

# Royal National Institute of Blind People RNIB-Tate House

## Inspection report

Tate House  
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## Ratings

Overall rating for this service

Good ●

Is the service safe?

Good ●

Is the service effective?

Good ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Good ●

# Summary of findings

## Overall summary

This inspection took place on 4 September 2018 and was unannounced. This is the first inspection of this service since the provider changed from RNIB Charity to Royal National Institute of Blind People (RNIB) in 2017.

RNIB-Tate House is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. RNIB-Tate House accommodates up to 39 older people and people living with a sensory impairment in one adapted building.

There was a registered manager in place. 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.

When we visited enough staff were deployed to meet people's needs safely. Some concerns were raised with us that staffing pressures could lead to care becoming more task focused on occasion than people would wish. We have made a recommendation regarding how staffing is calculated so dependency factors and changing care needs are acted upon in a timely way.

People told us they felt safe and they knew who to speak with if they had any worries or concerns. Staff had completed safeguarding training. They said they would raise any issues of concern with a manager and were confident managers would take appropriate action.

Detailed risk assessments were in place. Staff knew how to support people safely without placing undue restrictions on them.

Medicines were stored safely and people told us they received their medicines as prescribed. We have made a recommendation regarding how medicines are ordered to reduce the potential for error.

The provider had a robust recruitment policy and procedures in place. Staff received training and support to fulfil their roles effectively.

People had assessments of their needs before they moved into the service. Care plans were comprehensive and guided staff on how to support people in a way that met their care preferences.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The environment was suitably adapted to meet the needs of people living with a sight or a physical

impairment and this helped to maintain and enhance people's independence. Equipment was kept in a good state of repair. The premises were clean and tidy and staff had access to personal protective equipment to reduce the risk of the spread of infection.

People's health and nutritional needs were met. People who used the service and relatives were extremely positive about staff approach and attitude and people told us staff respected their privacy and dignity.

People could follow their own individual pastimes and pursuits or they could choose to participate in a range of activities, which the activities organiser and volunteers organised. There were good links with the community. For example, the service hosted a Quaker meeting, which the public could attend.

There was a complaints procedure and people felt able to raise concerns and complaints.

Care staff described managers as supportive and they commented on a good team ethic. The provider had obtained external advice regarding their quality and monitoring systems and they acted upon any advice provided to them. Audits and checks were undertaken and these were used to drive improvements in quality and safety.

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

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service was safe.

Sufficient staff were employed but the provider needed to review how they determined staffing levels.

Safeguarding procedures were in place and staff had received training on these to keep people safe.

Staff had a good understanding of risk affecting people including people living with sight loss and knew how to minimise risk.

The provider followed robust recruitment procedures.

Effective systems were in place to ensure correct storing and administration of medicines. The provider should follow best practice guidance on ordering medicines.

### Is the service effective?

Good ●

The service was effective

Assessments were completed to look at people's needs and choices and staff respected people's decisions regarding their care.

Staff received appropriate training and support to fulfil their roles effectively.

The service was meeting the requirements of the Deprivation of Liberty Safeguards.

People's nutritional and health needs were met. Staff contacted health professionals as needed and acted upon their advice.

The environment was suitably adapted to meet people's needs.

### Is the service caring?

Good ●

The service was caring

People who used the service and their relatives spoke positively

about staff and warm, caring relationships existed.

Staff were knowledgeable about people's care preferences and respected their choices.

People were involved in decisions about their care and support planning.

Staff treated people with respect and dignity. Staff promoted people's independence.

### Is the service responsive?

Good ●

The service was responsive

Care plans were comprehensive and these included people's preferred care preferences.

Staff supported people to undertake activities of their choosing. Good community links had been established.

The provider had a complaints policy and people told us they were asked for their views on the service. Complaints had been acted upon when received.

People's future wishes including wishes regarding end of life care were considered.

### Is the service well-led?

Good ●

The service was well led

Management systems were in place to safeguard people and promote their welfare. Audits and checks were used to identify shortfalls and drive improvements.

Care staff reported a good team ethic and they said managers were approachable and supportive.

Good professional relationships existed with external organisations.

# RNIB-Tate House

## 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 comprehensive inspection took place on 4 September 2018. One inspector and an expert by experience carried out the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications that had been sent to us as these would tell us how the provider managed incidents and accidents that affected the welfare of people who used the service. We contacted the local authority safeguarding and contracts and commissioning teams for their views. We used this information to plan the inspection.

