan was in place when shifts were not always covered by a qualified nurse. Further recruitment was planned for. Children and young people were supported with their prescribed medicines from trained staff.

Is the service effective?

Good

The service was effective.

Staff were trained and knew children and young people well so that they could effectively meet their individual needs. Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and gained consent from people before supporting them and undertaking tasks. The managers understood and worked within the remit of the Deprivation of Liberty Safeguards.

Children's and young people's nutritional and hydration needs were met and the guidance of dieticians was followed. Staff referred children and young people to healthcare professionals when needed and worked closely with healthcare and other professional therapists involved in children and young people's healthcare and support. The home was purpose-built to meet the individual needs of the children and young people living there.

Is the service caring?

Good

The service was caring.

Young people told us that staff were kind and caring. Relatives described staff as friendly and welcoming. Staff respected children and young people as individuals and maintained their privacy and dignity. Young people were listened to and their views were acted on.

Is the service responsive?

Good

The service was responsive.

Children and young people were involved in planning their care and support as far as possible. Care plans were detailed, personalised and contained information to enable staff to work with children and young people to maintain their wellbeing. Staff knew children and young people well and how to meet their care needs. Staff encouraged and supported children and young people with their activities and learning to achieve their potential. Young people knew how to raise a concern or complaint if they needed to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The home had a positive culture and staff were supported in their job role to be person centred, inclusive and empowering toward children and young people who lived there. Children and young people were not actively encouraged to share their views and give feedback on the quality of the service. The provider had some systems to monitor the quality of the service provided, but these had not always been effective in identifying where improvement was needed.

RNIB Pears Centre for Specialist Learning

Detailed findings

Background to this inspection

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

The inspection visit took place on 14 November 2016 and was unannounced. The inspection team consisted of one inspector, a specialist advisor and an 'expert by experience.' A specialist advisor is someone who has current and up to date practice in a specific area. They advise CQC inspection teams but are not directly employed by the CQC. The specialist advisor who supported us had experience and knowledge in providing nursing care to children and young people living with complex health conditions. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of care service. We told the registered manager that one inspector would return on 15 November 2016 to complete the inspection and give feedback to them.

We co-ordinated our inspection visit to take place jointly with the Office for Standards in Education, Children's Services and Skills (Ofsted). Ofsted inspectors used their specific framework in conducting their inspection of the residential part of the specialist learning centre of Pears Court.

The provider had completed a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the service. This included information shared with us by the commissioners. Commissioners are people who work to find appropriate care and support services paid for by the local authority and health care. We reviewed statutory notifications sent to us from the provider. A statutory notification is information about important events which the provider is required to send us by law.

We spoke, and spent time with, three children and young people living at the home, three relatives and one social worker. We spoke with seven care staff, three nurses, the team leader and registered manager.

We reviewed a range of records, including four children's and young people's care plans, one medicine administration record and four children's and young people's risk assessments. We reviewed staff training, team meeting records and quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

Children and young people who lived at the home felt safe living there. One young person told us, "I am safe here because I am never left alone in the home. When staff are not with me in my bedroom, I have an intercom monitor so they can hear me. They know if I need them." Relatives said they believed the home offered their children a safe place to live.

Staff understood their responsibilities to protect children and young people from the risk of abuse and said they completed safeguarding training on a yearly basis. One staff member told us, "I've never had any concerns here, but if I did, I would tell the manager. They would listen and do something immediately. But, if I was worried my concerns had not been listened to, I'd go further and report it to the person's social worker and CQC." There was information displayed in the home to remind staff, and children and young people living at the home, what abuse was and what to do if they had any concerns.

However, when we asked one agency staff member about what action they would take if they witnessed, for example, a staff member shouting at a child or young person, they told us they would intervene and tell the staff member to 'calm down.' We asked this agency staff member if they would take any further actions, such as recording or reporting the incident and found they were not aware of the importance of reporting concerns. We discussed this with the team leader who showed us information about how to report concerns was contained in the 'induction booklet' given to all agency care staff. The registered manager told us, "We do sometimes use care agency staff to cover shifts and always request the same staff to ensure some consistency and also so they know what our policies are here. We'll give feedback to the agency so that this training need can be addressed and will remind agency workers of our induction booklet information which is given to them."

