Raye of Sunshine Care Services Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 27 and 28 September 2016 and was announced. The provider was given 48 hours' notice of the inspection because the location provides a domiciliary care service and we needed to be sure that someone would be in to facilitate the inspection. The service had not been inspected since re-registering at the location address on 2 December 2014. At this inspection we found three breaches of Regulations in relation to the management of medicines, maintaining accurate records and monitoring and improving the quality of services.

Raye of Sunshine Care Services Ltd. is a specialist care provider, supporting children in their own homes. The aim of the service is to ensure families remain away from the hospital setting where possible and support is offered to children and their families. The service offered specifically designed training packages directed towards children's individual care requirements, in partnership with the child's multi-disciplinary team.

The people who used the service were all young children with complex care needs who did not have the capacity or capability to contribute their verbal opinion to the inspection. However, we observed and evaluated the interactions between the children, their parents and care staff which provided evidence of the quality of care provided.

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.

People received their medications as prescribed and care plans were used to outline key aspects of medicines management. Care staff were familiar with the range of medications used and what they were used for. There was no use of covert medicines being administered at the time of the inspection.

However a much more comprehensive policy was needed in relation to medicines management as the current policy being used for medicines management did not follow clinical, professional and industry guidance. We did not find any evidence of medication audits being undertaken. Staff said they were not always confident that the training they received was sufficient for the complex care packages they were involved with. There were no clear plans in place for reassessment of staff competencies over time, or following medication changes.

These issues meant there was a breach of Regulation 12 (2) (g) the proper and safe management of medicines; of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not have appropriate arrangements in place to manage medicines safely. You can see what action we told the provider to take at the back of the full version of this report.

The relatives of children who used the service told us they felt that staff had the right skills and training to do

their job. There was a process of staff induction in place which was used to audit the progress of new staff relative to the induction process.

However there was no overarching staff training analysis or matrix in place that would assist the service to understand what types of training were needed and the dates training had been achieved or was planned. The Managing Director and Registered Manager were unclear when asked about mandatory training for their staff.

Staff received supervision and appraisal from a nurse, who acted as their immediate line manager. We saw records in staff personnel files of meetings that had previously taken place.

We found there was insufficient planning in place to ensure that the necessary theory and practical training was provided to the care team.

At the home visits, we observed care staff demonstrated a good awareness of the child's needs and how to deliver effective care interventions. We found that each package was overseen by a lead nurse who was responsible for care planning, implementation and review.

Families were actively involved in discussing the care plan and in making care decisions on their child's behalf.

We saw that all care plans had been discussed with the multidisciplinary team and developed by the care provider. Records needed to be more person centred and include more information about the child's presentation.

Records showed a number of errors and amendments in record keeping, for example some had incomplete dates, some had amendments made that were not initialled, there was some overwriting of errors, some use of abbreviations without a supporting checklist, and minimal evidence of supervision or countersigning by the registered nurse responsible for the care plan.

These issues meant there was a breach of Regulation 17(2)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance, because the service had failed to maintain securely and accurate, complete and contemporaneous record in respect of each person using the service. You can see what action we told the provider to take at the back of the full version of this report.

Although the provider did not provide services to anyone aged over 16 at the time of the inspection we found that staff had not received training in relation to MCA/DoLS, or best interest's decision making.

Families we visited were positive about the care team input, and we observed evidence of good, positive relationships between the child, the care team and the family members. At the home visits, it was apparent that care staff were respectful of working within the family home environment, and showed consideration of family privacy and dignity. We observed that staff were kind and caring when delivering care and they treated all the children with consideration and respect.

The needs of children were assessed by experienced members of staff before being accepted into the service and pre-admission assessments were completed.

We found that the service was open and responsive to suggestions and feedback from staff and families.

Relatives told us that should there be a need to complain they felt confident in talking to the manager directly and had regular discussions with management.

There were systems in place to record what care had been provided during each call or home visit.

Care staff said they felt able to talk to the registered manager about any aspect of the care package.