We spoke with nine people who used the service, four visitors and a visiting healthcare professional. We spoke with the registered manager, the deputy manager, two care supervisors, three care staff, one activity organiser and three volunteers. We reviewed care records and associated medicine records for four people who used the service. We looked at records relating to the management of the service including four staff recruitment files, training records, staff rotas, maintenance files, meeting minutes, quality assurance audits, complaints management and maintenance records. We looked round the service, attended a staff handover meeting and we spoke with the facilities manager.

# Is the service safe?

## Our findings

People told us they felt safe living at RNIB - Tate House. All the people we spoke with said they thought the staff were very competent and dealt with any issues that might arise. One person told us, "They [Staff] know what they are doing." Another person said, "Staff keep an eye on us all the time," and, "I feel totally safe here. Staff give me security and peace of mind."

Safeguarding procedures were in place and staff had received training on these. Staff demonstrated a good awareness and understanding about safeguarding. They told us they would speak to a manager if they had any concerns and were confident managers would act upon any issues raised. The registered manager was aware of their responsibility to liaise with the local authority if safeguarding concerns were raised.

Risk management policies and procedures were in place. Staff completed risk assessments on a range of topics such as nutrition, falls, distressed behaviours and moving and handling. Staff were aware of risks including risks associated with sight loss. They knew how to support people to minimise risks without causing undue restrictions. Several people told us they wore a personal pendant or wrist alarm so they could call for assistance when mobilising independently. People accessed advice from the RNIB specialist team regarding adjustments to help maximise their independence and keep them safe. For example, the specialist team advised on bedroom furniture for one person who had a stroke to facilitate ease of movement and accessibility.

The facilities manager ensured maintenance checks of the premises and equipment were undertaken regularly. They kept comprehensive records of the checks completed and of action taken in response to any identified shortfalls. The facilities manager had responsibility for safe working practices and staff training in the use of these. For example, they supplemented annual training for staff with fire talks in meetings, practical training sessions and memos to alert staff to policy changes. Staff told us they had been trained on the use of aids such as slide sheets to evacuate people safely.

People who used the service knew about the procedures they needed to follow in the event of an emergency such as a fire. A personal emergency evacuation plan (PEEP) plan was devised for each person and a copy of this was held in the person's room. Copies of these were also kept in an emergency pack near the front door for ease of access in the event of an emergency.

Measures were in place to ensure staff were appropriately qualified and personally suitable for the responsibilities of the role they were to undertake. Records showed managers followed the provider's policies and procedure when they recruited new staff.

On the whole people told us they thought there were sufficient staff to attend to their needs in a timely manner. Several people however told us they planned their personal care needs around staff routines because they had to wait for attention at busy times such as mealtimes or at night. One person told us they would like more staff to support them to go out. Staff told us increased dependency levels sometimes impacted on their ability to provide support to other people as promptly as they would wish.

Staffing comprised a care supervisor on each shift, together with four care staff during the morning, three care staff in the afternoon and two care staff overnight. In addition, there was a registered manager and deputy manager, activity support, and ancillary staff such as maintenance staff, cooks and domestics.

While we acknowledge care staffing was increased for a period in response to increased dependency levels this was reactive to immediate needs at the time.

We recommend the provider reviews their staffing and develops a systematic approach to determine staffing levels and improve care delivery.

Medicine policies and procedures were in place and staff who administered medicines had received medicines training. Staff were following established systems regarding medicines handling and staff stored and administered medicines correctly. A care supervisor told us recent changes meant prescriptions were sent electronically from the GP surgery to the dispensing pharmacist. A copy or 'token' of the prescription was not kept in the service. This practice did not meet National Institute for Clinical Excellence (NICE) guidance 'Managing medicines in care homes' and posed a potential risk of errors being made. Medicines delivered to the service should be checked against a record of the order to make sure all medicines ordered had been prescribed and supplied correctly.

We recommend the provider review best practice guidance regarding medicines handling in a care setting.

Despite this people told us they were confident staff managed their medicines correctly and said they received their medicines as prescribed. One person said, "They [Staff] are excellent and very thorough [about my medicines]." Staff completed medicine administration charts (MARs) and topical charts to show people had received their medicines and creams as directed. Staff completed risk assessments for people who wanted to look after their own medicines.

