



Evaluation of the WellChild 'better at home' project

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EXECUTIVE SUMMARY

Background

The 'better at home' project evaluated the role and impact of the dedicated WellChild Parent Educator, the better at home simulation suite and e-learning packages. The project funded by the WellChild charity and developed for a collaborative partnership between Edge Hill University and Alder Hey Children's NHS Foundation Trust was funded by WellChild for a period of 24 months. This was a unique partnership between hospital and university with a significant higher education involvement. Traditionally training has been limited to either the bedside or often delivered on an ad hoc basis at home. This project provided a structured programme of skills training across the hospital, home and simulation suite environments.

In response to key legislative and strategic guidance documents, a scoping exercise of the training needs for families and carers and discussions with nurses, children and young people requiring complex medical care, has highlighted the need to support the families and carers of children with complex medical needs and to provide a uniform and structured approach to training in the most appropriate setting. In addition there is a necessity for tailored programmes to help parents and carers feel "brave" enough to care for their child safely in the non-medical environment. It is with this mandate in mind that this nationally unique project was granted funding.

The 'better at home' project consisted of the dedicated parent educator role, the development of e-learning interactive materials for parents and carers and the development of a 'better at home' simulation clinical skills suite at Edge Hill University. Furthermore, the project funding included evaluation of the 'better at home' project.

Project aims

Within the context of this evaluation carers are defined as relatives, friends or neighbours who are not in a paid, employment role. Paid carers refers to staff employed by the NHS or care agencies. Children refers to children and young people.

The aims of the project were

- To evaluate parents and carers' engagement with and experiences of the role of the WellChild Parent Educator.
- To evaluate the use of the 'better at home' suite and to ascertain the experiences of parents and carers who engaged in clinical simulation.
- To evaluate parents and carers perceptions of the clinical e-learning materials.

Methods

This was an exploratory, evaluative study. Data was collected using semi-structured interviews with parents and carers of children with complex medical needs. Interviews were conducted with families in the North West region of the United Kingdom and were carried out within both a home and hospital environment.

A framework approach to data analysis (Richie and Spencer 1994) was utilised within this evaluation as this has been deemed appropriate for analysing applied qualitative research.

Findings

Parents and carers identified a real need for the parent educator role, which was described as enhancing the clinical skills and confidence of parents/carers. This was seen to directly and positively impact on the quality of life of the family as a whole, the main carer and the child. Carers also respected the professional registered children's nurse status of the parent educator and this seemed to have impacted on the level of confidence they felt following their training. The evaluation has highlighted that parents and carers have previously encountered difficulty in accessing training and that there can be a lack of consistency in training. Parents/carers also voiced a lack of confidence in the perceived competency levels of paid carers

Despite some parents/carers identifying difficulties in being able to access the 'better at home' suite facility, those parents/carers that utilised the suite they reported that the benefits of being able to practice emergency clinical skills in a realistic environment was a key issue. Furthermore, the ability to practise in a 'safe' and supportive environment resulted in perceived enhanced levels of confidence of parents/carers in caring for their child.

Recommendations

Recommendations from the evaluation include:

- The ongoing provision of a flexible and accessible clinical skills programme for parents and unpaid carers of children with complex medical needs in the form of a parent educator. Training should be accessible at various stages of care delivery from hospital to home and then to better at home suite.
- Parents/carers should continue to be provided with access to the 'better at home suite' at Edge Hill University to support and consolidate their skills training.
- The use of the 'better at home' suite should be maximised by using the facilities for the provision of training for paid carers.
- Consideration should be given to the development of a mobile 'better at home' suite/facility to broaden access to simulation training for parents/carers.
- The further development of e-learning packages to support parent/carer training underpinned by continued evaluation with a larger cohort of users.

