Royal National Institute of Blind People

# RNIB Pears Centre for Specialist Learning

## Inspection report

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

Tel: 02476369535

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30 August 2018
31 August 2018

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

This comprehensive inspection took place on 30 and 31 August 2018. The first day of the inspection was unannounced. The second day of the inspection was announced to the provider.

The inspection was carried out to determine what improvements the service had made since the previous inspection.

The previous inspection visit was conducted on 1 February 2018, 15 February 2018 and on the 5 April 2018. Following this inspection we asked the provider to take action to make improvements in relation to consent, safe care and treatment, safeguarding, good governance and staffing. The service was rated as 'inadequate' and placed into special measures as a result. This led to varying the terms of their registration. The provider sent us an action plan to tell us what they were going to do to make improvements, however during this inspection we found that insufficient improvements had been made.

RNIB Pears Centre for Specialist Learning; 5 Pears Court (Bungalow 5) provides specialist accommodation, nursing and personal care for up to six children and young people living with complex health and medical needs who require long term ventilation and/or other complex health requirements.

Bungalow 5 is one of a group of specialist built bungalows at the Pears Centre. The centre provides care for children and young people up to the age of nineteen. At the time of the inspection two children/young people lived in Bungalow 5 at the time of our inspection visit. Both of these children received accommodation and personal care as a single package under one contractual agreement. CQC regulates both premises and the care provided. Therefore the quality of the accommodation and the care provided were looked at during this inspection.

The ethos of RNIB at the Pears Centre is to provide children with and young people with high levels of care in a homely environment, and to support and encourage them to participate in activities which will develop their social and communication skills. The centre also comprises of a specialist school, and children are encouraged to access education. The school and all on site accommodation are registered by Ofsted. Ofsted regulate and inspect services that care for and provide services for children and young people, and services that provide education for learners of all ages.

Only Bungalow 5 is registered with the Care Quality Commission (CQC).

One child in Bungalow 5 was due to be removed from the home and transferred to another placement. We had been made aware that alternative suitable accommodation is currently being sought by commissioners for the young person who is still placed in Bungalow 5. The RNIB have applied to cancel their registration with the CQC and Ofsted and are therefore working closely with commissioners to find alternative suitable placements for children accommodated at the RNIB Pears Centre for Specialist Leaning. Information and findings of the latest Ofsted report can be found on the Ofsted website.

There was no 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. An interim manager operated the day to day running of the home who was on annual leave during the time of the inspection. This provided the inspection team with a good opportunity to determine how effectively the home was being managed in the absence of the interim manager.

Not all staff in Bungalow 5 had received the appropriate level of safeguarding training to ensure the safety of children and young people in their care. The provider had stated that staff would receive the appropriate level of safeguarding training for staff at the service, following our previous inspection visit on 1 and15 February and 5 April 2018. However, we found that the provider had not met their own agreed action plan to provide all staff with level three safeguarding training. We found evidence that highlighted a lack of staff knowledge in safeguarding which meant that not all incidents were being appropriately identified, reported and investigated as safeguarding concerns.

Following our inspection visit on 1 and 15 February and 5 April 2018 we spoke with the interim manager. The interim manager was responsible for the management and clinical leadership of Bungalow 5. However, following our visit they confirmed they were also responsible for the overview of the whole of the Pears Centre, which included providing clinical managerial support across the Pears site. This meant they were not always located in Bungalow 5 to oversee the management of the Bungalow. We were concerned that this meant there was a lack of focussed leadership to continue to make the required improvements within Bungalow 5.

There was a lack of leadership for staff at the home during weekends and bank holidays as during these periods the home was managed by various agency nurses. Whilst attempts were made to use the same agency nurses to provide familiarity and continuity of care, there were occasions when agency staff did not have a good understanding of the care and support needs of children and young people in Bungalow 5. Agency nurses managed the home in the absence of the registered manager and which led to inconsistent management and leadership of the home.

We identified a lack of robust analysis and overview of incidents, complaints, feedback and safeguarding concerns. We saw little evidence of trends and patterns being identified to ensure that future risks could be effectively mitigated, which placed the children and young people at the risk of harm.

There was some evidence of the provider actively seeking feedback from parents, carers and children through the use of questionnaires, however there was no evidence of improvements to service provision having been made in response to the feedback provided.

On the first day of our inspection the provider had failed to display a poster in the reception area of the site, showing the most recent CQC rating. The provider had failed to display a copy of the CQC ratings on their website, in a accessible format.

Ensuring that inspection ratings are clearly visible and accessible to children and young people, parents, commissioners is important so that people who may use or commission the service are aware of how the service is currently performing. The provider had been advised about this prior to this inspection, but failed to take action to ensure they were compliant with CQC regulations.

Both of the care records that we viewed were incomplete. One care record did not contain any information relating to the child's most recent hospital stay and staff in the home were unable to locate this information when asked to provide it.

Children and young people were not always supported in a way that respected their privacy and dignity. We observed a medical procedure being performed in a communal area and no consideration was given to ensure the young person was comfortable with the procedure being performed in full view of members of the public, unqualified administrative staff and the CQC inspection team.

