RNIB Charity

Wavertree House

Inspection report

Somerhill Road, Hove, East Sussex,
BN3 1RN
Tel: 01273 262200

Date of inspection visit: 1 & 2 June 2015
Date of publication: 20/07/2015

Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

We inspected Wavertree House on the 1 and 2 June 2015 and was unannounced. Wavertree House is a residential care home providing care and support for up to 36 people. On both days of the inspection 31 people were living at the home. Wavertree House is designed to provide care and support for people living with eye sight loss. Most people living at Wavertree House were living with various degrees of vision impairment. Support was also provided to people living with dementia, diabetes and epilepsy. The age range of people living at the home varied from 50 – 100 years old.

The home was adapted to provide a safe environment for people living there. Flooring was a different colour and texture to help orient people to a slope, steps and lift. Hallways and corridors were free from equipment and wide enough so people could move freely around the building.

Accommodation was provided over three floors with a lift and stairs connecting all floors. Each person living at the home had their own flat which enabled people to feel in control of their day to day living and retain as much independence as possible.

Wavertree House belongs to the provider RNIB which is a national charity. The history of RNIB dates back to 1868 when Dr Armitage founded the British and Foreign Society for Improving Embossed Literature for the Blind.

Summary of findings

In 1902, the organisation was renamed the British and Foreign Blind Association and, after receiving a Royal Charter, it became the Royal National Institute for the Blind in 1953.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Both people and staff felt staffing levels required improving. Staff members commented they didn't have sufficient time to sit and chat with people. One staff member commented, "We miss that time to sit and have a cup of tea with people." Formal mechanisms were not in place for determining staffing levels which demonstrated staffing levels were based on the individual need of the people. We have therefore identified this as an area of practice that needs improvement.

Care plans and risk assessments did not consistently reflect the good practice being undertaken by staff. Where people had been identified at risk of depression, experiencing mental health needs or had complex nutrition and health care needs, risk assessments failed to consider any triggers or how best to support the person to meet their care needs. We have therefore identified this as an area of practice that needs improvement.

Staff understood the principles of consent to care and treatment and respected people's right to refuse consent. However for people living with dementia, care plans failed to consider their ability to make decisions and what support they may require to make day to day decisions. Best interest decisions were being made before the completion of a mental capacity assessment. We have therefore identified this as an area of practice that needs improvement.

People had neutral comments regarding the quality and variety of food. The provider had experienced problems with sustaining a chef and therefore was in the process of contracting the kitchen out to an external agency. People felt improvements were being made and the registered manager was committed to the on-going work required to ensure people's expectations of the food improved.

People were supported to take their medicines as directed by their GP. Records showed that medicines were obtained, stored, administered and disposed of safely. However, adequate protocols for the use of 'as required' (PRN) medicines was not in place. We have therefore identified this as an area of practice that needs improvement.

People's privacy and dignity was respected and staff had a caring attitude towards people. We saw staff smiling and laughing with people and offering support. There was a good rapport between people and staff.

Staff received training on sight loss awareness. People commented they felt well supported in relation to their vision impairment and were supported to maintain eye health. Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. Staff had clear guidance about what they must do if they suspected abuse was taking place.

People spoke highly of the activities coordinators and the opportunities for social engagement. One visiting relative told us, "I love the way they have integrated Mum into the community here and I really love the activities they do here."

Staff were knowledgeable about people's health needs and knew how to respond if they observed a change in their well-being. Staff were kept up to date about people in their care by attending regular handovers at the beginning of each shift. The home was well supported by a range of health professionals.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Wavertree House was not consistently safe. Formal mechanisms for determining staffing levels were not in place and people and staff felt staffing levels required improving.

People received their medicines on time, however, for people who received 'as required' medicines (PRN), adequate protocols were not in place for the administration of 'as required' medicines. Risk assessments did not always document the measures required to keep people safe.

People told us they felt safe living at Wavertree House and staff were aware of the measures to keep people safe. Recruitment systems were in place to ensure staff were suitable to work with people.

Is the service effective?

Requires improvement

Wavertree House was not consistently effective. Care plans failed to reflect the level of support people required with decision making. Best interest meetings were convened before the completion of a mental capacity assessment.

Care plans did not consistently reflect the management of people's nutritional and complex healthcare needs. Work was required to improve communication within the home.

Staff received on-going training to make sure they had the skills and knowledge to provide effective care to people. People could see, when needed, health and social care professionals.

Is the service caring?

Good

Wavertree House was caring. The home was designed to promote independence for people with a vision impairment.

People were supported by responsive and attentive staff who showed patience and compassion to the people they were supporting. Staff respected people's privacy. People were supported to express their views and wishes about all aspects of life in the home.

