Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

RNIB Wavertree House

Somerhill Road, Hove, BN3 1RN

Tel: 01273262200

Date of Inspections: 27 February 2014
19 February 2014

Date of Publication: March 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Cleanliness and infection control	✗ Action needed
Staffing	✓ Met this standard

Details about this location

Registered Provider	Royal National Institute of Blind People
Overview of the service	RNIB Wavertree House provides residential and personal care for up to 44 older people. The home is specifically designed to cater for the needs of people with varying degrees of visual impairment, other disabilities and the associated problems of old age. There are particular adjustments in place in the home to meet the needs of people with a visual impairment.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether RNIB Wavertree House had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Cleanliness and infection control
- Staffing

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 19 February 2014 and 27 February 2014, observed how people were being cared for and talked with people who use the service. We talked with staff.

What people told us and what we found

At the last inspection in November 2013 we found the Royal National Institute for Blind People (RNIB), Wavertree House non-compliant with cleanliness and infection control. This was because the service did not have an infection control lead; policies and procedures did not reflect current legislation and the service had no quality assurance framework in place to monitor cleanliness and infection control.

Following receipt of concerning information about the delivery of safe care and claims that there were insufficient numbers of staff to meet the needs of the people who used the service, we carried out a responsive inspection.

During the inspection we spoke with six people who used the service and seven members of staff, these included the area manager, assistant manager, four care workers, a domestic care staff and a supervisor.

We observed the delivery of care and treatment of people. People we spoke with confirmed they were happy at RNIB Wavertree House. One person told us, "It's wonderful, I'm so impressed."

Staff we observed had an understanding of the support needs of people who used the service and were confident about meeting those needs. We found that the documentation used for care planning had been reviewed recently, was detailed and person centred.

We saw that the service was kept clean however, there were still not effective systems in place to reduce the risk and spread of infection.

During our inspection we looked at staffing rotas and observed levels of staffing. We also spoke with staff members and people who used the service. We saw that the service had enough qualified, skilled and experienced staff to meet the needs of people.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 09 April 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced Care, Treatment and Support that met their needs and protected their rights.

Reasons for our judgement

Care and Treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Before a person joined the service, we saw that pre-admission assessments took place. The assistant manager told us, "People can self-refer and we work closely with the local authority. We will go and meet the person and understand what their care needs are and whether we can support them. We always encourage people to come and look round RNIB Wavertree House as well." We found that the service operated a month's trial period which provided people with time to establish whether RNIB Wavertree House was the right home for them. One person told us, "I stayed here for three days before I made a decision about living here; it gave me time to decide whether this was the right place." This demonstrated that people were provided with sufficient time and information to make an informed decision about the service.

RNIB Wavertree House supported people experiencing partial sight loss, the blind and/or hearing loss. We examined eight care plans in detail. We found that care plans provided a detailed medical history and level of sensory impairment for the person which included relevant information on the level of visual and hearing loss. We saw that care plans included information on the person's preferences for lighting. For example, we saw that one person preferred normal bulbs to higher watt bulbs. This meant that the service was taking into account the environmental and emotional needs of people.

Care plans were sufficiently detailed which enabled care staff to provide safe care to people. We saw that care plans were robust and comprehensive detailing information on people's personal care needs, mobility, continence, nutrition, financial management and social and community. We found that care plans were written in first person account (written from the perspective of the person) and were meaningful to the person. For instance we saw that one person liked a shower every morning by a female care worker. This demonstrated that care and support was being delivered in a person centred way to meet the individual's needs.

We saw that assessments were supported by a range of risk assessments. Risk assessments included falls, showering unassisted, fainting, medication, nutrition and manual handling. We examined eight risk assessments as part of the delivery of care and treatment. We saw that risk assessments were person centred and a specific risk to that person. For example we saw that one person smoked. The assistant manager informed us that recently the person was found smoking in their room. We saw that the risk assessment stated the risk of harm if the person was to burn themselves and the preventive measures implemented to reduce the risk of harm. This meant that care and treatment was planned in a way that was intended to ensure people's safety, rights and welfare.

We looked at how the service managed when a person became unwell. We saw that the service worked with health and social care professionals. Care plans included evidence of multi-disciplinary notes from other people involved in the delivery of care, such as healthcare professionals. We saw that people were registered with the local General Practitioner (GP's) and had access to other healthcare professionals, including district nurses and dentists. For example we saw that the service had contacted the emergency out of hour's dentist for one person. We found that people's ends of life wishes were recorded and the service recorded people's preferences for palliative care. For example we saw that one person wished to remain at RNIB Wavertree House if their health deteriorated and for a Rabbi to be present. This meant that service was taking into account the physical, religious and emotional needs of people.