Families were complimentary about the input from qualified nursing staff and felt that they provided good advice and support.

The service was unclear about key quality standards and did not have clear ways of monitoring or reviewing the performance of staff or the organisation.

At the time of the inspection the service did not operate a formal system of auditing and we did not see any evidence of medication audits or quality assurance systems, with the exception of the auditing of staff personnel files.

We found the service had policies and procedures in place, which covered various aspects of service delivery but these needed re-evaluating to ensure the service had incorporated quality standards based on best practice and industry guidance.

These issues meant there was a breach of Regulation 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance, because the service had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. You can see what action we told the provider to take at the back of the full version of this report.

The service worked in partnership with the referring hospitals to ensure timely and safe discharges into the home environment.

The service was able to use health and social care funding in a flexible way in order to meet the needs of the child being supported.

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.

Medicines were not managed in a safe way.

We did not see evidence of arrangements for on-going medicines training and updating of competencies within the home care package.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The relatives of children who used the service told us they felt that staff had the right skills and training to do their job.

There was no overarching staff training analysis or matrix in place that would assist the service to understand what types of training were needed.

Care records we saw showed a number of errors and amendments in record keeping.

Is the service caring?

Good

The service was caring.

Families we visited were positive about the care team input, and we observed evidence of good, positive relationships between the child, the care team and the family members.

The relatives of children who used the service told us they were involved in developing their care and support plan.

There was good liaison with the families of children using the service.

Is the service responsive?

Good

The service was responsive.

The needs of children were assessed by experienced members of staff before being accepted into the service and pre-admission assessments were completed.

The service was open and responsive to suggestions and feedback from staff and families.

Relatives told us that should there be a need to complain they felt confident in talking to the manager directly.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service did not operate a formal system of auditing and we did not see any evidence of medication audits or quality assurance systems, with the exception of the auditing of staff personnel files.

The service was unclear about key quality standards and did not have clear ways of monitoring or reviewing the performance of staff or the organisation.

Raye of Sunshine Care Services Limited

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.

This inspection took place on 27and 28 September 2016 and was announced. The provider was given 48 hours' notice of the inspection because the location provides a domiciliary care service and we needed to be sure that someone would be in to facilitate the inspection. The service had not been previously inspected since registering with the Care Quality Commission at the present location address on 2 December 2014.

The inspection team consisted of one adult social care inspector from the Care Quality Commission and a specialist advisor in medicines. Before the inspection visit we reviewed the information we held about the service, including information we had received since the service registered such as notifications of incidents that the provider had sent us. We also liaised with external agencies including the contract monitoring team from the local authority. Before the inspection, we did not ask the provider to complete a Provider Information Return (PIR).

The people who used the service were all young children with complex care needs who did not have the capacity or capability to contribute their verbal opinion to the inspection. However, we observed and evaluated the interactions between the service users, their parents and care staff which provided evidence of the quality of care provided.

We reviewed the care records of three people that used the service and records relating to the management of the service. We looked at documentation such as care plans, four staff personnel files, policies and procedures and quality assurance systems.

During our inspection we went to the provider's head office and spoke with the nominated individual/managing director, the office manager, four care staff members and the registered manager. We visited two children in their own homes and spoke with their relatives and two care staff members. We also contacted one other relative over the telephone as part of the inspection in order to seek feedback about the quality of service being provided.

At the time of our inspection there were six children using the service.

Requires Improvement

Is the service safe?

Our findings

The relatives we spoke with told us their children were safe using the service. The relative of one person who used the service said, "I have confidence in the manager and feel that the service is safe." Another relative said, "Raye of Sunshine is a safety blanket for me; I'm happy because all the staff are doing the same things."

The service had appropriate systems and procedures in place which sought to protect people who used the service from abuse. The service had a safeguarding policy and associated procedures which were up to date. Staff we spoke with demonstrated a good understanding of local safeguarding procedures and how to raise a concern. 75% of care staff had undertaken safeguarding training and the care staff we spoke with confirmed they had recently undertaken this training. It was not clear to identify from the records we saw, if and when the remaining staff had been scheduled to attend this training in future.