Staff knew the people they were caring for well and communicated with them sensitively.

Is the service responsive?

Good

Wavertree House was responsive. People received care and treatment that was responsive to their needs. Staff members recognised the psychological impact on people on losing their eye sight.

People were supported to take part in activities within and away from the home. People's religious needs were not overlooked and people received support within the home to meet their religious needs.

Summary of findings

People and their relatives felt confident approaching the registered manager with any concerns or queries.

Is the service well-led?

Good

Wavertree House was well led. Staff spoke positively about the registered manager and their leadership style.

There was an open and transparent culture within the service and the engagement and involvement of staff and people was encouraged by and used to drive improvements.

There were a range of systems in place to assess and monitor the quality and safety of the service and to ensure that people were receiving the best possible support.

Wavertree 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 checked 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 home, and to provide a rating for the home under the Care Act 2014.

We visited the home on the 1 and 2 June 2015.

This was an unannounced inspection. The inspection team consisted of two inspectors and an Expert by Experience who had experience of visual impairment. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection, we spoke with 13 people who lived at the home, three visiting relatives, five staff members, activities coordinator, chef and the registered manager. Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority, looked at safeguarding concerns that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home.

Before the inspection, the provider completed a Provider Information return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We utilised the PIR to help us focus on specific areas of practice during the inspection. Wavertree House was last inspected in October 2014 where we had no concerns.

During the inspection we reviewed the records of the home. These included staff training records and procedures, audits, five staff files along with information in regards to the upkeep of the premises. We also looked at seven care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at Wavertree House. This is when we looked at their care documentation in depth and obtained their views on how they found living at Wavertree House. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Requires improvement

Is the service safe?

Our findings

People told us they considered themselves to be safe living at Wavertree House, the care was correct and the environment was safe and suitable. One person told us, "Whenever I have pressed my emergency bell, staff have rushed over." Visiting relatives confirmed they felt confident leaving their loved ones in the care of Wavertree House. However, concerns were raised by people over the adequacy of staffing levels. We also identified areas of practice which were not consistently safe.

Feedback from people and staff was that staffing levels required addressing. One member of staff told us, "Staffing is tight, especially around meals times and medicines rounds." Another member of staff told us, "We don't have sufficient staffing." A consistent theme when talking to people was that staffing levels required improved. Although people confirmed if they pressed their emergency bell staff responded in a timely manner, people felt staff lacked the time to sit and have a chat or a cup of tea with them in their flat. Staff members also commented that for them, the lack of staff meant they did not have the time to spend individually with people.

Staffing levels consisted of four staff members in the morning and one supervisor, three in the afternoon and one supervisor, two waking night staff and one sleeping staff member. The registered manager and deputy manager provided support throughout the day and on-call support at night. The registered manager told us, "Staffing levels have increased this week; we increased our morning shift from three staff to four staff members. Hopefully this will have a positive impact."

The registered manager acknowledged that staffing levels had been discussed at staff meetings and it had been brought to management's attention that people and staff felt staffing numbers were insufficient. The registered manager identified that staffing levels were calculated on an informal basis and a formal system for determining how many staff were required to safely meet the needs of people was not in place. The registered manager told us, "We work on a ratio of one to seven. We assess people's needs individually and from this would increase or decrease staffing numbers dependent upon people's individual needs. However, this is not formally calculated or documented."

Throughout the inspection, our observations found that staff were often busy. At lunchtime, people were brought to the dining room at 12.00pm but not served their meal until 12.30 or 12.35pm. One person told us, "They're very kind to bring me to the dining room, but the only way for them to be organised is to bring some people very early and it's a long wait." People received the care they required and needed, the impact of the staffing levels meant staff members did not always have the time to spend with people on a one to one basis and staff members commented they could feel rushed. It was also identified by the inspection team that people were waiting in the dining room a significant time before being served there lunchtime meal. This is not a breach of regulation but we have identified this as an area of practice that needs improvement.

Mechanisms were in place for people to self-medicate which included self-medicating risk assessments. The provider worked in partnership with the local pharmacy to ensure people received a blister pack which was easy for them to navigate in line with their vision impairment. For example, large print was made available on the blister pack so people could easily identify what medicine needed to be taken and when. For people who preferred staff to provide support with their medicine regime, people expressed confidence in the skills of staff.

The medicine storage arrangements were appropriate. These included a drugs trolley and suitable medicines storage cupboards. Only trained staff administered medicines individually from the medicines trolley and completed the MAR chart (Medication Administration Record) once the medicine had been administered safely. Staff were professional in their approach checking that each person wanted to receive their medicine and preserved the dignity and privacy of the individual. For example, staff discreetly asked people sitting in communal areas if they were happy taking their medicines there.