The provider minimised risks of harm and injury to children and young people. Children and young people's individual risks to their health and wellbeing were assessed and their care plans described the actions staff should take to reduce those risks. One staff member told us, "[Child's name] has complex health support needs. Any trips out are planned for, so that a driver and two clinically competent staff accompany this young person. We always take their emergency equipment bag. This goes everywhere with this young person in case of any medical equipment failure." We observed this young person's emergency bag was with them at school and during their journey back home with staff.

Assessments had been completed to determine whether children and young people were at risk of developing sore or damaged skin. Equipment, such as special mattresses for beds, were used to reduce the risks of skin damage. Staff told us that advice and guidance was sought from a specialist tissue (skin) viability nurse when required. One nurse told us, "If we have concerns we contact them and they are supportive." One young person had a wound care plan for their sore skin and this followed advice given by the tissue viability nurse.

Another young person's care record described their skin as being 'broken down, red and bleeding.' A body map had been completed but this was not signed or dated. There was no care plan to state what action was

being taken to prevent further deterioration and promote healing. No photographs had been taken of the damaged skin area so that progress could be monitored. Care notes recorded that a dressing had been applied to the damaged skin and one nurse told us this was a recurrent area of skin breakdown. We discussed this with the registered manager. They assured immediate action would be taken to implement care plans for the management of skin damage, with photographs to record progress of healing. They said they would identify a staff member to become lead person for skin care in the team and source tissue viability training for nurses to refresh their knowledge. This would be additional to the involvement of the tissue viability services.

Specialist medical equipment was used to support the care needs of children and young people. We checked six items of equipment in one bedroom which included ventilators, a suction machine, feeding pump and an oxygen concentrator. The equipment was clean and in good working order. One staff member told us, "The equipment is crucial to people's day to day health and wellbeing and also in the event of an emergency."

Staff knew how to deal with health emergencies that might arise from time to time. One care staff member told us, "The training we have is excellent. I know what to do if a child or young person chokes, for example on lung secretions, and their tracheostomy has become blocked." A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help people breathe. Another staff member told us, "We would call the emergency services if needed." All staff confirmed to us they would call the emergency services if they felt further professional support was needed and would then contact the manager on call; either the registered or deputy manager.

Staff told us that in the event of a fire, they would call the emergency services and make every effort to ensure children and young people were in a place of safety behind two fire doors. However, staff could not describe children's or young people's Personal Emergency Evacuation Plans (PEEPS) and could not identify any specialist equipment to support evacuation for individuals. Care records contained individual PEEPS but these did not include all relevant information, such as equipment needed to evacuate the child or young person to safety. We discussed these with the team leader who took immediate action to update the PEEPS. The registered manager informed us they would remind staff of the fire safety procedure and children's and young people's amended PEEPS.

Young people told us there were always enough staff on shift. One young person told us, "We always have one to one staff, plus there are other staff in the home as well. One staff member told us, "I have worked here several years and always feel we have enough staff. There have been times when there has been no nurse, but I feel confident with the team I work with. We always have on-call nurse telephone support if needed and the manager is also on-call and would come in if needed."

During 2015, the registered manager had informed us about their challenges in recruiting suitably skilled and qualified nursing staff and explained that this meant that, on occasions, there were shifts when there was no nurse on duty. Their contingency plans to ensure children and young people were safely cared for when there was no qualified nurse within the home included on-call nurse support and all non-nursing staff (care staff) were trained at 'level three' in health and social care before working in the home. Care staff also completed advanced health care competency training to ensure they had the skills and confidence to meet children and young people's needs. The registered manager told us that children's parents and their social workers were made aware of these contingency plans and were happy with the arrangements in place until further planned recruitment, that was underway, took place.

At this inspection, the registered manager and team leader told us progress had been made in recruitment

which meant a nurse was on most shifts. The registered manager gave an example of a weekend when two nurses were off sick at short notice and no nursing cover had been available. The registered manager told us that the people living at the home had 'nurse oversight' packages of care and they would not admit anyone with a 'nurse led' package of care because they were not able to cover every shift with a nurse. However, nurses were always supported by level three advanced care staff who knew children and young people well. The team leader planned the staff duty rota and referred to staff competencies, such as the use of specialist suction equipment in the event of a child's or young person's breathing tube becoming blocked, so that sufficient and suitably skilled staff were on shift. One young person told us, "I prefer nurses and care staff I know to provide all my care and support."