We asked one member of staff what they would do if they suspected signs of abuse against people who used the service and they stated that they would contact the office and speak to their manager. Staff we spoke with were able to tell us about the different forms of potential abuse.
The service had a whistleblowing policy in place and this told staff what action to take if they had any concerns. Staff we spoke with confirmed they were aware of the policy.

We noted that a newly appointed safeguarding lead was due to commence in post in the next week following the date of the inspection.

There was a separate 'care team risk assessment' document in use which considered issues relating to the delivery of care in the home environment such as manual handling, communication, safety around the home, infections, medicines administration, theft, domestic tasks, visitors to the home, community trips and holidays, fire and travelling to/from the place of work late at night. This meant that staff considered any environmental risks to the person receiving care and support or to themselves at each home visit. Each risk assessment had a corresponding form that identified the specific risk or hazard, the existing control measures and further control measures required to reduce any further potential risk.

We found there were robust recruitment procedures in place and required checks were undertaken before staff began to work for the service. Personal details had been verified and at least two references had been obtained from previous employers. Criminal Records Bureau (CRB)
checks or Disclosure and Barring (DBS) applications had been obtained. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people. There was also evidence of identity and address checks. This showed us that staff had been recruited safely.

New staff were given an employee handbook at the start of their employment which identified the principles and values underpinning the service. These referenced equal opportunities, health and safety at work, accident/incident reporting, family emergencies, fire, whistleblowing, dealing with confidential information, records security, use of IT/telephony, training and education, dress code and appearance. Staff we spoke with confirmed they had received a copy of the handbook.

During the inspection we looked at four staff personnel files. We saw evidence in these files of appropriate disciplinary action being taken where relevant and there was an up to date disciplinary policy and procedure in place.

We looked at how the service managed accidents and incidents. There was an accident and incident policy and procedure in place and details of any accidents and incidents were recorded appropriately, including any remedial action required to reduce the risk of any future potential harm.

There was a business continuity plan in use which was being updated at the time of the inspection and covered areas such as loss of staffing and bad weather. However, this needed to be more comprehensive in order to identify a wider range of potential business disruptions and the action required in response.

We saw that adequate supplies of personal protective equipment (PPE) were available in the homes we visited including gloves, aprons and sterilising hand-gel which would assist with minimising the potential spread of infections. We saw that staff wore PPE as required/appropriate and 85% of care staff had received training in infection control. The manager told us that every week either they or the managing director visited each home to ensure adequate supplies of PPE were in place. This also provided an opportunity for relatives to speak to the managers, who verified that these visits took place.

At the time of our inspection visit, we found staffing levels to be sufficient to meet the needs of people who used the service. We saw that new referrals were not accepted into the service unless there were sufficient staff available to meet people's needs safely. We verified this by looking at new referral information. When a new referral was received, no care was provided until it was determined that there was enough capacity within the existing staff group to meet the child's needs and where this was not determined, new staff members were recruited prior to the provision of any care and support.

We looked at how the service managed the administration of medicines. We found that medicines were prescribed, monitored and reviewed by a hospital consultant. The consultant informed the GP of the medications to be prescribed and the GP then issued a prescription to the family.

The families of children using the service were responsible for arranging for the prescription to be dispensed through their local pharmacy, and they contacted the GP to arrange for repeat prescriptions as necessary. The majority of medicines administration was undertaken by the family concerned and they also worked alongside the staff member. All medicines were stored in the home, under family responsibility, though none were observed to be in secure cupboards and families maintained responsibility for the disposal of any unused medicines. Some medications were correctly stored in a refrigerator, when this was known to be necessary.

Parents and care staff attended multidisciplinary team meetings prior to hospital discharge and discussed medicine management with the prescribing consultant at these meetings. This helped to ensure that everyone understood the medicines in use and the reason for them.