Although there were sufficient qualified and trained staff on duty to care for children and young people in the home safely, we found evidence of nursing staff being called away to other bungalows on the site to provide nursing care and support. This practice means that staffing levels were reduced in Bungalow 5.

Providing treatment of disease, disorder and injuries (TDDI) in locations other than Bungalow 5 is a breach of the providers current CQC registration. The inspection team found evidence of nurses from Bungalow 5 visiting other Bungalows on a frequent basis to support a children who have complex health needs. For example, on the first day of inspection, a registered nurse from Bungalow 5 was called to Bungalow 1 to assist a member of care staff who was administering an injection to a child. Nursing care and treatment should not be provided in any other Bungalow on the site, as they are not registered to provide nursing care.

Some risk assessments were in place and were regularly reviewed to assist staff in mitigating the risks of harm to children and young people. However, we found that some risk assessments did not contain essential information to mitigate the risk of harm to children and young people.
The home was clean and well maintained. Bedrooms were bright, colourful and personalised.

The children accommodated in Bungalow 5 had been taken on a number of trips and outings since the previous inspection visit. This had been made possible due to increased and sustained staffing levels. There was evidence of trips being tailored to accommodate the likes and preferences of the child/young person. However, despite the hydrotherapy pool being re-opened, neither resident of Bungalow 5 had been given the opportunity to use this facility.

Medicines were administered to children and young people by staff that are trained and competent. A weekly audit of medicines is undertaken. However, when we asked to see some Medicines Administrations Records (MARs) they were unavailable. The current system in place to archive records including MARs does not facilitate the retrieval of documents and information when required. Not being able to access and cross reference information prevents learning from incidents and robust analysis.

There was evidence in the records seen, of the voice of the child. Where young people can communicate, their views regarding their treatment and care was documented and responded to whenever possible. We saw in one care record that transition to adulthood was considered, and things were being put in place to ensure that the young person was provided with opportunities to develop their independence in a safe and well-managed way. However, we observed that this young person was not given the opportunity to consent to care. We observed staff suctioning one young person without consulting them to ensure that they had consented to the procedure being carried out in a public place.

This inspection found that the service had not made adequate improvements and had not completed all the actions identified by the provider, to be made before our inspection visit. Changes to the interim manager's

role to include clinical oversight of the entire Pears site, reducing the time spent overseeing Bungalow 5 also reduces the registered managers ability to focus on making improvements to the home.

We found four continuous breaches of regulations in relation to safe care and treatment and safeguarding service users form abuse, staffing and good governance. We also found four breaches of regulations in relation to dignity and respect, person-centred care and notification of incidents and failure to display ratings. We made one recommendation about infection control.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'.

The service was kept under review and we have found that not enough improvement was made. We have not taken immediate action to propose the cancellation of the provider's registration in line with our enforcement procedures as the provider has submitted an application to cancel their registration with CQC. The RNIB intend to close the RNIB Pears Centre for Specialist Learning on 7 November 2018.

The maximum time for being in special measures will usually be no more than 12 months.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to any reports after any representations and appeals have been included.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate**

The service was not safe.

Not all staff had been trained to the appropriate levels in safeguarding and this may result in staff not being able to effectively identify and respond to safeguarding concerns.

Whilst we found there to be a number of risk management plans in place within care records, key information about the risks to children and young people's health needs were incomplete. Staff did not have guidelines and information to enable them mitigate risks associated with certain health conditions to ensure the safety of children and young people.

Appropriate systems were not always in place to ensure that people received their medicines safely and effectively..

Whilst staff were recruited safety, nursing staff were frequently called to support staff elsewhere. This practice meant that staffing levels were reduced, and children could be left unattended by a nurse in an emergency.

There was a heavy reliance on temporary staff. Whilst the home does make efforts to ensure that the same agency nurses are used to provide familiarity and continuity of care.

Quality of contributions to care records were variable. One of the care records were incomplete as pertinent and important health information was found to be missing.

Although the home was clean and well maintained, infection control guidelines were not always adhered to.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

The care records reviewed showed that young people had been consulted about their care needs and their capacity to consent to treatment and care had been assessed and considered, protecting their rights under the Mental Capacity Act 2005.

Whilst we saw some evidence of children and young people being given the opportunity to voice their views and preferences, effective outcomes were not always delivered to meet children and young people's needs.

Supervision was carried out for all staff on a regular basis. Staff had received training to reflect some needs of the children and young people they supported.

The home has been purpose built to effectively meet the needs of children and young people with complex health needs and disabilities.

Children and young people were sufficiently supported with their nutritional needs.

## Is the service caring?

**Requires Improvement**

The service was not always caring.

Children and young people's dignity and privacy were not respected. Door to bedrooms were left open when a young person was asleep and a medical procedure was carried out in a public place in full view of the inspection team leaving a young person visibly embarrassed.

There was evidence of children and young people being involved in decisions regarding their care and treatment. We also saw some evidence of transition planning and providing young people with opportunities to be more independent provided it is safe to do so.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Children and young people were being supported to take part in an increased number of social activities. However, opportunities for children and young people to develop their social relationships were limited.

Children and young people did not always have their needs, preferences and choices met.

Children and young people were not always being supported to participate in some activities which were important to their

wellbeing and development.