The registered manager told us that during November 2016, of the 84 nursing shifts on the rota there were four where there was no nurse on duty. The registered manager explained they had one nurse vacancy which they were in the process of recruiting to. They were confident this final nursing post would be filled early in January 2017. At this inspection, the registered manager and the Head of Children's Health and Care Services told us they would write to update children's and young people's parents, social workers and the commissioners of their services on the progress in recruitment. The Head of Children's Health and Care Services said they would send us a copy of this following our inspection, which they did.

Medicines were stored and administered to children and young people in a safe way. Staff told us they had received training to administer children's and young people's medicines through their gastrostomy feeding tubes. A feeding tube is a device that has been inserted into a person's stomach through their abdomen; this tube can be used to administer medicines. We saw one staff member administer a child's medicines safely, explaining to the child what was happening. We looked at this child's medicine administration record (MAR), which showed they had received their medicines as prescribed to them. One young person told us, "Staff are helping me to self-administer my own medicines. They support me when needed. I am getting on well doing my own." Some children and young people had medicines 'as required' such as for pain relief. Information was available for staff to tell them when children and young people's 'as required' medicines should be given. This ensured these medicines were given consistently and when children and young people needed them.

Good

Is the service effective?

Our findings

Children and young people told us staff had the skills they needed for their role. One young person told us, "The staff are good." Another young person told us, "I understand my equipment and needs and will tell staff." Relatives felt staff were skilled to effectively give the care and support needed by their children.

Staff told us they received a detailed induction when they started working at the home. One nurse told us, "I am on my induction now and shadowing another nurse, it has been very informative and not at all rushed." One care staff member said, "If I have been unsure about a certain task, I have been able to ask for more time to become competent, I have never been rushed to sign off as competent in something."

Staff described training and clinical specialist training as 'comprehensive' and 'very good' and gave them the skills to carry out specialist health care interventions safely. Staff told us there was an in-house trainer who was a registered children's nurse who co-ordinated external training and delivered and organised in-house training to the team. Staff said the training provided was detailed and informative and included completion of the Coventry & Warwickshire Children & Young People's Interactive Competency Framework. This framework was used to train all staff in the competencies required for the safe and effective care of people living at the home. The framework is supported by the Department of Health and Together for Short Lives (TfSLs); a charity that supports children and young people who are expected to have short lives. The registered nurses said they assessed care staff as competent in a variety of health care tasks for children and young people, such as suctioning, care of tracheostomy and management of long term ventilation.

Nursing staff were not able to name any national guidance in use to support their best practice, such as continence management, pain assessment, or infection control. National guidance provides up to date information and resources to nurses to ensure people receive care that is based on current best practice. We discussed this with the registered manager who informed us they were a member of Together for Short Lives (TfSLs) and would remind staff of the resources available to them. The registered manager said they would give consideration to having named lead staff members in specific areas such as infection control.

Nurses informed us they received clinical one to one meetings with a member of staff. The head of children's health and care services told us the staff member undertaking nurse supervisions was a qualified nurse educator and provided specialist knowledge in children's palliative care. This supported the clinical skills and knowledge of nurses working at the home. This was recognised by the registered manager as an important tool to support nurses because they (the registered manager) did not have a clinical nurse background.

One nurse said, "We often have a four hour shift overlap and use this time to reflect informally on events and to learn together." Staff told us they had three shift handovers each day, weekly team meetings that were 'good in updating them about children's and young people's needs' and were supported to develop further skills. One nurse told us "I am due to attend a conference about long term ventilation." Staff explained the handover time was used to pass on key information about children and young people and also to update care plans.

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 made on their behalf must be in their best interests and as least restrictive as possible. Staff worked within the principles of the Act. One staff member told us, "I gain young people's consent by explaining what I am doing clearly in a way they understand, I never force children or young people to do things."

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 Deprivation of Liberty Safeguards (DoLS). The team leader and registered manager informed us that no one had a DoLS in place. The registered manager told us that when young people reached eighteen years of age, they were offered a front door key card. One young person had recently been offered this but had decided they did not want it and felt staff enabled them to come and go as they wished to.