We saw that there were no controlled drugs in use at the time of the inspection. Some medications were administered via Percutaneous Endoscopic Gastrostomy (PEG) tubes and nebulisers, which represented a more complex medicine administration procedure than just oral administration, with increased safety and infection control issues to consider. Medicines administered by PEG were outlined in the child's nutritional care plan, and additional training workbooks were completed by staff in relation to the administration of medicines by PEG or nebuliser.

Most medicines management within the homes we visited was undertaken by the family. One parent told us, "I go through all the medicines with the staff, especially when there is a new prescription". Parents also prepared medication which was then administered by the care staff.

There was a policy in pace for medicines management but this did not follow clinical, professional and industry guidance and the service was not accessing up to date external professional and industry guidance in relation to policy development. We found a much more comprehensive policy was needed in relation to medicines management, including for example assessment of capacity, the use of covert administration, storage and dispensing of medicines, the use of 'Pro re Nata' (as required) medication, application of external preparations, and person specific information regarding specialist medication administration procedures.

One staff member told us that they would like to have, "more detailed guidance in the care plan." In particular, clearer procedures and guidance on the reason for administration for staff giving 'as required' medications were needed to ensure consistency and safety.

We saw a number of errors in the records relating to the administration of medicines and amendments in record keeping which were not in compliance with recognised record keeping guidelines, for example amendments made that were not initialled, spelling mistakes, overwriting of errors, use of abbreviations without a supporting checklist, and minimal countersigning by the registered nurse responsible for the care plan.

There was a combination of record sheets in use within the service, with some use of medicine administration records (MAR's) issued from the pharmacy, and some use of 'Word' document records created by the service provider. The use of duplicated and different record keeping systems had the potential to be unsafe.

In two MAR charts and service provider documents there were gaps in the signing of when medications had been given, typically when families had administered the medicines. As both care staff and family were administering medication using the same record sheet families should be signing for all the medications they administered to minimise the risk of duplication errors. In discussion with the families and care team there was general agreement that this would be a safer system for everyone.

In the documents we saw some medicines were type written within the document and there were also examples of handwritten additions of medicines. Some of the items prescribed on the MAR sheet were not included on the provider record such as creams and lotions. These were being applied by care staff but there was nowhere to sign for them. One parent had written a newly prescribed medicine on the MAR sheet but this had not been seen or countersigned by the registered nurse leading the care package.

Transferring information from the MAR sheet to the provider document presented a risk of errors being made. We saw one example where a handwritten medicine dosage was altered by overwriting. Staff had signed the documents using initials but there was no record of staff and family details and their initials for reference.

We did not see any evidence of review for the use of 'as required' medicines. From the documentation we saw some 'as required' medicines were being given on an almost daily basis which indicated a review with the prescribing consultant was required.

The service documented and highlighted any known allergies in red at the top of the MAR sheet, and this

also included the GP name and contact details. This was very clear and useful information. There was a 'Care Team Risk Assessment' in relation to medicines administration which provided summary information for care staff on how to respond for example in the event that medications were missed or given incorrectly.

Staff told us that they were not confident that the training they received was sufficient for the complex care packages they were involved with. Some training was provided by the hospital staff whilst the new referral was still in hospital and prior to the care package commencing in the family home.

Due to the complex care needs there are additional training considerations related to medicines management, for example some medications were given on the basis of assessment of heart rate or oxygen saturation levels. Most of the clinical training was provided by the hospital staff prior to discharge home, and we did not see evidence of arrangements for on-going training and updating of competencies within the home care package.

The administration of medicines was included on the staff induction checklist, but did not detail what this included. The care staff were provided with a 'medication workbook'; this was self-directed learning and each staff member was assessed by a registered nurse to determine their competence, when they completed the workbook.

There was limited practical training regarding medicines administration. There was a 'supervised shift' document in use which checked that the care staff 'administer and sign for medication' but it did not refer to any other aspect of medicines management.