BACKGROUND

Medical advances have enabled increasing numbers of pre-term infants, neonates with congenital impairments and children with critical illness to survive and have improved prognosis (Kirk 2001; Murphy 2008). This has resulted in the emergence of an increased number of children with continuing health care needs, some of whom remain dependent on the technology that enabled them to survive. The term 'technology dependent' may apply to children requiring long term oxygen therapy, parenteral nutrition, those with tracheostomies and a number of children who require long term ventilation support (Murphy 2008; Hewitt-Taylor 2008). In addition, these children may have associated problems with speech, hearing, vision or mobility. Moreover, the prevalence of children with complex needs requiring technology assisted care is increasing and is likely to continue to rise (Hewitt-Taylor 2010).

The National Framework for Children, Young People and Maternity Services (2004) and research with children and young people requiring technology assisted care or medical interventions supports the ethos that the best place for children to be cared for is in their own homes, where their psychological, developmental and social needs are best met (McKenzie 2000; Noyes 2000; Balling & McCubbin 2001). When children requiring ongoing complex care are cared for in their home environment their parents generally provide the type of care that would usually be the domain of professionals. Parental participation was originally promoted as a means of reducing the adverse effects of hospitalisation on sick children and has gradually evolved from parental provision of every day child care activities, such as bathing, to the performance of clinical procedures such as measuring vital signs, drug administration and use of high technology equipment. This relocation of intensive and complex nursing care from hospital to domiciliary settings transfers care giving from professional to lay carers, thus blurring the boundary between lay and professional care (Kirk 2001). Parents are increasingly involved in performing highly technical procedures that would formerly have been considered part of professional, particularly nursing, practice (Kirk 2001; Hewitt-Taylor 2005) and in some cases performing clinical procedures that would be considered extended nursing roles.

For most parents, feelings of obligation and strong desire to bring their child home are seen as the key motivating factors in acceptance of responsibility for providing complex clinical care, in many cases the alternative to parental care giving being the child's continued hospitalisation (Kirk 2001). However, research suggests that caring for the technology dependent child can be socially isolating for parents (Townesley and Robinson 2000), can lead to sleep deprivation, stress and depression and can impact on family relationships (Kirk et al 2004). Despite this increase in the shift of clinical responsibility to lay parents and carers within the home environment there is little evidence available on the preparation that parents have for this role. NHS England (In press) Quality Standards for the Care of Paediatric Long Term Ventilation (Domain 1) states that parents, primary carers and immediate family should be provided with a competency training programme facilitating safe care at home. In addition, the Department of Health (2011) NHS at Home: Community Children's Nursing Services identifies the necessity for training and ensuring ongoing competence of parents, carers and non-registered staff and also the increasing need for skilled practitioners to deliver that training.

The 'better at home' project comprised of the following three key elements:

The Parent Educator Role

The parent educator role utilised an experienced nurse clinician who was responsible for delivering clinical skills training to parents/carers of children with complex medical needs. The remit of the parent educator also included working with Edge Hill University in the development of the 'better at home' simulation suite and the development of e-learning materials. The parent educator was recruited on secondment from Alder Hey Children's Hospital NHS Foundation Trust on a 0.5 WTE basis, initially for a period of 12 months and then extended to 24 months.

The WellChild parent educator facilitated a programme of clinical skills training based on the child's medical needs and the parents/carers existing level of training. Clinical skills training was conducted either in hospital prior to discharge or within the home environment. In addition, parents/carers were offered the opportunity to consolidate their skills within the 'better at home' suite. As all the children with complex medical needs were patients of Alder

Hey Children's NHS Foundation Trust the relevant procedural policies and competency assessment guidelines were adhered to.

The 'better at home Suite'.

Following initial clinical skills training parents were offered the opportunity to consolidate their skills within the 'better at home' suite. The 'better at home' suite at Edge Hill University was completed in 2013. The 'better at home' suite is a simulation suite that emulates a home rather than an acute clinical setting. The challenges involved in caring for people at home are very different from those encountered in a hospital environment. By providing the opportunity for training in a 'home from home' environment, the suite better prepares students, health professionals and carers/parents to care for people with complex needs in a realistic home environment. The 'better at home' suite is configured as a small flat and has simulation and video recording equipment which enables users to practice techniques and interaction, and receive feedback on this, in a safe setting.