At the beginning of each shift, supervisors check the MAR charts to check for any omissions or errors in the administration of medicines. Where errors had occurred, for example a person being administered the wrong medicine, mechanisms were in place to address the omission and ascertain what had happened. Following any omissions, the registered manager and deputy manager completed investigations and staff members received competency checks on the administration of medicines.

Requires improvement

Is the service safe?

Once assessed as competent and safe to administer medicines again, staff members would be reinstated to administer medicines. One staff member told us, "We have a good system of monitoring and identifying any medicine errors to ensure no harm occurs to the residents."

Some medicines were 'as required' (PRN) medicines. People took these medicines only if they needed them, for example, if they were experiencing pain. Individual guidelines for the administration of PRN medicines were not detailed enough to ensure staff gave them in a consistent way. PRN protocols were in place which provided information on the purpose of the medicine and when to be administered. However, information was not available on whether the person was able to inform staff members if they were in pain. For people living with dementia, they may not consistently be able to verbalise to staff if they are in pain, however, PRN protocols did not consider this or identify any behaviours which the person may display if they experienced any pain. MAR charts reflected people received PRN pain relief on a regular basis and staff members confirmed they had sufficient understanding of people's needs to know if they were experiencing and pain or discomfort. We have therefore identified this as an area of practice that needs improvement.

A positive approach to risk taking was fostered by the organisation and staff. One staff member told us, "People are living with sight loss, does not mean they cannot take risks and be independent." The design of Wavertree House meant that each person had their own flat which included a kitchen, bathroom and bedroom/living space. Many people commented that moving into Wavertree House was made easier due to having their own flat and the feeling of retaining some control and independence. Throughout the inspection, we saw people freely coming and going, people went out shopping independently and people were encouraged to spend the day as they so choose. The registered manager told us, "We orient people to the building and build on their skills and abilities to help them be independent and take every day risks." One person told us how they enjoyed being able to cook within their own flat and when required, staff provided support.

Risks to people were assessed and risk assessments developed. These included mobility, mental health, manual handling, food preparation and cooking. Risk assessments considered the level of risk and the actions required to minimise the risk of any harm. However, where people had been identified as experiencing depression or mental health needs. Their risk assessments failed to identify the triggers or record the management plan on how to meet and support the person with their mental health needs. One person's care plan reflected they had been feeling low in mood and it was felt the individual was suffering with depression. However, the risk assessment for mental health failed to reflect this and recorded, 'showing no signs of mental health issues'. Staff members had a firm understanding of the person's needs. One staff member told us, "We have been working with the person and exploring how we can improve their mood." Recording on the risk assessment failed to reflect the good practice being undertaken by staff. We have therefore identified this as an area of practice that needs improvement.

Staff recruitment was managed safely and effectively. The provider carried out staff recruitment checks, such as obtaining references from previous employers and verifying people's identity and right to work. Necessary vetting checks had been carried out though the Government Home Office and Disclosure and Barring Service (DBS.) These checks identified if prospective staff had a criminal record or were barred from working with children or people at risk. We reviewed staff records and found that they included completion of an application form, a formal interview, two valid references, personal identity checks and a DBS check.

Staff received training on safeguarding adults. Staff and records confirmed this, staff knew who to contact if they needed to report abuse. They gave us examples of poor or potentially abusive care they may come across working with people at risk. They talked about the steps they would take to respond to allegations or suspicions of abuse. Staff clearly recognised that any form of abuse was not to be tolerated. One staff member told us, "People have the right to be safe and free from abuse." Staff were confident any abuse or poor care practice would be quickly identified and addressed immediately by any of the management team. In the absence of the management team, staff were aware of their own responsibilities under the Care Act 2014 to raise a safeguarding concern with the local safeguarding team.

Systems were in place for the monitoring of health and safety to ensure the safety of people, visitors and staff. For example, weekly fire alarm tests, weekly water temperature

Requires improvement

Is the service safe?

tests and regular fire drills were taking place to ensure that people and staff knew what action to take in the event of a fire. Gas, electrical, legionella and fire safety certificates were in place and renewed as required to ensure the premises remained safe. On-going work to the premises was required and the registered manager acknowledged that the aspects of the premises and décor had been neglected. For example, water damage was identified by windows, cracks in the wall were also observed. A five year maintenance plan was in place which had identified concerns with the interior and exterior of the premises along with recommendations and an action plan. The registered manager told us, “We are keen to make improvements to the actual premises and décor of the home, especially the corridors.”

Requires improvement

Is the service effective?