The use of self-medication was not appropriate as children who used the service did not have capacity or capability to undertake this independently and were reliant on others to administer medicines as prescribed. However, we did not see any policy on self-medication, which would be required to ensure individuals were supported to take their medicines safely, and a formal assessment and recording of the individual's capacity to manage their own medication was absent from the care plans, which would demonstrate that this has been considered.

These issues meant there was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; the proper and safe management of medicines, because the provider did not have appropriate arrangements in place to manage medicines safely. You can see what action we told the provider to take at the back of the full version of this report.

We asked care staff how they ensure that excessive or inappropriate use of medicines was highlighted. Staff told us they would contact the family and the management team if they had any concerns that excessive, inappropriate or unlicensed medication was being given. They may also raise a safeguarding alert (depending upon the circumstances and if there was any detriment to the child) and issues could also be raised at the multidisciplinary review. Care staff were not aware of any 'non-prescribed' medicines being administered to date.

The Registered Manager told us that if errors were noted then a clinical decision would be made as to the potential severity of the situation, if this was indicated, and to clarify any further action needed. The service had not previously reported any medicines errors prior to the date of the inspection.

Requires Improvement

Is the service effective?

Our findings

The relatives of children who used the service told us they felt that staff had the right skills and training to do their job. One relative said, "[Staff member] is perfect and I have no problems; I couldn't say a bad word about them; [staff member] is professional, always good with doing notes and knows what they are doing." Another person commented, "I'd say all the workers here are competent and they all know about [my relative's] needs."

There was a process of staff induction in place which was used to audit the progress of new staff relative to the induction process. The managing director and registered manager were unclear when asked about mandatory training for their staff. They had some awareness of the Skills for Care mandatory training modules, and said that an external trainer provided some training but there was uncertainty about what this included. We found that better planning was needed to ensure that the necessary theory and practical training required was provided to the care team.

We asked staff about the training they received and we received mixed comments. One member of staff told us that the internal training provided "did not prepare me," with another staff member commenting, "When I started I had an induction and I did training at the hospital before [child name] was discharged home."

We reviewed staff training certificates, which showed staff had completed training in a range of areas including moving and handling, safeguarding, first aid, medicines, infection control and cardio pulmonary resuscitation (CPR). Staff also received specific training in the use of items of equipment that may be required when supporting children in their own homes after discharge from hospital and were assessed as being competent by the hospital staff prior to the commencement of any equipment use.

However there was no overarching staff training analysis or matrix in place that would assist the service to understand what types of training were needed and the dates training had been achieved or was planned. The manager told us that a new staff member was being recruited who would oversee the provision of training in future.

The lead nurse for one care package had provided refresher training which was specific to the individual child and the care staff concerned told us this had, "improved my confidence and skill." However, this was instigated by the nurse, and not as part of an organised programme of training.

We spoke to the registered manager about this issue and identified the shortfall of training and competency audits, which gave rise to our concerns regarding the effectiveness of the training received by staff.

Staff received supervision and appraisal from a nurse, who acted as their immediate line manager. We saw records in staff personnel files of meetings that had previously taken place. This gave staff an opportunity to discuss their performance and identify any further training they required. For example one supervision record we saw identified that discussions had taken place regarding progress to date, clinical competencies, training needs, documentation and recording, any concerns and what the staff member enjoyed about the

job.

As a result of this discussion the staff member had identified the need to attend a 'train the trainer' course which we saw had then been completed prior to the date of the inspection. One staff member told us, "[Staff name] is the lead nurse and supported me through my training at the hospital. Colleague support is great; we're all working together to make it work for the child and their family." Another staff member commented, "I get supervision from one of the nurses; I feel more supported now than I previously did."

Each care package we looked at provided care to a child with complex care needs, including ventilation and enteral feeding, within their own home. We found that each package was overseen by a lead nurse who was responsible for care planning, implementation and review. The children we visited and the care packages discussed with relatives at home visits had all been recently commenced, being a few months in duration, with care plans still in the early stages of implementation and 'teething problems' still being addressed. Relatives told us that if they were unhappy with a particular staff member, this was discussed with the manager with a view to replacing the individual.