E-learning Materials

To support the parent/carer training, the 'better at home' project involved the development of e-learning packages covering the following content, tracheostomy care, gastrostomy care, oxygen, suction and care of the long-term ventilated (LTV) child. These packages, developed with a mobile platform in mind, would be available to parents and carers at home and would be used to support and consolidate training and also to refresh clinical skills knowledge.

Recruitment to the 'better at home' Project

Parents/carers that participated in the project were identified by the parent educator. The inclusion criteria included parents or unpaid carers of children with long term complex medical needs. Initially, the parent educator conducted a scoping exercise that enabled her to identify the current provision of parent/carer skills education. This exercise initiated contact with specialist nurses and community nursing teams who were requested to identify and refer parents/carers that were deemed suitable to participate in the project. These potential points of referral included nurse specialists for tracheostomy and gastrostomy care, the WellChild nurse, transitional care and high dependency unit staff and the community

children's nursing team. Initially recruitment to the project was slow however this in part was believed to be due to the complex nature of the children's' medical and social needs and its impact on the availability of families for training. Also, extensive networking was required to support understanding of the unique nature of the role and thus aid referrals from both community and acute services. Following a successful open event for the 'better at home Suite' at Edge Hill University in January 2014 the number of referrals increased. The open event aimed to showcase the 'better at home suite' to staff working with children with complex medical needs within a community setting.

METHODS

Recruitment to the evaluation

Parents/carers who were deemed to be suitable to be involved in the evaluation of the WellChild parent educator role were initially identified during skills training and parents/carers were asked permission for their details to be shared with the researcher. Following this, contact was initiated and verbal and written information was given to potential parents/carers prior to gaining written consent. Parents/carers were interviewed on completion of training.

Data collection

Semi-structured interviews explored parents/carers experiences of their engagement with the WellChild parent educator. Parents/carers who had used the 'better at home' suite facility were asked to describe their experiences of this element of their training. The interviews were conducted either within the hospital setting or at home and were audio recorded and subsequently transcribed, checked for accuracy and analysed. Interviews were conducted by one researcher (PK).

Ethical procedures

Approval for the evaluation was gained through the faculty research ethics committee. Written consent was obtained from parents/carers prior to interview.

Data analysis

Data was extracted thematically and processed in accordance with the framework principle (Ritchie and Spencer 1994). The framework approach as described in this analysis was developed in the context of analysing applied qualitative research and the principles of the approach have proven to be versatile across a wide range of studies. Evaluation applied research is distinguished from theoretical research through its requirements to meet specific information needs and its potential for actionable outcomes. The framework approach is deemed to be systematic and explicit, applying the principles of undertaking qualitative analysis to a series of interconnected stages that guide the process. The five key stages of the framework approach, namely familiarisation, identifying a thematic framework, indexing, charting and mapping were followed during data analysis (Richie and Spencer 1994; Ritchie and Lewis 2003).

1. Familiarisation - Transcribed interviews were read in their entirety in order to facilitate immersion in the data. At this point, key ideas and recurrent themes were identified.
2. Identifying a thematic framework -The framework was initially constructed based on the original evaluation aims and interview guide, but then developed according to the themes and keys issues raised by the parents/carers.
3. Indexing - The thematic framework was applied to the data in its textual form. The interviews were read and annotated according to the thematic framework with indexing references recorded on the transcripts. This involved making judgements as to the meaning and significance of the data both as it stands and within the context of the interview as a whole.
4. Charting - Charting enabled the analyst to build up a picture of the data as a whole by considering the range of attitudes and experiences for each theme. A chart was devised with headings and sub-headings devised from the thematic framework. Data was then lifted from its original context and rearranged or 'charted' according to the appropriate thematic reference.
5. Mapping and interpretation - When all the data had been sifted and charted according to core themes, key characteristics of the data were synthesised and the interviews were mapped and interpreted as a whole. The thematic charts were reviewed and parents and carers experiences were compared and contrasted, searching for patterns and connections.