We found that people who used the service were offered a wide range of activities. The service employed two dedicated activities co-ordinators and we saw that activities were offered daily. Activities included arts and crafts, shuffleboard, exercises, classical stories and news stories. We saw that the activities programme was displayed throughout the service. We also informed that the activities co-ordinators informed people daily what activities would be provided. The assistant manager informed us that 'resident's' meetings are held regularly. This was an opportunity for people to discuss the service, any concerns they had and what activities they would enjoy doing. We were also informed that people could receive one to one activity support. This was to ensure that all the people who used the service had an opportunity to socialise in the service. One person told us, "We have meetings where we can request what we would like to do." This showed that there were opportunities for meaningful activity and social engagement for people who used the service.

On the day of the inspection, we spoke with six people. One person told us, "It's very pleasant here, staff are friendly and approachable." Another person told us, "It's wonderful, I'm so impressed." People we spoke with were happy with the care received. One person told us, "They give me my freedom but when I need help, they are always there." We observed that people were relaxed in the service choosing to spend time in their room or communal areas. We found that people were able to bring their own furniture, pictures and ornaments. For example, we saw that one person had decorated their own room with pictures and objects of importance to them. We saw that where applicable, people were wearing hearing aids, glasses and appropriate footwear. People presented as well dressed in clean clothes. We observed staff interaction and saw that people were treated with dignity and respect. Staff knew people's names and we saw staff talking to people at face level, taking into account sensory or hearing loss. This meant that provider was taking into account the physical, social and emotional needs of people.

We found that there were arrangements in place to deal with foreseeable emergencies. Training records we viewed showed staff had received training in first aid and fire safety.

There was an out of hours on call facility within the organisation which the care workers could ring for any support and guidance needed. We saw that the service had adequate fire fighting equipment and first aid facilities. The service had a comprehensive business continuity plan which included measures on what to do in the event of a gas leak, water leak and loss of electricity. This demonstrated that the provider had procedures in place for dealing with emergencies.

Cleanliness and infection control ✖ Action needed

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was not meeting this standard.

People were not fully protected from the risk of infection because policies and procedures did not reflect current guidance and there was no system in place to monitor standards of cleanliness and infection control.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

At the last inspection in November 2013, we found RNIB Wavertree House non-compliant with cleanliness infection control. This was because the service did not have an infection control lead and infection control audits had not been completed to identify any possible risks with infection control.

Following our inspection, the provider sent us an action plan outlining the steps they intended to take to rectify the issues identified. The action plan submitted identified how the service would make improvements in infection control. Actions included the appointment of an infection control lead, audits to be completed and for policies and procedures to be updated. The provider indicated that these changes would be completed by 31 January 2014.

In 2010 the Government issued advice to all providers of health and social care entitled, 'The Code of Practice on the Prevention and Control of Infections and Related Guidance' (CoP). This gave all providers a framework for managing the control and prevention of infection in the provision of health and social care services. Providers must follow the guidance or have equivalent or better systems in place.

At the last visit to RNIB Wavertree House, we found that the service's 'infection control policy' had not been reviewed to include the requirements of the CoP. The action plan submitted identified that the policy would be amended to reflect the guidance. We reviewed the 'infection control policy' and found it included detailed information on infectious diseases and standard universal infection control procedures such as hand washing and protective clothing. The policy though had not been updated to include the requirements of the CoP or standards equivalent to the CoP. In order to have achieved compliance with the CoP, providers were expected to have demonstrated how they meet each criterion of the CoP. The CoP contained 10 criterions, these included quality assurance systems such as audits. We found that RNIB Wavertree policies and procedures did not reflect how each criterion would be met or how compliance would be

achieved. We also identified that policies and procedures referenced the 'Care Standards Act 2000'. Cleanliness and Infection Control was previously governed by the 'Care Standards Act 2000'. The CoP was implemented in 2010 and was now the official body of guidance for cleanliness and infection control. This meant that the service's infection control policy did not follow or reflect current legislation and guidance.

The service had not undertaken quality assurance audits on infection control. Criterion one of the CoP documented that all social care organisations needed a quality assurance framework to monitor the standards of cleanliness and infection control and to identify any shortfalls in practice or where procedures had not been followed. Social care organisations must either follow the CoP or had equivalent standards in place. On the day of the inspection, we could not find any evidence that RNIB Wavertree House had a quality assurance framework in place, thereby reducing the risk of healthcare associated infections and ensuring people are cared for in a clean environment. We saw that the service had a cleaning rota and dedicated domestic care workers were employed on a full time basis. The assistant manager told us that each floor was dedicated a domestic care worker. We were informed that the domestic staff undertook daily cleaning tasks but did not record that the task had been undertaken. The lack of documentation meant that the provider would be unable to audit whether daily cleaning tasks had been undertaken in line with protocol and procedure. This meant that cleanliness and infection control was not governed by an assurance framework and the provider had no mechanisms to monitor, review and assess standards of cleanliness and infection control.