We saw that staff were becoming more familiar and settled within the new care packages. At the home visits, we observed care staff demonstrated a good awareness of the child's needs and how to deliver effective care interventions.

Though the children in receipt of care packages were unable to give consent in relation to their care and treatment, their families were actively involved in discussing the care plan and in making care decisions on their behalf. Care plans contained a declaration form that was signed by relatives to identify that they had read and understood the contents of the care plans.

We saw that all care plans had been discussed with the multidisciplinary team and developed by the care provider. At the time of the inspection, the care plan format was in the process of being changed. A range of different documents were in use and a standard outline care plan template was expected to be agreed soon after the date of the inspection which would improve the care planning process.

Each child had a person-centred care plan called 'All about Me' which identified for example what was important to the child, what made them happy and key relationships. However, we found that record keeping documentation associated with the care plans was task focused, which was largely due to the need for complex interventions and monitoring.

We found records needed to be more person centred and include more information about the child's presentation. The records we saw also showed a number of errors and amendments in record keeping, for example some had incomplete dates, some had amendments made that were not initialled, there was some overwriting of errors, some use of abbreviations without a supporting checklist, and minimal evidence of supervision or countersigning by the registered nurse responsible for the care plan.

These issues meant there was a breach of Regulation 17(2)(c)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance, because the service had failed to maintain securely and accurate, complete and contemporaneous record in respect of each person using the service and persons employed in the carrying on of the service. You can see what action we told the provider to take at the back of the full version of this report.

In the care planning documentation we saw there was a copy of an assessment of complex care needs undertaken by the commissioning organisation. This was a detailed and thorough summary of care needs

but this was not always fully reflected within the care plan in the child's home. Specific intervention care plans were also in place in relation to identified individual care needs.

Care plans also contained an agreement form between the parents of the child receiving care and support and the organisation. This gave details of funding arrangements, an outline of care provision and the total number of hours to be delivered during term time and school holidays.

One parent showed us an 'early warning system flowchart' that they used for advice as to when their child should be referred to hospital or require emergency care. There was also a 'daily routine' schedule that had been developed by another parent, which made essential daily tasks very clear for everyone involved including staff and relatives.

The parents that we spoke with told us they were all well informed and clearly able to express their opinion in relation to the care package. This helped to minimise the potential impact of any areas lacking effective oversight from the care provider.

We saw that Nursing and Midwifery Council (NMC) checks were carried out to ensure that all nurse registrations were current.

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. We checked whether the service was working within the principles of the MCA.

The MCA is relevant for anyone aged over 16 years who is assessed as lacking capacity to make certain decisions for example in relation to their care and treatment. Raye of Sunshine is registered to provide services to people aged up to 18 years of age, and though they did not provide services to anyone aged over 16 at the time of the inspection we found that staff had not received training in relation to MCA/DoLS, or best interest's decision making. There was no agreed policy or process for assessing capacity, or supporting people to make decisions, and no paperwork in place to record capacity issues or any best interest's considerations.

As staff had not received any training in a best interests' decision making process, they did not actively use this approach at the time of the inspection. One parent and one staff member talked with us about staff acting as an 'advocate' for the child when admitted to hospital. The staff member told us that this was about representing the child's best interests and providing support and information to the hospital staff as to how best to meet their care needs. This showed that they understood how the child's best interests could be considered and represented.

Good

Is the service caring?

Our findings

Families we visited were positive about the care team input, and we observed evidence of good, positive relationships between the child, the care team and the family members. We saw that staff were fully engaged with the child they supported and attentive to their physical and emotional needs whist they carried out care and support tasks in a friendly manner, explaining what they were doing as they interacted with them. We saw lots of smiles and laughter between children and staff members throughout the duration of our visits at each house we visited.