FINDINGS

A total of 22 unpaid carers were recruited to the project by the WellChild Parent Educator. Families received training both within the home (n=15) and hospital environment (n=7). 11 carers consented to participate in the evaluation. Interviews were conducted both within the home (n=5), hospital (n=4) and the 'better at home' suite at Edge Hill University (n=2). Families were trained across a wide geographical distribution that included Liverpool (n=12), North Wales (n=3), St. Helens (n=2), Sefton (n=1) and Blackburn (n=4). Parents/carers received training over a number of sessions which ranged from one session to eleven sessions depending on need; the average number of sessions being six.

The children within the project that were being cared for had been diagnosed with a number of conditions and required a variety of technology-assisted care interventions (Table 1).

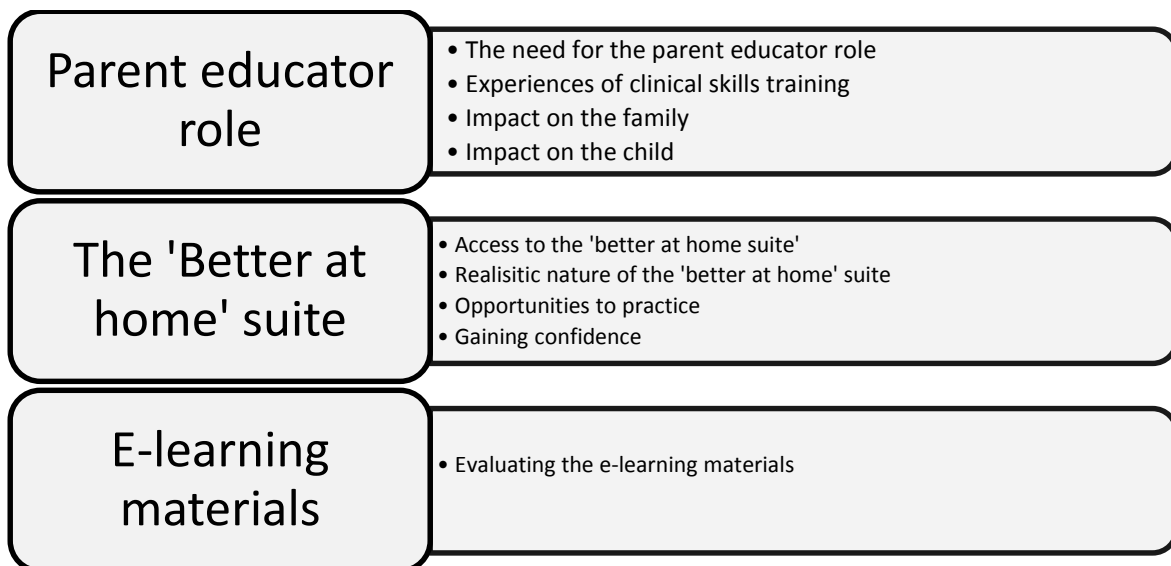
Diagnosis	Technology-assisted interventions
Neurological disorder	Invasive ventilation
Chronic lung disease	Non-invasive ventilation
SMARDS (Spinal muscular atrophy with respiratory distress)	Tracheostomy care
Scimitar syndrome	Oxygen
Bronchomalacia	Suction
Tracheomalacia	Gastrostomy feeds
Retts syndrome	Jejunostomy feeds
Epilepsy	Broviac catheter care
GORD (Gastro-esophageal reflux disease)	Intravenous medication
Developmental delay	
Cleft palate	
Pfeiffer syndrome	

Types of diagnosis and technology assisted care.

The findings will be discussed within the thematic structure of the thematic framework. Direct quotes ('in-vivo') are used to illustrate findings and are advocated as a means of staying 'true'

to the data (Ritchie and Lewis 2003). The findings section is structured according to the three elements of the 'better at home' project, parent educator role, simulation suite and the e-learning package.