We saw that the front entrance to the Pears Centre was gated and locked with an intercom system. This was for the safety and security of children and young people living in bungalows within the Pears Centre. None of the young people living at 5 Pears Court felt this restricted them. One young person told us, "I go out with staff because I need their support. I just ask them and we plan what I want to do."

Staff informed us that children and young people living at the home had their nutritional and hydration needs met by prescribed 'enteral feeds' given through their gastrostomy. For example, children and young people had a gastrostomy which a tube is passed into their stomach through the abdomen. Dieticians provided guidance to staff about the quantity of 'enteral feeds' and water children and young people should be supported to have every twenty four hours. Children's and young people's weight was monitored and the registered manager informed us if they had any concerns these would be shared with the dietician.

Children and young people living at the home had very complex health needs and were potentially life limited. They were all receiving palliative and symptom management to maintain their health. Staff gave us examples of multi-disciplinary team and interagency working and care records confirmed this. Medical cover was primarily provided by local GPs and GP on- call services. This was backed up by advice from Specialist Consultant Paediatricians at local acute centres such as Birmingham Children's Hospital.

Staff informed us they were also part of a wider multi-disciplinary team based at Pears Centre that supported children and young people to maintain their health. Therapists, based at the Centre, included speech and language therapists, physiotherapist, an education support nurse (a children's nurse), a behaviour support nurse and specialist on site education services. One staff member told us, "Having the physiotherapists based here most of the week, is really beneficial for the children and young people because physio is so important for them on a day to day basis. When the physiotherapist has a day off, we have all the information so we can offer the physio so children's and young people's muscles don't get too tight or their breathing gets bad."

One child and two young people invited us to see their bedrooms and these were personalised. The registered manager informed us that the provider had given in-depth consideration to the design and decoration of the home and what would be most effective in meeting children's and young people's needs. Young people told us they felt the purpose built bungalow was 'homely' whilst also providing them plenty of space to manoeuvre their specialist wheelchairs.

Good

Is the service caring?

Our findings

Young people told us they were happy living at the home and that staff were kind and caring toward them. One relative told us, "Yes, from what I have observed when visiting, I can say staff are kind, they ask my child if they are happy there." Another relative said, "Staff do care, from the beginning I've known my child is cared for. I've asked my child to rate staff out of ten and they told me nine."

During our inspection visit, we observed staff interactions with children and young people living at the home. We saw a high level of personalised care given in a relaxed way, with easy rapport between children and young people and the staff team. One child had no verbal communication, but we saw staff engaged with them at a level suitable to this person's age, showing kindness and compassion toward them. Interactions were meaningful and young people were able to express themselves and were understood by staff. For example, we observed one young person playing a game of 'Connect-4.' The young person indicated to the staff member (their opponent in the game) where they wanted their counter placed, which the staff member acted upon. The staff member was careful to sit at the young person's eye level (as directed in their communication care plan) and maintained excellent eye contact. We saw this young person smiling and enjoying themselves whilst playing the game.

Young people felt involved in making decisions about their care, support and treatment. Care and support observed was very personalised to the needs of people. For example, we saw staff asked young people what they wanted to do and where they wanted to spend their time. Care plans were very personalised and although they did not always record children and young people's involvement, young people confirmed to us they were involved in planning how their care needs were to be met.
Young people's views were listened to and they were supported to meet their potential. Nursing staff explained that some children and young people attended the on-site specialist learning centre and other children and young people went to sessions or attended other local specialist schools. One young person told us they had found their science classes too easy and had shared their views with staff. The provider had supported this young person to access and attend a local school to study for GCSE in sciences. This young person told us, "I really like science. It's going well."

One staff member told us, "[Child's name] enjoys arts and crafts and wanted to create a display in the lounge. We listened to this idea and agreed to this, giving them one wall with shelves and they created a great display based on famous world landmarks." We saw other craft work made by this young person, and others, was displayed in the home.

One young person told us they contacted their family members whenever they wished to, they said, "Most days I send a message to my family." Staff explained that they supported children and families to keep in touch but also encouraged young people who had reached eighteen years of age to keep in contact with their families themselves.