At the home visits, it was apparent that care staff were respectful of working within the family home environment, and showed consideration of family privacy and dignity. One parent told us, "It was strange at first to have other people in your home, especially at night." They then explained how they had become accustomed to this now, after only a few weeks since the start of the care and support package at home. Another parent said, "Staff are very attentive to [my relative] and his brother as well."

The children we visited all had very complex and multiple health care needs and had spent the majority of their life in hospital until the home care package was developed and put in place. The families we spoke with were all pleased to have their child at home with them.

During our inspection we looked to see how the service promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights through the care planning process. Support planning documentation used by the service enabled staff to capture information to ensure children received the appropriate help and support they needed to meet their individual and cultural needs.

The views and opinions of people were actively sought. The relatives of children who used the service told us they were involved in developing their care and support plan and were able to identify what support they required from the service and how this was to be carried out

We observed that staff were kind and caring when delivering care and they treated all the children with consideration and respect. They showed concern for the wellbeing of the child during care interventions and spoke about each child and family with consideration and respect.

We looked at how staff communicated with the children they supported and we found a range of communication skills were apparent with staff using verbal, gestural and symbolic communication appropriate for the age and level of understanding of the child concerned.

Care staff demonstrated person-centred approaches, considering the individual needs and preferences of the child and the family. Care plans were openly discussed and families encouraged to express their opinion and make suggestions. One parent told us, "I like to contribute and be involved," and "The care plan does cover all the main things that it needs to."

There was good liaison with the families, with some families contacting the office or registered manager several times every day, which demonstrated that when an issue arose that could not be dealt with by the care team on site in the home, additional advice and support was available.

One parent commented, "I like the polo shirts the care team wear as they don't stick out and look more normal when they are out with the child." Another parent told us how they were currently negotiating additional staff hours to enable them to support their child whilst attending hospital appointments and to act as an advocate for them.

Good

Is the service responsive?

Our findings

We found that the process of care planning started when the child was still in hospital with care staff working with and shadowing the hospital staff to learn how to meet the child's care needs for a period of six weeks or longer, if required. Staff attended multidisciplinary planning meetings, prior to the package commencing, to ensure good practice in complex care planning.

We looked at how new referrals to the service were assessed. The needs of children were assessed by experienced members of staff before being accepted into the service and pre-admission assessments were completed. This included gathering background information from a variety of sources including other health and social care professionals and from those individuals who were important in children's lives. The manager told us that the service did not accept any new referrals until it was determined that the service could meet the needs of each individual referral.

Discharge summaries from the hospital were available to assist with care planning and provided a range of relevant information to ensure a good transfer of care between the hospital and the care provider. For example, the discharge summary document for one child outlined their full range of care needs and medication on discharge, which provided the basis for on-going care planning for the home care package.

We found that the service was open and responsive to suggestions and feedback from staff and families. Families were encouraged to provide feedback in relation to staffing and care packages, and this was acted on by the care provider. The care team and the provider listened to families opinions and incorporated this into the care planning process. The provider had made changes to service delivery, in response to requests from families, demonstrating a positive and responsive approach to changing needs.

One parent told us, "The service is only a phone call away," and this gave them confidence that they had someone to turn to if assistance was needed. The parent also said, "I feel confident with the service," as they had previously received support from other agencies that had not been positive.

Another parent commented, "They have done right by me," and "They act on my requests, and listen to what I say," which demonstrated a positive responsiveness from the care provider.

At the home visits we undertook we saw care staff were very responsive to the needs of the child being supported, and to requests and interactions with the family. One parent told us they had, "Great communication" with the care staff, especially when they were at work or away from the family home. They told us care staff would send text messages and telephone updates when needed. This would be important in the event that emergency care was needed, as due to the nature of their illness, the child's condition could deteriorate and they could become ill very quickly without an appropriate response and intervention.

Care staff were recruited from the local area in which they worked and this enabled them to be more responsive and flexible in relation to working hours and undertaking activities in the local community, where appropriate.