## Is the service well-led?

Inadequate

The service was not well led.

There were a lack of effective systems in place to monitor the quality of the service or identify the concerns that we found.

The provider did not keep the Care Quality Commission (CQC) informed of notifications in relation to incidents as required by law.

There was limited information to show that were incidents had been reported and investigated that lessons had been learnt and shared with staff and the wider organisation.

The ratings from the last inspection were not displayed in the service. The ratings were also not displayed on the providers website. This was despite the CQC providing instruction, support and guidance about this concern on numerous occasions.

The interim manager has carried out several audits into historical and current incidents and complaints. Despite this, there was little evidence found of any learning and improvements being made to mitigate future risk.

The interim manager informed us that they had not been aware that nurses had been practicing in other bungalows and this highlighted a lack of managerial oversight.

Some incidents that had been recorded had not been reported to CQC by way of a statutory notification as the interim manager lacked understanding that these incidents were safeguarding concerns.

An interim manager and clinical lead has been successfully recruited since the previous inspection. However the interim manager has clinical responsibility for the whole Pears site, reducing the time that they have available to make the improvements that are needed in Bungalow 5.

Staff, including agency nurses are receiving supervision which provides them with an opportunity to reflect and continually develop their practice.

# 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 previous inspection of RNIB Pears, Bungalow 5 took place over three days on 1 and 15 February and 15 April 2018.

Several significant and serious concerns were found as a result of the inspection, and a total of five breaches of regulations were found. In response to these breaches, additional conditions were imposed on the provider's registration. The registered provider is currently registered to ensure that the regulated activity "Accommodation for persons who require nursing or personal care and treatment for disease disorder and injuries" is managed by an individual who is registered as a manager in respect of that activity at or from RNIB Pears Centre for Specialist Learning. The registered provider must only accommodate a maximum of 6 service users at RNIB Pears Centre for Specialist Learning.,

The conditions that were imposed on the providers original registration in April 2018 are as follows;
1.(The provider must review all service users' risk assessments including, but not limited to, the use of equipment, and the safe movement of service users. Reviews must be carried out no less than fortnightly and must be carried out by a nurse registered with the Nurse and Midwifery Council (NMC).
2.Equipment checks must be carried out no less frequently than daily, and a record of those checks must be made and kept.
3.A dependency tool must be implemented and utilised to determine adequate and safe staffing levels. Assessments of service user's needs must be carried out by a registered nurse and these assessments used to help ascertain required staffing levels. If staffing levels fall below levels determined by them as required to provide safe and effective care, the CQC must be notified.

4.□A person registered as a nurse with the NMC must be available to advise and/or assist in Bungalow 5 at all times.
5.□The CQC must be provided by the provider with weekly written update and which outlines measures they will put in place to meet the imposed conditions.

This inspection, carried out on August 30 and August 31 2018, was to ensure that the provider was acting within their conditions of registration and was making satisfactory progress and improvements to the quality of care being provided to children and young people.

Services in special measures are kept under review. Any service that is in special measures are expected to have made significant improvements within a six-month period. When services are re-inspected and are given a further rating of inadequate for any key question or overall, we may take action in line with our criminal enforcement procedures to begin a process if preventing the provider from operating the service and their registration may be cancelled.

As part of our inspection planning we looked at the information we received from commissioners of services and other regulators, including Ofsted. Commissioners are the professionals who have the authority and responsibility to find and fund suitable placements for children and young people with complex needs.

Prior to our inspection Ofsted conducted a full, comprehensive inspection of RNIB Pears on July 17 July 2018 and 18 July 2018 which included a review of Bungalow 5. We used information and findings from this report to inform the planning of our inspection. The full Ofsted report is published and available on Ofsted's website. The provider has agreed to close their service on 07 November 2018.

This inspection was unannounced. The interim manager of Bungalow 5 was on annual leave during the inspection. As part of our inspection process we later contacted the interim manager to gain their feedback. As the interim manager was away, it enabled inspectors to review how effectively the home was run when the interim manager was unavailable. Staff were made aware on the first day of the inspection that we would be returning to carry out a second day of inspection activity.

On the first day of inspection, the inspection consisted of a CQC inspector from the Children's Team and a CQC inspector from the Adult Social Care team. Both of these inspectors were present for the second day of inspection and were joined by two Specialist Professional Advisors (SpA's), one SpA was a pharmacist and the other a paediatric nurse.

During the first day of our inspection visit we had concerns that treatment of children and young people was taking place by qualified and unqualified staff in the Pears Centre, outside Bungalow 5. This was outside the provider's condition of registration, to provide treatment for disease, disorder or injury (TDDI).

In response to these concerns, inspection team members visited Bungalows 1, 3 and 4 to determine if treatment for disease, disorder or injury was being carried out by staff outside of Bungalow 5.

We looked at the statutory notifications that had been submitted to the CQC by the provider to inform our inspection planning. A statutory notification is important information about events that the provider is required to notify us of by law.

We looked at two people's care records as part of our inspection process, training records, accident and incident logs, medicines records and daily incident logs, staff rotas, heath and safety records, and policies

and procedures that are in place in Bungalow 5.