Care supervisors completed a stock check regularly and they checked controlled medicines at each shift change. Controlled medicines are drugs that can result in harm if misused. They include painkillers such as morphine and some tranquilisers and stimulants. A care supervisor told us a pharmacist from the clinical commissioning group (CCG) reviewed people's medicines, together with the GP. When we visited four people's medicines had been reviewed.

The premises were clean and tidy, which was important for people with sight impairment and there were no trip hazards. Staff had access to personal protective equipment, which helped to prevent the spread of infection. People told us the service was clean. One person said, "They [Staff] are good cleaners."

The registered manager showed us audits the deputy had completed. They told us they acted on any concerns raised with them and any shortfalls identified were entered onto the continuous improvement report so progress could be monitored. Any required actions were discussed and feedback presented to staff at meetings. We found the registered manager acted upon professional advice. For example, a community pharmacist had recommended changes regarding the type of thermometer used to monitor temperatures in the medicines fridge. We saw a new thermometer was in use when we visited.



# Is the service effective?

## Our findings

People who used the service were positive about staff and the quality of care provided. One person who used the service told us, "Everything about the place is excellent, the food, the staff." Another person said, "The staff are very good and competent. I feel very fortunate to be here." Comments from relatives included, ""[Name] couldn't be in a better place," and, "I feel very comfortable with the staff, and with [Name] being here."

People's needs and choices were assessed before they were admitted so people could be confident their needs could be met before they moved in to RNIB-Tate House. Assessments included reference to any additional support people might require. For example, records showed people had been referred to the local vision support centre. Specialist advice was also available through RNIB including counselling services for people with failing eyesight to help them prepare and deal with a life changing experience. Staff told us they currently had 10 people who were due to be assessed with a view to helping them maintain or develop their skills.

Assessments included information regarding people's choices about their identified care needs. For example, one person had hearing loss. They had decided not to wear hearing aids or attend an audiology clinic and staff respected this.

Staff and volunteers had access to appropriate training and support so they had the skills and knowledge they needed to support people including people living with sight loss. Staff told us they received good training and support through a mix of online learning using a computer, classroom and practical face to face training. One staff member told us the visual awareness training they completed had provided them with practical skills they needed to fulfil their role effectively. We saw these skills used to good effect throughout the day in the way staff and volunteers carried out their work. A new member of staff told us their induction had been good and the registered manager and deputy had been helpful and supportive. They said, "The team ethic here is good, there is an open friendly environment."

A role of staff 'champions' for specific areas such as infection control, safeguarding, moving and handling, and palliative care had been introduced. This was so staff who had a particular area of interest or expertise could share best practice and professional ideas. A care supervisor who had been appointed as a champion told us their role was at an early stage of development and they were not entirely sure what it involved as yet.

Staff assessed people's nutritional needs and their food preferences were recorded and met. Nutritional risk was identified and referrals made to the speech and language therapy (SALT) team and GP when needed. Additional monitoring and checks were being carried out for people who had low weight or had lost weight and progress was recorded and discussed at the handover meeting we attended.

People told us the food was of a good quality although some said meals could be served later. We saw the quality of food provided and mealtimes were discussed at 'residents' meetings' and action taken was

reported back, together with survey results, through meetings and displayed on a 'You asked; We did' board.

We observed lunch and sampled some of the food served, which overall was tasty and well cooked. The meal time was a pleasant social occasion and staff support was offered discreetly and promptly where required.

People told us they had access to healthcare services such as GPs, Dentists and Chiropodists. Relatives told us they had no concerns regarding people's access to healthcare. A relative told us communication between staff and family was very good and they were always kept informed if the GP was contacted. People could choose to attend the GP surgery or see the GP when they visited the service. A visiting healthcare professional told us they had a "Good rapport" with staff. They said staff contacted them for professional advice when needed and staff always acted upon any advice given to them.

Although some aspects of the premises were tired and dated the environment was well laid out for people living with sight loss. The facilities manager told us adaptations had been made in line with the RNIB 'Visibly better' accreditation scheme to maximise people's independence, confidence and safety.