Children who used the service had a care plan that was personal to them with copies held in their own home and in the office premises. This provided staff with guidance around how to meet their needs, and what kinds of tasks they needed to perform when providing care.

There were systems in place to record what care had been provided during each call or visit. Care plans contained a document, which was completed by staff at each visit, which recorded when care and support had been provided, any general observations such as the child's oxygen levels and body temperature, if any food or liquids had been given, if any suction had been undertaken or tracheotomy changes done. We checked these documents and found they were being filled in correctly by staff and extensive records were in place for each day.

Relatives told us that should there be a need to complain they felt confident in talking to the manager directly and had regular discussions with management. The service had a complaints policy and procedure and we saw that they followed this consistently. We saw evidence where complaints had been recorded and investigations had been carried out following issues raised, for example if the family had requested an alternative carer.

Requires Improvement

Is the service well-led?

Our findings

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.

The registered manager told us that changes to the management team were being made and a new registered manager was due to commence in post shortly after the date of the inspection, with the existing registered manager undertaking a clinical lead role in future.

An up to date registered manager's certificate was on display in the office premises in addition to an appropriate certificate of employers' liability insurance.

People we visited all told us that the registered manager had visited them in their own homes.
The manager told us that it was important for the manager and senior office staff to visit people in their own homes to establish positive relationships and to demonstrate respect for each individual.

However, we received mixed comments from the relatives we spoke with. One parent commented, "Input from the office can sometimes cause confusion." Another parent told us, "There is a lack of organisation from the office" and "I organise them" in response to a question about how the care package is managed. A third person said, "If there are any last minute changes to the care package I can ring the office and the manager always sorts it out."

Care staff said they felt able to talk to the registered manager about any aspect of the care package. One staff member told us, "I ring the office if there are any issues and the manager always answers and listens to me." A second staff member commented, "I feel well supported by my line manager."

During the course of the inspection we observed the manager ringing staff from the office to provide a range of update information. For example one conversation was about the status of one child's hospital visit that had occurred the previous day. Another conversation was about rota cover.

Families were complimentary about the input from qualified nursing staff and felt that they provided good advice and support. One parent said, "The lead nurse is very good and I have confidence in her." The nurse had worked closely with the family to develop the care plan and organise the care package to meet identified needs.

We spoke with the registered manager and the managing director about how the service monitored the quality of service delivery. At the time of the inspection the service did not operate a formal system of auditing and we did not see any evidence of medication audits or quality assurance systems, with the exception of the auditing of staff personnel files. Both the registered manager and the managing director were very enthusiastic about the service and were keen to develop it and improve the overall quality

assurance framework.

The service was unclear about key quality standards and did not have clear ways of monitoring or reviewing the performance of staff or the organisation.

We found the service had policies and procedures in place, which covered various aspects of service delivery but these needed re-evaluating to ensure the service had incorporated quality standards based on best practice and industry guidance. We spoke with the managing director and registered manager about these issues and during the course of the inspection the managing director contacted their business advice service in order to make arrangements for the immediate review of all policies and procedures.

These issues meant there was a breach of Regulation 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance, because the service had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. You can see what action we told the provider to take at the back of the full version of this report.

The service worked in partnership with the referring hospitals to ensure timely and safe discharges into the home environment. We saw that where additional support had been identified as being needed for one child in order to support a holiday abroad after the start date of the initial package of care, the service had contacted the relevant commissioning authorities to request additional funding and this had been granted.

In addition we found that where health and social care funding had been provided for the package of care for one child, the service was able to use this funding and the available staff hours in a flexible way in order to meet the needs of the child, after discussion with the family who had initially requested if the joint funding in place could be used more flexibly. This enabled staff to meet the child's health and social care needs as well as supporting the family as a whole.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have appropriate arrangements in place to manage medicines safely. Regulation 12(2)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Regulation 17(2)(a) The service had failed to maintain securely and accurate, complete and contemporaneous records in respect of each person using the service and persons employed in the carrying on of the regulated activity. Regulation 17(2)(c)(d)