We were unable to speak with children and young people, as one young person declined to speak to us, and one child's health condition meant they were unable to communicate with us. We did not speak to any of the children's relatives during this inspection. One child was subject to a full care order and the other young person is over the age of 16 and did not give us consent to contact their relatives.

We spoke with fourteen members of staff. This included two team leaders, one agency nurses, members of care staff, the safeguarding locality manager, members of the senior management team including a newly appointed care consultant, and the Director of Education, Safeguarding and Care. We also spoke to two health professionals that provide support to the home but are not employed or otherwise affiliated with the RNIB. The interim manager was also spoken to when they returned from annual leave.

Inadequate

# Is the service safe?

## Our findings

At our previous inspection we found that risks were not always managed and mitigated to ensure that children and young people were kept safe from harm. Staffing levels were inadequate and safeguarding concerns were not always recognised and appropriately investigated.

During this inspection we found the provider had made some improvements to the safety of service, however, continued failings in risk management and a continued lack of monitoring and reporting of safeguarding concerns meant we continue to rate safe as 'Inadequate.'

At our previous inspection we found incidents were still not being reported and investigated thoroughly and staff had not been trained in safeguarding to the appropriate levels. Following the previous inspection visit on 05 April 2018, the provider confirmed safeguarding training would be sourced and delivered to all staff and managers by May 2018.

During this inspection we found that only six members of staff had completed the appropriate level of training in safeguarding children and young people. This meant that the signs of abuse and neglect may not always be identified and responded to protect children and young people from the risk of abuse. It is recommended by the intercollegiate guidance (published by the Royal College of Paediatrics and Child Health 2014) on safeguarding children, that all staff who support children should receive Level 3 safeguarding training.

Managers and staff were not always recognising some incidents as potential cases of abuse and neglect. There were two events that had been logged as an incident, but no statutory notifications had been made to the Care Quality Commission (CQC). This was because staff had failed to identify these incidents as potential incidents of neglect. This meant that learning from incidents was still not always being considered and disseminated to the wider organisation. For example, we saw an incident log for a child who had not been given a dose of vital medicines. The member of staff we spoke to did not understand why this omission of medicines could be deemed as an incident of neglect. When we asked to see the corresponding medicines record to review how this medicines error had occurred, the medicines record could not be located.

This was a continuous breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse.

At the previous inspection of the service we found there was a lack of investigation and learning from incidents, we were told was this due to a lack of management resources in the home. During this inspection a interim manager had been recruited and there were only two children accommodated in the home, staffing levels and resources in Bungalow 5 had not been reduced. However, despite management resources being in place we found that analysis and overview of accidents, incidents and feedback was still not robust. There was no monitoring of trends and patterns to assess any risks and planning. The interim manager for

Bungalow 5 did not have oversight of all the safeguarding incidents and concerns that were made in relation to the entire site to ensure lessons were learnt. This meant there were limited opportunities to identify safeguarding issues, concerns and make improvements when things went wrong.

At our last inspection we found the provider had failed to ensure risks to children and young people's health and wellbeing were safely managed. During this inspection we found that although some improvements had been made we identified further concerns about how the provider managed risks. Whilst management plans were in place in care records and were subject to regular review by the interim manager and clinical lead, we found that some risk management plans could not be located. Despite children and young people in Bungalow 5 being at increased risk of conditions such as MRSA and sepsis, there was no risk management plans relating to those conditions in place. The care records that we reviewed for the children in Bungalow 5 were not always complete.

For example, in one of the records reviewed, despite one child recently being hospitalised for sepsis, there was no evidence of any discharge notes in the care record or any update to risk management plans to support staff in recognising the signs and symptoms of sepsis. When asked to provide this information, staff were unable to locate the records. This child was also due to be transferred to another setting and up to date care records were required to inform future care planning and clinical decision making.

One child had a medical condition which effects their lungs and a condition which makes their bones more susceptible to breaks and fractures. However, there was no risk management plan in place to inform staff of the steps they can take to mitigate the risks associated with these conditions. There was no guidance to support staff in identifying these potentially life-threatening conditions in the home. Therefore we could not be sure that the risks associated with this child's health condition were being managed safely.

Staff that we spoke with told us that they had not received training around sepsis. Non clinical staff told us that they would approach a registered nurse if they had concerns that a child or young person was displaying symptoms of this condition. However, as training was not in place for all staff, we could not be assured that non clinical staff members would be able to recognise the early signs of this life threatening condition. NICE guidance states that all healthcare staff involved in assessing clinical conditions should be given regular and appropriate training in identifying people who might have sepsis. This includes primary, community care and hospital staff, including those working in care homes.

In one care record viewed, one young person had been fitted with a different type of tracheotomy in May 2018. Following their tracheotomy change, they had told staff on several occasions that their tracheotomy site was painful and sore. In the young person's care record there was no evidence of any contact being made with the young person's consultant for further guidance and advice until August 2018. We asked staff why there has been a significant delay in seeking further medical advice and responding to the young person's needs. The staff member told us there would have made earlier contact with the consultant but failed to provide any evidence of this contact being made.

This was a continuous breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe Care and Treatment.

We saw that the provider had risk assessments in place to ensure that children and young people are moved safely between bedrooms and around the site. These risk assessments could not be located at the time of the previous inspection.