Our findings

People and their relatives expressed confidence in the skills of staff members. One person told us, "Staff are excellent here. I have found them so hard working and they are a great support to me." Another person told us how pleased they were with the level of support they received surrounding their sight loss. People raised concerns regarding the quality of food but expressed they felt improvements were being made but this had been an on-going issue. The inspection team identified areas of good practice but also areas that need improvement.

Wavertree House provided care and treatment to people living with dementia. To provide safe and effective dementia care, an understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) was required. The MCA 2005 is a person centred safeguard to protect the human rights of people. It provides a legal framework to empower and protect people who may lack capacity to make certain decisions for themselves. Staff observed the key principles of the MCA in their day to day work. Staff members understood the importance of gaining consent from people before providing any care. Spoke clearly and gently and waited for responses. One staff member told us, "We always ask people, give them choices and respect their right to refuse care." Staff members understood that the MCA 2005 was decision specific and that for people living with dementia they may require additional support to enable them to make an informed decision.

For people living with dementia, consideration is required as to what decisions they may require support with. Care plans failed to demonstrate what level of support was required to enable people living with dementia to make informed decisions. Information was also not available on how the person experienced their dementia, or how their dementia affected their day to day routine. Some people were living with dementia but who also had no vision. Their care plans failed to reflect the impact of living with dementia and sight loss and also how this affected their decision making ability. We asked staff members how they gained consent from people living with dementia, sight impairment and communication difficulties. One staff member told us, "One person's body language will tell us if they are unhappy or want us to stop." Another staff member told us, "One person can't tell us what they want to eat, but if they don't eat what it is offered, it's there way of saying, they don't like it." Care plans failed to reference the good level of knowledge and understanding held by staff. We have therefore identified this as an area of practice that needs improvement.

The Deprivation of Liberty Safeguards are an integral part of the MCA 2005. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a person is only deprived of their liberty in a safe and correct way. On the day of the inspection one person was subject to a deprivation of liberty safeguard and the registered manager had submitted a further four applications. Staff had a firm understanding who was subject to a deprivation safeguard and what it meant for the individual. One staff member told us, "It allows us to keep residents safe but it must be a least restrictive manner."

The registered manager and deputy manager were working in partnership with other healthcare professionals to ensure the delivery of care was in the best interest of people and meeting their needs. Minutes of best interests meetings held were available however copies of the mental capacity assessment were not available. A best interest meeting can only be held if it is deemed that the person lacks capacity to make a specific decision. The registered manager acknowledged that a mental capacity assessment had not yet been undertaken despite a best interest meeting being held and acknowledged that one would be undertaken the following day. We have therefore identified this as an area of practice that needs improvement.

The registered manager told us, "Retaining a full time chef has been problematic, therefore we are contracting our kitchen out to an external company, we hope to have this completed in the next six to eight weeks." In the interim, agency chefs were employed. The same agency chef was used throughout the week and the provider tried to ensure the same agency chef at weekends. The registered manager acknowledged that due to the high use of agency chefs, there had been on-going concerns regarding the quality and variety of food. Recently a scenario occurred whereby the agency chef at the weekend had not been informed to make homemade soup for people in the evening; this consequently meant this suppertime option was not available for people. People told us that scenarios

Is the service effective?

like this had occurred previously but felt things were improving. The registered manager and staff recognised this on-going issue and expressed a commitment to the on-going work required.

People had neutral comments about the quality and variety of food. One person told us, "It could be more varied but it's definitely getting better." Another person told us, "It's quite average."

We spent time observing lunchtime in the communal dining room. Thought and consideration had gone into making the lunchtime meal a pleasurable and social experience for all. Tables were laid with table cloths and table matts. Both were a contrasting colour to help people visually recognise where their plate was. The lighting within the dining room was of a setting to help maximise people's vision. People sat with groups of friends or with another person whom they got along with. People were observed chatting, interacting and laughing with one another. Cutlery was of a good standard and condiments were available so people could flavour the food the way they liked. People were supported to make decisions on what they preferred to eat and two options were made available to people.

Staff members brought out people's meals individually. Staff clearly explained to the person what they had and explained where things were on the plate (for those who required this). Adapted cutlery was made available to people to promote their independence. People were encouraged to be independent throughout the meal and staff were available if people wanted support, extra food or drinks. There was lots of chatter and laughter during lunch time and people enjoyed a sociable experience whilst having their meal. Records showed that people's weight was monitored and where risks were identified the GP had been contacted. Where food and fluid charts were required to monitor people's nutrition and hydration these were complete.