There were clear contrasts between walls, floors, work surfaces, crockery and equipment and specialist lighting fitted to communal areas such as in corridors and the dining room. Corridors had different floor textures where corridors joined and all handrails and lights switches were in contrasting colours. The lift had braille buttons and a voice to identify the floor (we sometimes call this a 'talking lift'). In people's rooms their bedding was in plain colours not strong patterns so that people could locate missing items more easily and wardrobes had open panels to make people's clothing accessible. Bedroom doors had large clear numbers, raised for ease of identification using touch. The gardens were well laid out with handrails and seating. There were several small gardens rather than one large one, making it easier to get around without becoming disorientated.

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. People's capacity was considered as part of the assessment process and consent policy agreed regarding personal care requirements, medical intervention, religious and cultural requirements, nutrition, environment, use of moving and handling and use of photographs. People's files included their preferred wishes and details of anyone with lasting power of attorney for health and welfare and financial affairs, together with information regarding people's preferred wishes regarding religious and funeral arrangements.

Staff completed training on MCA and DoLS. We saw staff introduced themselves and checked out people's preferences with them before they completed any tasks. People told us staff supported them to make their own choices and decisions regarding their daily routines. One person said, "I have great freedom here. I don't like communal activities so I don't join in but I have my music and my DAISY reader." A DAISY or digital

accessible information system assists people who have problems using regular printed material.

## Is the service caring?

### Our findings

Warm, caring relationships existed between people who used the service, relatives and staff. Examples of quotes we received from people who used the service included in terms of care provided, "Excellent," "Couldn't be better," and, "I feel safe and at peace here."

We saw numerous examples of positive interactions between people who used the service and staff throughout our inspection. Staff spoke to people in a friendly and respectful way. Staff used the person's name when speaking so they would know they were being addressed, they introduced themselves and told people where they were standing in relation to the person and when they were moving away or leaving the room. Staff took great care to make sure people knew where their food and drinks were located so they could eat and drink independently. Staff were kind and patient and they responded promptly and willingly when support was requested. Regarding staff people's comments included, "They are obliging and helpful," "They make life as easy as possible" and, "They are not pushy." One person described staff as, "Sympathetic and helpful even in small things."

People who used the service looked clean and well dressed in comfortable clothes. People told us they could make their own hairdressing arrangements or a hairdresser attended fortnightly and a manicurist weekly. One person told us, "I am very happy here. I wouldn't want to be anywhere else." Another person commented, "I am very satisfied. They [Staff] are obliging and willing in every way." Another person simply said, "It's lovely here."

Visitors confirmed they were always made welcome at any time and were invited to participate in any celebrations or events.

People were involved in decision making such as the choice of minibus and were asked to feedback on issues such as accessibility from their perspective. Care records included details about people's history, lifestyle choices and care preferences. For example, "I wish to be involved in all decision making and to be as independent as possible. I wish my daughter to be involved in all changes in my health and the outcomes of my appointments." Care plans also documented family involvement. For example, one relative told us they still liked to take their family member's personal clothing home to wash and appreciated being able to do this. We were told another family used to visit during the evening to make sure their loved one was in bed and settled for the night.

Staff were knowledgeable about the people they supported and were respectful about people's privacy, dignity and choices. People's care plans were kept under review, updated regularly and any changes were discussed at handover meetings. This ensured essential information was passed to new staff on shift so people received consistent care that met their needs and care preferences. This happened at the handover meeting we attended when one person requested their care plan was updated to request a female member of staff.

Not all people living at the service knew what was in their care plan although they confirmed staff asked

them about their care requirements. Most people told us they thought staff probably made a record of what was discussed. One person said their family dealt with paperwork on their behalf and at their request.

People could access advocacy services to help resolve issues or concerns when needed.

## Is the service responsive?

### Our findings

People's care plans were well written, clear and easy to understand and follow. Those written for people's daily routines and activities of living were exceptionally detailed and person centred. Care plans included good detail regarding the level of care people had requested and focused on solutions to maximise people's independence, choice and control. Care plans covered in detail the things people said were important to them including how they liked to dress, their religious and cultural needs and any care at night. For example, one person's care plan included 'I would like hourly checks through the night. Please offer me a cup of tea if awake'. Changes to care were discussed and agreed with the person and relatives when appropriate.

People's social and leisure needs were well catered for. There was an activities organiser who organised activities, together with a group of volunteers. No pressure was placed on people to participate in group activities and several people told us they preferred to spend time on their own but needed support to go out shopping. Other people told us they enjoyed the activities on offer. Communal areas contained TV, audio books, DVDs and CDs. People also had their own TVs and radios in their bedrooms.