People were respected by staff and their privacy and dignity was maintained. We observed staff knocked and informed people when they were entering their bedroom. Staff understood how to maintain

confidentiality and told us they would only share people's personal information with those authorised to receive it. People's care records were not kept in a secure cupboard, but were in an office in the home. We saw that staff checked visitor's identity, such as social workers, and asked the purpose of their visit and did not leave visitors unattended in the home. This meant confidential information was not accessed by people without authority.

Good

Is the service responsive?

Our findings

Staff informed us that where possible children and young people, and their parents, were invited to visit the home before moving in. However, this was not always achievable due to the complex health conditions that children and young people were living with. Staff responded innovatively to support children and young people in these circumstances. For example, one staff member told us, "One child recently moved to live here from an extended hospital stay. During the two months prior to their admission here, I went to spend time with them at the hospital and build up a relationship so that their move here would be less stressful to them. I think it had a positive effect on them that they were able to recognise my voice."

Staff knew children and young people well and could all describe their needs and how they were met. One staff member told us, "We involve young people in planning their care where possible and depending on their age and abilities." Another staff member said, "One child can't make difficult choices regarding their health or care plan, but we always promote choices through activities, encouraging them to do things they enjoy."

Care needs were assessed and used to create detailed personalised care plans. For example, care records described 'A typical morning' and 'A typical afternoon / evening' for children and young people so that staff had information about their preferences. One young person liked to get out of their wheelchair and have a stretch on their bed after school. We observed that staff took this young person straight to their bedroom when they came home from school. Staff were responsive when this young person asked for oral and nasal suction, to enable them to feel comfortable, before being transferred onto their bed.

Children and young people were supported to follow interests in the home and local community. One young person had an adapted remote control to a shared video game console to enable them to use it independently. Young people were supported with arts and crafts, themed parties and movie nights in the home. One young person told us, "I like listening to audio books." One staff member told us that outings were tailored to children and young people's individual interests and age and explained, "Recent individual trips out have included a local wrestling match and a local rugby match." Another staff member told us, "Two young people have shown an interest in cooking and baking and we support them in the kitchen, although they cannot eat food themselves, we have encouraged this and they have enjoyed joining visitors in a social dining experience." We asked one young person if they enjoyed cooking experiences and they told us, "Yes."

Children and young people living at the home carried a folder with them called 'Vital Information.' Children and young people took this with them to school, hospital appointments and anywhere else they went to. This folder contained essential care information, risk assessments and other personal details that may be needed by other services supporting the child or young person or in the case of emergency services being required. This information enabled staff, who may not know the child or young person well, to respond to their individual needs and provide continuity of care.

The home provided accommodation, support and nursing care for children and young people up to the age

of twenty years. The nurse said, "When a young person reaches eighteen or nineteen years old, we start to encourage them and their relatives to think about future options. Any discussions will include the young person and multi-disciplinary team professionals, such as their social worker and other people close to them such as their parents." Three young people living at the home had reached eighteen years of age and would, in the future, transition from children's to adult services. One staff member told us that transition was not easy for young people but staff made every effort to support young people moving between services. One nurse told us, "We do have a self-contained apartment that parents have used in the past when they need to stay over a night, but we would also use this to help a young person transition from full support from staff in the home and to assess whether less support would work for someone or not." Supporting transition between services meant that young people continued to receive a person centred approach to their health and support needs.

One young person told us they emailed the registered manager if anything concerned them or they wanted to discuss something. Another young person said, "I'll tell the manager if something is not right." Young people felt listened to and had no complaints about their care at the time of our inspection visit. The registered manager told us they received emails and would ensure they spent time with young people to resolve any issues raised. For example, one young person had been unhappy when their jumper had not been washed according to the instructions and the registered manager explained to this young person what action they had taken so the issue would not happen again.

Requires Improvement

Is the service well-led?

Our findings

Two young people told us they knew who the registered manager was and felt they could contact them by email, as their preferred communication method, whenever needed. One young person said, "The manager will come and see me if I ask them to." Relatives felt happy with the quality of care the service provided to their children.

Staff informed us that the registered manager was based on the Pears Centre site, was always contactable, and had daily contact with staff on shift at the home and visited most days. A non-clinical team leader was on shift in the home and was extra to the nursing and care staff team. Nurses described the organisational structure up to the registered manager and Centre manager. One nurse said, "Everyone is very approachable". Staff said they enjoyed working at the home and they felt safe in their work and were well supported. One staff member told us, "I've worked here for five years. I am proud of the work we do, it makes a big difference to the young people in our care." This staff member added, "It is like family here. Hats off to our managers - they do a good job."