Important information regarding medicines in children's health records was not always clear. For example, in one case record we saw a letter from the child's consultant advising the discontinuation of a prescribed medication. However, on the child's vital information sheet which agency staff will view and staff will refer to in an emergency, this medication was still listed as being administered. The staff that we spoke to was confused and unclear of why this was the case. Failing to keep vital information updated increase the risk of children being given medication that is not needed and may have a detrimental impact on their health and wellbeing.

When we asked staff to provide the medicines records that correspond with some of the accident and incident logs that we reviewed, they were unable to locate this information. Information relating to recent hospital admissions was also missing from a care record and staff were unable to locate it when asked.

Whilst the medicines records review clearly showed when medicines had been administered and are double signed by staff, the recording of any topical prescribed medications such as creams and lotions were recorded on the back of the MAR. This increased the likelihood of staff re-applying prescribed creams in error if they did not turn the MAR sheet over to check for written entries. No Topical Medicines Administration Records (TMARs) were in use and we found some inconsistent and confusing practice in the recording of topical medicine applications.

Medicines were administered by staff who had received specialist training on the safe administration of medicines. Regular checks were in place to ensure that staff remain competent to administer medicines safely. We saw that medicines were safely and appropriately stored at the correct temperature to ensure they remained effective. There was a weekly stock check of medicines carried out by an agency nurse to ensure medicines were given as prescribed. A lockable cabinet was stored in each bedroom. This helped to mitigate any medicines errors as keeping medicines relating to each child in their bedrooms prevented incorrect medicines being administered by mistake.

All Medicines Administration Records (MARs) had a photograph of the child or young person that they related to, which helped staff to ensure they were administering the right medicines to the right child.

During the first day of our inspection we were told by an Ofsted Inspector who was also present on site during the first day of our inspection, that a nurse from Bungalow 5 had been called to attend Bungalow 1 to support a member of care staff with a clinical task. Staff we spoke to told us that nurses are routinely called to assist care staff in other Bungalows which are not currently registered to provide treatment or nursing care under their current condition of registration.

The inspection team identified in Bungalow 1, one child was epileptic and was being fed via a gastronomy. Children who are gastronomy fed have a tube inserted through their abdomen which delivers nutrition directly to the stomach.  The child's care records showed that nurses from Bungalow 5 were called to assist care staff to deliver care to the child on a daily basis.

One child in Bungalow 1 required daily medicines to be injected. In Bungalow 3 a child was fitted with an abdominal catheter. This is a tube that is inserted through the abdomen to allow for urine to be drained directly from the bladder. It was recorded in the daily care records that Bungalow 5 nurses are being called to provide advice and support to care staff. There was evidence in care records of nurses being involved in catheterisation changes, giving injections and administering medicines to a child who had been having a seizure for a significant period of time. This was a breach of the providers conditions of registration. Operating outside of  conditions of the providers CQC registration was a criminal offence under Section 33 of

the Health and Social Care Act 2008.

As nurses are being regularly called away from Bungalow 5 to provide nursing assistance and care to the unregistered locations, staffing levels in Bungalow 5 were diminished during these periods. We reviewed staffing rotas and saw rotas that one registered nurse was available. If only one nurse is on duty in Bungalow 5 and is then called away, no nursing support is available for the children and young people in the home.

We heard from staff and reviewed staff rotas which showed that the interim manager and clinical lead is not routinely available in Bungalow 5 at weekends and over bank holidays. In their absence the nurse on shift becomes responsible for Bungalow 5. We had concerns that agency nurses and team leaders were not aware of all the roles and responsibilities of the registered manager and that due to changes in staffing there is a lack of continuity and consistency in how the bungalow is operated during these periods. We found that the way incidents were reported were variable and lacked consistency which demonstrated a lack of consistent leadership in the home.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

Agency and temporary staff were still being used routinely to provide care and treatment to children and young people in Bungalow 5 and these staff may not always have a comprehensive understanding of the children and their complex needs, although where possible the provider did make efforts to use the same agency staff to ensure that young people are being cared for by staff who were familiar to them.

Staff were recruited safely and Disclosure and Baring Service (DBS) checks were being carried out by the provider to ensure that staff are safe to work with children and young people. The nurses who worked in Bungalow 5 were registered nurses which means that nurses in Bungalow 5 hold valid and current registration with the Nursing and Midwifery Council. We saw evidence to show that nurses who work in Bungalow 5 have up to date and valid PINs.

Infection control guidelines were not always followed by staff. During our inspection we found that the home was clean and well maintained. We observed staff to be using gloves when in contact with children and young people. However, despite staff receiving infection control training, we observed staff performing a clinical procedure without the use of aprons. One agency nurse that we spoke to told us "Staff here don't really use aprons. I don't get it really as if you put on gloves you should also put on an apron" The National Institute of Clinical Excellence (NICE) clinical guidance (2017) states that where there is a possibility that bodily fluids might splash onto the clothes of health professionals a plastic apron should be worn. Therefore we cannot be assured that procedures to prevent the spread of infection are as robust as they could be. We recommend the provider follow best practice and guidance in relation to infection control.