The key themes within the framework analysis which related to the parent educator role included the need for the role, experiences of clinical skills training and the impact on the family and child with complex medical needs. Key themes related to the 'better at home' simulation suite included access to the better at home suite, its realistic nature, the opportunity to practice skills and an increase in confidence. Key thematic findings of each element are portrayed below.



Thematic findings of the Evaluation of the Parent Educator Project

The Parent Educator role

The need for the parent educator role

Parents and unpaid carers identified that there is a lack of training available for unpaid carers and family members and that in some cases they had been waiting for training for some considerable period. It was felt that the nurses didn't have time to provide this aspect of care. One mother highlighted this.

"It's not the nurses' fault, they just don't have the time" (p5).

This perceived lack of training subsequently led to parents embarking on their own informal training to enable their family members to help out in the care of their child.

“I just need to learn his medicines, his mum and dad are doing those with me” (p9).

The consequence of this parent led training clearly has implications for patient safety.

Parents/carers also highlighted inconsistencies in the delivery of their own skills training. One father described how they had experienced different training from different professionals.

“It’s better to have the one person doing it at any one time.....some people are different, doing their different ways, they chop and change” (p6)... “ They had different people doing it, it was a bit confusing” (p1).

Parents/carers also voiced a lack of confidence in the competency levels of paid carers. One mother described how this perceived lack of skill also affected the acquisition of skills within the child’s school.

“The carers are trying to train teachers in the school but the carers don’t even know what they are doing” (p4).

Experiences of clinical skills training

Parents/carers stated that training by the parent educator provided consistency and enabled carers to learn at their own pace. One aunt explained this.

“It’s better than having lots of people teaching you different things, we were learning at a good pace but if we didn’t understand something she would go over it” (p2).

The parents/carers valued training that was delivered at home as this made training more accessible when they didn’t have to arrange for someone else to care for their child. Several of the parents expressed that training would have been difficult to access if they would have had to travel.

“My father would never have driven all the way there and I wouldn’t have been able to keep taking our sister” (p4).

The flexibility of the parent educator role was therefore deemed crucial by many of the families in allowing carers to access training. This flexibility related to the different times available for training, as the following mother highlighted.

“The role needs to be flexible to fit in with the family, which I found it was. That was important” (p5).

An important theme that resonated throughout the interviews was the confidence in caring for their child that the clinical skills training by the parent educator instilled in parents. The following mother described how the training had steadily built up her confidence.

“I’ve got the confidence which I have built up gradually, by going a bit further” (p5).

Moreover, parents also felt more confident in allowing others that had been trained by the parent educator to provide care for their child, thus allowing them to ‘let go’. One aunt described how the training had meant that she could spend more time with niece.

“She (mother) feels more relaxed because she knows that we know what we are doing.....it’s given her [mother] peace of mind when (daughter) comes up to her dads and we can look after her as well” (p2).

Carers also respected the professional status of the parent educator and this seemed to have impacted on the level of confidence they felt following their training. The following mother described how a strong clinical background meant the parent educator had credibility through her previous role and experience.

“It’s important that she has the hospital background...more understanding and professional” (p1).

The parents identified that there was a need for the provision of ongoing or refresher training. One parent who did not regularly look after his daughter expressed that skill could fade with time if they were not refreshed.

“I only just got this place so I was going to start having her (daughter) every other weekend so I needed to refresh my memory” (p4).

Impact on the family

An important aspect of this project was to evaluate the impact of the parent educator role on the family. Carers that are family members disclosed that prior to training that they had distanced themselves from the child due to fear of their complex medical needs. The following grandfather expressed that they felt ill equipped to deal with the needs of their granddaughter.

“Before I used to like push her away just for fear of something going wrong or not being able to cope” (p3).

This could result in the mother being the only one who felt able to care for the child’s complex needs. One mother described how her family did not volunteer to look after her daughter with complex needs as they did with her other children.

“Family were frightened of her condition so it was like no, she stays with me and then the other kids would go and everyone used to take the other kids but (daughter) was always with me” (p1).

Following training, extended family members felt able to include the child with complex needs in family activities from which they had previously been excluded. The following mother explained how the training had enabled this.