The RNIB and the library supplied books and a volunteer read a local newspaper aloud daily. When we visited a volunteer was assisting a group of people to complete a crossword puzzle. People told us they had games and puzzles, an exercise class, a knitting group, church services and card games and staff organised regular outings to local attractions. People could also participate in RNIB clubs such as the music club if they wished. Although no one currently belonged to the music club a visitor helped one person on a one to one basis taking them through new pieces of music to enable them to play independently.

Facilities and events at RNIB-Tate House were opened to community groups. For example, a local Quaker meeting was held at the home. A care supervisor told us people were encouraged to see RNIB-Tate House as their home and to do as they would do at home. They said one person went out each evening and picked flowers for their room. Another person had arranged for their bridge club to meet at the service.

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard ensures people with a disability, impairment or sensory loss are given information they can understand, and the communication support they need. Care plans included a communication profile to identify people's communication needs and guided staff on how these were to be met.

The provider had a complaints policy and procedure in place. We checked two complaints records and these showed the complaints had been investigated and responded to in a timely way. No one we spoke with said they had raised a complaint. People said they were asked for their views and would speak with the registered manager or their allocated carer if they had any issues or concerns and were confident action would be taken were they to do so. One person told us they had requested a change of allocated staff (keyworker) and another care worker had been assigned to them straightaway, which was very successful. They said, "[Name of staff] is a real friend to me."

We looked at thank you cards families had sent, which included such comments as 'thank you for all the

care and love you gave [name]', 'thank you for all the love, care and attention you gave [name], over the years [they were] with you', and 'I don't know how to start to say thank you for all that you did for [name], and the way you looked after the whole family.

Palliative care plans were completed and these included people's future wishes regarding their end of life care and support. When we visited no one was receiving end of life care. We discussed the importance of developing on the existing plans when needed to make sure end of life care support plans contained the same level of detail and were as personalised as other care plans in place.

## Is the service well-led?

### Our findings

There was a clear management structure in place. People who used the service, relatives and staff knew the registered manager and could raise issues with them. Care staff told us there was a good team ethic, with an open friendly environment. One staff member told us, "Great relationship with [Name of registered manager and deputy]. They have the interests of the residents at heart." The volunteers we spoke with felt they were supported and appreciated. For example, two volunteers had attended a Buckingham Palace Garden Party, in recognition of their work at RNIB-Tate House.

In their PIR the provider told us the organisational strategy, values and behaviours were clear and provided a framework for staff around making everyday lives better for people with sight loss. People had support from the local vision support centre, which included an introduction to technology if needed. The RNIB national team also provided individual assessments and advice on environmental adaptations, technological advances and counselling services. People told us they spoke to each other and accessed websites for support. One person told us, "Things have changed greatly. My friends help me out if there is anything new about technology I need to know otherwise I check the 'web' for advice."

People using the service spoke positively about local managers and staff; they said they felt they were listened to and their views were acted upon. People were less sure about their role in influencing service development more widely in RNIB. No one for example could recall meeting with senior managers from the organisation and being asked about the care they received or how they might influence change at a strategic level.

People confirmed they could attend meetings at the service and were invited to give feedback through questionnaires. The results of the survey were on display in the form of 'You asked' and 'We did'. One example was the change to newspapers at people's request. Day to day issues were effectively shared between staff at handovers on every shift change and discussed at staff meetings.

The provider had obtained external advice and support from a quality assurance consultant who visited six monthly and produced a report. This gave the provider an oversight of the quality and safety of the service. Managers completed audits on a range of topics such as falls, accidents and incidents, medicines and care plans and the registered manager and deputy periodically checked these. Identified shortfalls from these checks and audits formed part of the continuous improvement plan. This contained a summary of the issue, together with the name of the staff member responsible for action, target date and progress. The registered manager told us they could seek further advice from other departments as needed such as human resources, learning and development, and health and safety. The registered manager and deputy met regularly with managers from other services to share good practice and professional ideas.

The registered manager had notified CQC appropriately of incidents in the service.

Staff encouraged people to maintain and develop existing community links and had made facilities available so people could host meetings at the service. The activity organiser attended a project advisory



group on isolation and loneliness for people with sight loss. Relatives spoke positively about staff attitude and approach.

The registered manager and staff had also developed good professional relationships with health and social care professionals. This was confirmed in feedback from external professionals.