Staff described the culture of the home as 'positive' and 'homely.' We observed the atmosphere was relaxed, open and friendly. One staff member said, "I can honestly say that I love coming to work here." Another staff member said, "We are a good staff team and well supported by the manager."

Nurses informed us they attended nurse meetings and nurse training days where they gained learning and received feedback relating to their practice. A nursing log book was used to communicate issues, give feedback and inform members of the staff team about any changes regarding the nursing care needs of children and young people. The nurses said there was also a daily update meeting, led by the registered manager or the deputy manager, which was attended by a representative from each home based on the Pears Centre site.

Weekly manager meetings took place and involved the team leader who had the opportunity to add any issues they wished to discuss to the agenda. Minutes were taken and actions from the previous meeting were discussed at the start of each meeting to record progress.

Some systems, such as audits, were in place to monitor the quality of the service provided. Some of these audits were delegated to staff members to complete. However, we identified the oversight from the registered manager's checks on these delegated audits did not always identify where actions for improvements were needed. For example, we looked at the medicines audit completed in September 2016. This identified items were stored in the medicine cupboard which should not be there, but did not give any detail what these were or the actions taken. The team leader informed us that the staff member completing the audit would have taken the action required but agreed this should have been recorded so that learning and overall improvements were made.

We were told that some checks were informally completed on a day to day basis and were not undertaken as an audit, such as infection prevention and control. We observed staff used personal prevention

equipment, such as gloves, when needed and equipment and the home were clean. However, a process of audit would promote any areas for improvements in being identified.

Analysis of incident and accidents took place and supported changes and learning. Staff informed us they received feedback through staff meetings and gave examples of changes in practice that took place as a result of reporting. For example, one young person had been supported with personal care on a special 'changing bed' in their bathroom. Staff observed and reported that this young person kept banging their knees on the wall and this was resulting in bruises. This young person's care plan was changed and the issue was resolved so the problem did not re-occur.

Young people and their relatives told us they felt they could contact staff and the registered manager if they needed to. However, they said they were not asked for their feedback on the service provided. The registered manager informed us that they did not seek feedback through surveys from children or young people, relatives, or visiting healthcare professionals as a part of their quality assurance processes. The registered manager told us, "This was done in the past but we found we had a low response rate, it is something we could incorporate again." This meant that opportunities were missed to seek feedback from children and young people and others such as relatives, to identify where improvements could be made to the service provided.

We identified that the registered manager's checks on care records were not always effective. For example, children and young people had individual 'at a glance checklists' to show when specific tasks, such as their tracheostomy tube should be changed. Daily care notes recorded the tasks had been completed, however, the information had not always been recorded on the 'at a glance checklist'. One nurse told us, "Staff have been reminded about completing this several times this year already." The registered manager told us they would address this recording omission with staff.

Written guidance about children's and young people's care given by specialist clinical staff, such as enteral feeding programmes from the dietician, were not directly transferred into care records. Instead, the guidance received was written into children's and young people's care records by staff at the home which left a potential risk for transcribing errors. For example, we saw one young person's gastrostomy feeding care plan stated 300mls of 'feed' to be given, but should have stated 450mls in line with the advice from the dietician. We discussed this with the registered manager and checks showed this young person was in fact being administered the correct amount of 'feed' through their gastrostomy and the error was in the transcribing. However, despite the care record being reviewed and signed by nurses, this recording error had not been identified. Immediate action was taken to correct this so that staff had the correct information to refer to which would minimise the risk of errors.

Staff told us the equipment used in the home was sourced, calibrated and serviced by a range of different services. There was a log of equipment for each individual child or young person living at the home and this was completed by staff to record serial number, dates of checks, testing and servicing or calibration. However, we saw there were some gaps in the information recorded in children's and young people's equipment logs. For example, some new equipment had no date of purchase recorded and no timeline for annual servicing and other tests required to ensure it was correctly maintained. We discussed this with the team leader and registered manager and on the second day of our inspection visit, the logs had been completed. The registered manager told us they would ensure checks on these records were effectively maintained so that essential equipment checks always took place as planned for.