At the last inspection we found that there was no robust systems in place to ensure that equipment was fit and safe for use. We also found a lack of personalised risk management plans in place within children and young people's care records. During this inspection we found that some improvements had been made. Evidence of daily equipment checks being carried out and there were individualised risk management plans, including personal evacuation plans in care records. Risk assessments were being reviewed fortnightly by the interim manager.

Requires Improvement

# Is the service effective?

## Our findings

At the previous inspection, we found that staff and managers had a limited understanding of Mental Capacity and only understood the Mental Capacity Act (MCA) in part. Staff had not received training about consent in relation to the (MCA) and consent to care. The Mental Capacity Act 2005 provides a legal framework for making decisions on behalf of people who may lack the mental capacity to make decisions 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.

During this inspection we found that training had been arranged by the provider and delivered to staff to ensure that they were competent in understanding the principles of the MCA and consent.

The MCA applies to everyone aged 16 and over. As one of the young people in Bungalow 5 were categorised as an adult, and their parents or other appropriate adults should no longer be asked to provide consent on their behalf. In one care record reviewed, we saw evidence to demonstrate that the young person, being given the opportunity to make decisions and consent to their care. Evidence planning to support the young person in their transition to adulthood had also been considered. The young person had been assisted to set up various social media accounts to enable them to contact family, and there was evidence of planning in place to support and educate them in sexual health and healthy relationships.

Children and young people's care and support needs were not always needs delivered to achieve effective outcomes. We heard that despite the good links that exist with other health professionals such as Speech and Language Therapists (SALTs), the needs of children and young people are still not always being effectively met. One child was due to have tasting sessions which are required to support his sensory and social development. Although the child has been assessed several months ago, at the time of the inspection no tasting sessions had been arranged or delivered.

There was good multi-agency working and liaison with other health professionals and children had good access to a range of health care services. One of the community children's nurses that we spoke to told us that there had been "some improvement in how staff review clinical incidents", but expressed their concerns that learning from incidents is not "considered and addressed at a wider organisational level".

Staff, including agency staff were receiving supervision to ensure that they are given the opportunity to seek support and to reflect and continuously develop their practice. Staff we spoke to value their supervision and felt that the supervision process was beneficial. We saw evidence of staff being provided with supervision whilst on site and the staff that we spoke to told us that they were able to ask for support and were expected to attend regular supervision sessions which ensure that their skills and competencies are tailored to meet the needs of the children in Bungalow 5. Agency staff told us that they are also now able to access supervision.

We reviewed training records and saw that staff had received training in paediatric basic life support, moving and handling and first aid to enable them to effectively respond to the needs of children and young people.

Bungalow 5 has been purpose built to support children and young people with complex and multiple health needs. The home is well maintained and suitably equipped to ensure that the needs of the children and young people who live there can be effectively met. Corridors are wide and flat to enable wheelchair users to move freely and with independence where possible. Each resident at the home had their own bedroom. We observed bedrooms to be spacious, bright and personalised. One child's bedroom was decorated with paintings that they had completed and both bedrooms had photographs of the children's family members and friends on the wall.

Neither of the residents in Bungalow 5 could ingest food or fluids independently and required feeding through a specialist feeding tube. Both children at the home were having their nutritional and hydration needs met.

Requires Improvement

# Is the service caring?

## Our findings

At the last inspection we found that staff did not consistently support children in a way that maintained their privacy and dignity. Children and young people were not being included in decision making regarding their care when appropriate for them to do so.

During this inspection we found that staff continued to support children and young people in a undignified manner whilst carrying out care and support.

The children and young people that live in Bungalow 5, have their own individual bedrooms that are bright and decorated with their art work and photographs of their family and loved ones. It was documented in the care record belonging to one child that they enjoyed listening to music. We heard music being played from their bedroom which was equipped with sensory equipment to meet their preferences and needs. However, the bedroom doors were found to be open at all times when the inspection team were on site and inspectors could see into one of the bedrooms even though one of the young people was sleeping. There was no record in the young person's care plan of the young person stating that their preference was to have their bedroom door open. This meant that the young person's privacy and dignity was not maintained and respected.

We observed staff to be making unwise decisions about children's and young people's dignity.
One young person who required regular suctioning. Suctioning is a procedure which is performed to remove mucus which facilitates proper breathing.This procedure was carried out in full view of members of the inspection team. Neither of the two members of staff consulted the young person to determine if they felt comfortable with being suctioned in the presence of professionals that they had never met, despite the young person being capable to communicate their feelings and preferences. This incident occurred in a communal reception area. Staff failed to consider asking the young person if they would prefer this procedure to take place in the privacy of a toilet cubicle which was vacant at the time. The young person appeared to be embarrassed by this incident and was observed turning their wheel chair away from staff and members of the inspection team.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Dignity and Respect.

Care planning was child-centred and the voice of the child was captured in care plans. Allied health professionals such as physiotherapists and speech and language therapists (SALTs) had contributed to care plans. In one care plan, the young person's physiotherapy routine had been photographed step by step so that care staff had a visual guide of how to effectively and consistently carry out his tailored physiotherapy routine. The young person's face was not visible in the photographs to preserve their dignity and privacy.