The CoP (framework for compliance) documented that an individual was designated lead in this area and was directly accountable to the service. We saw that a designated individual had been appointed as the lead but was not available on the day of our inspection for us to talk with them. Training records we viewed confirmed that the lead had attended infection control training held by the local authority. The assistant manager informed us that the designated lead was receiving sufficient training and support to maintain and develop their role.

We saw that the service had a separate laundry room which was equipped to deal with all laundry. The assistant manager told us that each person's laundry was washed separately. Any soiled laundry was separated and placed in a red bag and taken to the laundry room immediately. Care staff we spoke with confirmed this. We found that the service had a comprehensive and robust laundry policy which was accessible to all staff. People we spoke with confirmed that the laundry was washed on a weekly basis or sooner if required. On the day of the inspection we checked bed linen and found it to be clean and clear from stains. This demonstrated the provider had ensured people who used the service and persons employed were protected from acquiring a health care associated infection through appropriate laundering.

We spoke with six people. All confirmed that the service is clean with their rooms cleaned daily. One person told us, "They turn my mattress for me every week and strip my bed every week." Another person told us, "The cleaner is very thorough." We saw that Protective Personal Equipment (PPE) was readily available throughout the service and hand sanitisers were located throughout. During the inspection, we viewed communal areas, bathrooms and six bedrooms. We found the service to be clean and tidy.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

Staffing levels are satisfactory to meet the needs of the people who live in the home.

Reasons for our judgement

People who used the service benefitted from sufficient staff to meet their needs.

The assistant manager told us, shifts are broken up into, early, late and night. On the early shift we have four carers and one supervisor. During the late we have three care workers and one supervisor. On nights, we have a sleeping care worker and two working carers. A member of management is also on call for support. We were informed that the level of staffing was determined by the care needs of the people using the service. The assistant manager told us, "If we have people with higher care needs, more care staff will be required. It's about us identifying the care needs of people and also how care needs fluctuate." We were told that the service recently had two people join the service who required additional support. The assistant manager identified that additional care staff was required to meet the needs of people using the service and therefore an additional staff member was implemented for the early shift. This demonstrated that the service had a process in place which ensured staffing levels were flexible to meet the needs of people using the service.

We examined the staff rota for the following two weeks. We found that the service employed eight full time members of staff; these included part time workers, a relief worker, supervisors and night workers. We saw that the rota clearly documented how many workers, their hours and role. The service informed us that the rota was used as a working tool on calculating what shifts were covered and where additional hours needed to be covered. The assistant manager told us that when agency staff were required, the service worked closely with a local agency as many of the care workers had worked at the service previously. This demonstrated that the service had enough staff and people who used the service could expect a consistency of care.

The assistant manager also told us that there were systems in place to cover sickness, whereby additional staff would be utilised. We saw that there was a structured system in place for dealing with staff annual leave requests, and that the staffing rotas were planned in advance. We were informed by the assistant manager that the service would approach staff first to cover any absences and then agency staff would be contacted. This demonstrated that the service could respond to expected and unexpected changes in the service, for example to cover sickness, planned absences and emergencies.

The provider may find it useful to note that we spoke with four care workers who all confirmed the shifts were manageable with the staffing levels but that shifts did feel pushed. One care worker told us, "The morning routine can be extremely busy and we lack the time to just sit with people." Another care worker told us, "We work well as a team but I do feel rushed at times."

People we spoke with spoke highly of the care staff. One person told us, "They are excellent." Another person told us, "I can't complain." People we spoke with confirmed that their call bells were responded to promptly. On the day of the inspection, we found that the environment was calm and relaxed. Staff presence was felt and we noted staff sitting talking to people.

The provider may wish to note that people we spoke to expressed their wish to access the local community. For example one person told us that they use to enjoy going for walks. We were informed that they felt unable to do this as a staff member would not be able to go out with them due to staffing levels. We found that people spoke of their wish to access the community but staffing levels did not allow for a staff member to support them.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: Regulation 12 (1) (a) (b) (c) Paragraph (2) (c). The provider had not ensured effective systems were in place to assess the risk of and to prevent, detect and control the spread of a health care associated infection.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 09 April 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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