“She can be left with her aunty. It’s like a big thing for (daughter) because she’s like the other kids (p1).

This in essence brought the family together.

“This (training) has given us a bit of freedom, we’re now more of a family again. We’re quite happy to go out anywhere, we all know how to do trachys and things like that, and it’s all been a bonus really” (p3).

Furthermore by enabling family members to participate in caring for the child this allowed the main carer to take a break from their caring role. This break acted a catalyst in some cases to ‘allow’ parents to go and seek employment opportunities or to have some time for themselves. The following mother, since her family had received training, had felt able to go and seek training and education.

“So, I’ve started college on a Monday evening, but I can also relax now when I’m not there because I trust family members” (p1).

The opportunity for a break was discussed by some parents as meaning that time spent together with their child was now ‘better’, as the following mother described:

“As I can have a break from her I can also have more quality time with her because I’m not as tired and not as stressed if you will” (p1).

Subsequently, this allowed the main carer to focus on the other children in the family who they felt had not always received equal attention to the child with complex needs.

“She (mother) can spend a lot more time with the other kids now cos they feel like they’re missing out and that’s because she’s always concentrating on (daughter)” (p4).

Impact on the child

Parents and carers identified in the interviews that the parent educator role had a positive impact on the child in several ways. As other family members became more competent in

performing clinical skills this gave the child choice in who provided care for them, thus giving them a 'voice'. The following mother described how.

"She [parent educator] kind of gave her (daughter) her own voice back really and let her make decisions and just get involved" (p1).

In addition, parents conveyed that their child felt more confident in being cared for by family members that had received training compared to receiving care from paid carers. One father discussed how.

"I've seen her with (paid) carers that she's got and she's having her trachy changed, she's nervous cos she thinks they're gonna hurt her. With my uncle she's helping him, she loves it, absolutely loves it" (p4).

As previously identified, following the training, family members were able to involve the child in family activities from which they were previously excluded. Parents indicated that their child benefited from the inclusive nature of being able to participate in family pursuits.

"They can all go bowling together and they can all come round and play" (p2).

The 'better at home' suite

Of the 22 parents/carers that received training from the parent educator, 7 parents/carers utilised the 'better at home suite' to consolidate their training and were interviewed regarding their experiences. In addition, 4 carers were interviewed regarding their reasons for not utilising the facility.

The key themes within the framework analysis which related to the 'better at home' simulation suite included access to the better at home suite, its realistic nature, the opportunity to practice skills and an increase in confidence.

Access to the 'better at home' suite

Parents/carers were asked to discuss their reasoning behind why they chose not to use the simulation suite. The reasons that were given for not utilising the suite related to time and distance. Parents/carers of children with complex needs highlighted that due to the time demands of caring for their child, alongside other family commitments, accessing the suite presented some difficulties. Often, as described below, parents were juggling multiple demands on their time.

"You know it's difficult with having the others to pick up from school" (p5).

The distance to the suite and a lack of transport compounded the challenges of accessing the suite. One father stated that living a distance away from the suite created difficulties for him.

“It’s just hard isn’t it, when you live far away, it’s just hard getting people there isn’t it, with working” (p7).

Realistic nature of the ‘better at home’ suite

Those parents/carers who did access the suite for consolidation of skills training, repeatedly emphasised the realistic nature of the high fidelity simulation that was utilised. The following mother highlighted this.

“It feels realistic, even though it’s a doll and stuff like that” (p8).

The parents/carers also commented that the design of the suite also reinforced the realistic nature of the environment. The following grandmother described how the environment was like being at home.

“The surroundings themselves, it’s like being in a house rather, you do it in hospital in a side ward or a room. This sort of thing is like a home” (p11).

Opportunities to Practice

As part of the training, a number of scenarios were simulated. These included emergency skills that carers would not be able to practice without the use of high fidelity simulation. These skills included suction, unplanned tracheostomy change and resuscitation. The ability to practice these skills was highlighted by the following grandfather as being really important to them.