We saw evidence to demonstrate that children and young people had communication care plans in place. These care plans support were written to provide information for staff about how to effectively communicate with children and young people who cannot communicate verbally. The communication

plans were detailed and personalised. They provided guidance for staff about children and young people's preferred method of communication and how the young person and child communicates when they are stressed, anxious or in pain.

One young person has been supported in setting up social media accounts to enable [him/her] to communicate more frequently and independently with their family. We saw records to show that this activity had been subject to a risk assessment and this was regularly reviewed.

Requires Improvement

# Is the service responsive?

## Our findings

At the last inspection we found that incorrect staffing levels meant that children and young people were not having their needs met and were not being provided with opportunities to socialise or take part in activities which children of a similar age might enjoy.

During this inspection we found evidence that children and young people care and support was still not responsive to meet their needs.

At the time of this inspection, there was one child and one young person living in Bungalow 5. One child was due to be transferred from Bungalow 5 imminently. Staffing levels have remained consistent despite a reduction in the amount of children and young people living in the home since the last inspection.

We saw evidence to show that both occupants of Bungalow 5 had been taken on a range of activities over the summer holiday. Activities included trips to theme parks, trips to local parks and shopping centres and trips to a bowling alley. Trips were planned with the correct staffing levels to ensure that children were transported safely with the adequate equipment.

We viewed the personal daily activity log for one young person which documents all the activity he has experienced daily, but when inspectors asked to see the daily activity log relating to one child, staff could not locate it. The personal daily activity logs are used to record what activities the child has enjoyed and to help assist in the planning of future activities.

One young person living in Bungalow 5 is approaching 17 years of age and is transitioning to adulthood. Whilst this young people had enjoyed a range of activities over the summer, we saw no evidence of opportunities being created for this young person to support and encourage them to socialise with young people of a similar age. This young person's social needs were continually not being met. This meant that the young person may not been helped to reach other developmental milestones.

The RNIB Pears has hydrotherapy facilities which were closed during the previous inspection. Inspectors heard during this inspection that the hydrotherapy facilities were now in use. Staff at the RNIB Pears site were adequately trained to support children to safely use the facilities and all children had been risk assessed. This ensured that staff were aware of their medical conditions and how to support the children use the hydrotherapy pool. The most recent version of the RNIB Pears' Statement of Purpose (SOP) published 27 July 2018 states that the centre has its own hydro-pool which young people with appropriate therapeutic plans and individualised risk assessments have access to 52 weeks of the year.

Although both the child and young person in Bungalow 5 had therapeutic plans and individualised risk assessments in place, neither of them had been provided with the opportunity to use the pool over the summer holiday. We were told that one young person does not enjoy being in water, although we saw no evidence of this being recorded in the child's care plan. Staff told us that they believed that one child would enjoy the experience of being in the hydro-pool. We were told that the young person had not been taken

swimming due to having an infectious condition which would require the pool to be emptied and cleaned after use. Inspectors asked staff if there was any reason why this child could not be taken swimming on a Friday afternoon which would allow staff to have the pool cleaned during the weekend. Staff told us that there was no reason why this could not happen.

Records evidenced that one young person had voiced to staff on several occasions that they would like to go on holiday. The service's SOP clearly states that children and young people will be supported to go on an annual holiday provided it is safe and appropriate to do so. This young person had been waiting to go on holiday for two years. Therefore we could not be assured that the provider was meeting children and young people's social and leisure needs that would beneficial to their well being.

The above issues relate to a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care

Young people's views about their end of life needs were not always sought. In one young person's care record the views of the young person's parent around advanced planning for their end of life care was captured, however there was no evidence of the young person's views and wishes had been considered and documented about how they wished to be supported with their end of life needs

Inadequate

# Is the service well-led?

## Our findings

The service was rated as 'Inadequate' for well-led during our last inspection. This was because we found there to be no registered manager in place and a lack of clinical leadership and oversight of staff in Bungalow 5. We continue to rate the service as 'inadequate' for well-led, as there is no registered manager in post. We continued to find a lack of robust managerial oversight and several incidents that had not been reported by way of statutory notifications to the Care Quality commission (CQC). when issues were known

The interim manager was on annual leave during this inspection. This enabled the inspection team to observe if the home is effectively and safely managed when the registered manager is not available. We found that staff were unclear and unsure of where some of the documents we asked for were kept. Staff were unable to find hospital discharge information and some medicines records when asked to provide them and team leaders were unclear what training staff had received.

At the previous inspection, the inspection team found that competent care staff were often unable to take regular breaks due to a lack of provision for other qualified staff in the school to provide cover. During this inspection we asked to see evidence of the arrangements that are in place to provide cover to enable staff to attend to their own personal care, however, no evidence has been submitted to the CQC to demonstrate that staff receive regular breaks when children are at school.

We reviewed a log of incidents and accidents that have occurred in the home. Most of the incidents and accidents had not been signed off by the interim manager to show that these incidents had received managerial review and scrutiny. Some of these incidents dated back to January 2017. It was not clear if these incidents had been subject to any management oversight which is important to ensure that staff are responding to incidents consistently and appropriately. We were told that the provider was in the process of moving all accident and incident recording on line but this system had not been fully rolled out and not all staff had received training in how to use this system.

Some of the incident reports reviewed were of poor quality, and lacked detailed information that is needed to enable a detailed and effective analysis of events. Body maps were inconsistently used to document injuries to service users. Where investigations had taken place, it was unclear if learning had been shared and if this learning had led to changes being made. For example, we saw an analysis of an event where a child has sustained bruising. Whilst a detailed investigation into this incident had been conducted and it was identified that the injury had been caused by the position of a piece of medical equipment, staff we spoke to were unable to tell us of any changes that had been made to mitigate risk and prevent further injury to children and young people and staff.

The consistent lack of effective governance and quality assurance systems was a continuous breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider is required by law to notify the Care Quality Commission (CQC) of important events which occur within the service, However we found that two incidents of medicines errors had occurred in the

home however no statutory notifications had been submitted by to the CQC.

During this inspection, the provider had failed to display the CQC ratings from the previous CQC inspection in a conspicuous place. The ratings also had not been placed on the providers website. The provider had been informed prior to this inspection about the requirement to display the ratings but had taken no action to ensure that ratings were clearly displayed.

This was a breach of Regulation 20A (Regulated Activities) Regulations 2014.

An interim manager has been in post since April 2018 and was responsible for the management of Bungalow 5 including oversight of the clinical team.

Due to the concerns and issues identified during the previous inspection a Notice of Decision (NOD) was issued by the CQC to the provider informing them that additional conditions had been imposed on their current registration. The NOD was issued on 16 April 2018.

One of these conditions was that the provider should provide the CQC with weekly updates describing the measures that they have in place to make progress and improvement. The registered manager has been providing weekly updates and therefore the provider has met this condition.

A condition was also imposed to ensure that equipment checks are carried out no less frequently than daily and that a record of those checks are made and reviewed. We saw evidence of daily equipment checks taking place and those checks being documented. These checks help to ensure that equipment was safe and suitable for use, and therefore, the provider was meeting this condition.

Due to concerns regarding staffing levels found during the previous CQC inspection, a further condition was imposed to ensure that a person registered as a nurse with the Nursing and Midwifery Council (NMC) should be available to assist and advise in Bungalow 5 at all times.

The records reviewed showed that there was nursing staff available at all times in Bungalow 5, and procedures were in place to ensure that the staff who are employed to work in Bungalow 5 were safely recruited. However, there are still a significant number of agency nurses being used. The provider aims to ensure that the same agency nurses are used whenever possible to try an achieve consistent standards of care. Despite this, in the care records reviewed, we saw variation and a lack of standardisation in how agency nurses complete care records and other key documentation.

We also heard and found evidence of nurses being called away from Bungalow 5 to assist care staff to support children in other Bungalows. Therefore we were not satisfied that this condition was always being met as registered nurses were not always available in Bungalow 5 during the periods that they were providing treatment for disease, disorder and injuries in the other Bungalows.

We heard that there is only one nurse employed to work in Bungalow 5 that has experience as a paediatric nurse. One of the agency nurses that we spoke to told us; "I really want to be a permanent member of staff here, but I cannot afford to leave the agency due to the rate of pay being offered by the RNIB."

We reviewed staffing rotas and found that the registered manager was consistently not on duty during

weekends and bank holidays. We were told that in the absence of the interim manager the responsible nurse on each shift assumes clinical leadership in Bungalow 5. Inspectors are concerned that this arrangement leads to a lack of clear and consistent guidance and practice at the home during these periods.

Following the inspection the interim manager made a notification to the CCQ as one of the children in Bungalow 5 had not received a tracheotomy tube change. A tracheotomy is a tube that is inserted into the windpipe to support breathing. The child required regular tracheotomy tube changes to ensure that the site is clean and the risk of potentially serious infection is minimised. The tracheotomy tube change was completed four days over due. This could have had significant health implications for the child. This incident occurred whilst the interim manager was on annual leave, and staff in the home had not recorded this incident or made a notification to the CQC.

During the first day of this inspection, we saw the nurse had been called away from Bungalow 5 to assist a member of care staff in Bungalow 1 who was administering an injection to a child and required assistance. The inspection team visited Bungalows 1,3 and 4 during the second day of the site visit and found evidence in care records which showed that nurses from Bungalow 5 were daily being called to assist with the treatment and care of children in other Bungalows that are not registered with the CQC to provide treatment or nursing care. This is a breach of the provider's condition of registration.

The interim manager told us following this inspection "I was unaware that nursing staff have been called away to assist in other Bungalows." Therefore, the interim manager lacked managerial oversight of staff practice.

The CQC have invited the provider to review the way that the Bungalows are registered and to consider if Bungalows 1-4 should be dually registered with the CQC and Ofsted. The CQC received a variety of intelligence and information which indicted that there are several children and young people with complex medical conditions who may be receiving nurse led care and treatment in Bungalows 1-4, despite these locations not being registered for nursing.

A provider meeting was held with members of the senior management team including the registered manager for Bungalow 5 on 24 May 2018. CCQ inspectors informed the provider of the concerns that had been raised and asked the provider to consider their current registration arrangements. The provider has not submitted any applications to register any other of the Bungalows on the site to the CQC to date.