“You might have to deal with that at home, that you haven’t had a chance to practice and therefore if the need arose you could do those things” (p12).

Parents/carers were also able to practice skills repeatedly until they felt competent. One mother had gained confidence in being able to practice until they felt that she had ‘got it right’

“I just wanted to keep doing it and doing it” (p8).

The suite facilitated the video recording of the training sessions and this was used to enable parents to receive feedback on their skills. This visual feedback was seen as important by parents/carers as this mother testifies.

“The simulation was videoed and you were able to look back at it. It’s, yeah, it was really strange to see. Like inside I felt like I was shaking and I was a ball of wreck, but

when you actually watch it back I looked so calm and collected and just looked like a whizz kid doing everything so fast. It really bought my confidence out in myself, definitely” (p10).

Gaining confidence

All of the parents/carers that utilised the ‘better at home’ simulation suite recounted the impact that the simulation had on increasing their confidence to perform clinical skills. As one mother said about her experiences of the suite;

“I would go there every day I would, just to get that confident feeling. Feeling that confident, you feel like just on top o’ the world and ready for anything” (p10).

The simulation enhanced the confidence that they had been given through training at home or within the hospital by the parent educator. One mother described how the opportunity to access the simulation suite was vital to them.

“It was really good, gave you loads of confidence. It’s not just beneficial, I’d say it was essential” (p8).

E-learning materials

Five e-learning packages have been developed as part of the WellChild ‘better at home’ project. These include tracheostomy care, gastrostomy care, oxygen, suction and care of the long-term ventilated (LTV) child. Some of these packages have been demonstrated at progress meetings with WellChild and have been positively received. An evaluation survey has been incorporated within the package, however a wider audience of parents/carers would be required to collect sufficient quantitative data to enable valid and reliable analysis. Due to institutional reorganisation these packages are currently being transferred from the Faculty of Health and Social Care e-learning software (Moodle) to that which is used centrally within the University (iSpring). This has been discussed with the Director of Programmes for WellChild and a date for completion of transfer is required to coincide with the official launch of the ‘better at home’ suite in June/July 2015.

CONCLUSIONS

The parents and carers who participated in this evaluation described many positive benefits of the parent educator role. There was seen to be a clear need for the dedicated parent educator in order to address the difficulties carers had in accessing and receiving credible and consistent training. The parent educator role was evaluated positively in the ability of the role to be flexible to the individual needs of each family. This ensured that training was delivered to fit in with the busy commitments and lives of the families. Both parents and carers expressed that their confidence to care for the child with complex medical needs had increased following clinical skills training.

The parent educator role was described as having a positive impact on both the family and the child. Family members conveyed that being able to participate in care following training brought the family closer and enabled them to include the child in activities in which they had previously not been able to take part. It was also identified that when extended family members were able to participate in care that this allowed the main carer to take a break from their caring role and have time for themselves or focus on other children within the family.

The child with complex medical needs also benefited from the parent educator role. The child was perceived as being able to have more choice of who delivered their care, feel more confident in care delivery by family members and be included in family activities from which they had previously been excluded.

Some difficulties were encountered for families in accessing the 'better at home' suite due to time pressures and distance from their homes. However, those parents and carers who did use the suite described that the home environment and skills simulation was realistic and that being able to 'practice' skills was beneficial and helped to increase confidence in caring for their child.

RECOMMENDATIONS

Recommendations from the evaluation include:

- The provision of a flexible and accessible clinical skills training programme for unpaid parents and carers of children with complex medical needs in the form of a parent educator; the ideal mode of delivery being within the home environment.
- Parents/carers should continue to be provided with access to the 'better at home suite' at Edge Hill University to support their skills training.
- The use of the 'better at home' suite should be maximised by using the facilities for the provision of training for paid carers and other professionals.
- Consideration should be given to the development of a mobile 'better at home' suite/facility to broaden access to simulation training for carers.
- The further development of e-learning packages to support parent/carer training underpinned by continued evaluation with a larger cohort of users.

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