People's care plan included information on any dietary requirements such as soft diet, pureed diet or whether the person was diabetic and this information was recorded clearly in the kitchen for chefs on duty. For people with diabetes, information was available whether it was type one or type two but information was not readily available on the signs and symptoms of low and high blood sugars. Poor management of blood sugars can cause people to fall, affect the functioning of the kidneys and cause pressure ulcers. Staff members had an understanding of the signs and symptoms and what to look out for. One staff member told us, "If someone is dizzy that can be an indicator of low blood sugar." However, care plans failed to reflect this level of knowledge held by staff members. We have therefore identified this as an area of practice that needs improvement.

Wavertree House was providing care and support to people with very complex nutrition and healthcare needs. Some people required support to manage their vision impairment, diabetes, and mental health care needs. Care plans failed to consistently demonstrate the impact of the person's nutritional needs on their healthcare needs. One person had gained weight since moving into Wavertree House, they were also not consistently following a diabetic diet but due to their mental health needs they did not always understand the associated risks. The care plan failed to recognise and identify strategies to recognise the risks associated with weight gain on diabetes alongside the impact on the person's eye sight if the diabetes was not managed effectively. The registered manager told us, "We have been working with the person on a healthy eating plan but sometimes they wish not to follow the plan." Staff had been working in partnership with other healthcare professionals to effectively manage the person's needs but the care plan failed to recognise the impact of the person's nutritional needs on their healthcare needs. We have therefore identified this as an area of practice that needs improvement.

For people living with complex healthcare needs which also affected their swallowing and nutritional needs, some people felt their healthcare conditions were not fully understood by staff. One person told us, "People don't understand what my needs are as a result of my condition." Information was readily available in the person's care plan but the registered manager acknowledged further work was required to ensure all staff members understood people's healthcare needs and for staff to understand what it must be like living with such complex care needs.

We recommend that the service considers the Social Care Institute for Excellence: Better Life for older people with high support needs: the role of social care.

Staff members recognised the importance of open communication in promoting people's health and wellbeing. Staff explained how they handed over key information to staff coming in on the next shift, so that staff

Requires improvement

Is the service effective?

were kept up to date with changes to people's health. As staff recognised the importance of communication, staff members informed us of the lack of communication between staff and the activities coordinators. One member of staff told us, "It feels like were separate teams when we shouldn't be." This was also felt by the activities coordinators, who felt isolated from the whole team. One activity coordinator told us, "There was a staff meeting recently which we weren't aware of." The registered manager acknowledged the divide and agreed work was required to ensure the staff team include activities coordinator. We have therefore identified this as an area of practice that needs improvement.

Effective management of people's healthcare needs means people can live long healthy, autonomous and fulfilling lives. For people living with vision impairment eye health is a crucial determinant of quality of life. Staff members recognised that for people living with sight loss, reducing deterioration was imperative. One staff member told us, "Eye drops are an integral part of the management of people's healthcare needs. Only trained staff can administer eye drops." Another member of staff told us, "We have some people who have to have their eye drops at set times and it's important we administer those then." Staff received visions awareness training on their induction. This provided them with the tools to provide effective care which understands the needs of people with vision impairment. One member of staff told us, "We use touch and always introduce ourselves when talking to someone. This interaction was observed throughout the inspection.

People felt their healthcare needs were managed and maintained. One person told us, "They are good at contacting the district nurses and chasing prescriptions." Another person told us, "They always come to appointments with us if we wish." Staff worked in partnership with external healthcare professionals to promote and maintain people's healthcare needs. Healthcare professionals included dieticians, tissue viability nurses and speech and language therapists. People confirmed that if they felt unwell staff acted promptly and sought medical attention. Visiting relatives confirmed they were kept updated with any changes to their loved ones healthcare needs.

People's needs were met by staff that were effectively supervised. Staff said that they had participated in 'supervision' meetings and that the senior staff and registered manager were readily approachable for advice and guidance. Staff had their work performance regularly appraised at regular intervals throughout the year by the registered manager and deputy manager. One staff member told us, "We have supervision every month and its really useful and a good time to discuss the residents and any concerns."

Staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support the needs of older people, people living with dementia and people with a vision impairment. The provider had an on-going schedule of essential training for staff. Training was provided in-house through e-learning and the registered manager regularly encouraged staff to attend training provided by the local council. Staff spoke positively of the training opportunities and felt valued as employees. One staff member told us, "I really like that I get to choose what training I feel I need to do. I have just booked on to do the dementia and pressure awareness training provided by the council." The registered manager encouraged staff to progress with their career and staff were offered the opportunities to obtaining a National Vocational Qualification (NVQ (now care diploma). The registered manager demonstrated a strong understanding of the importance of having a skilled, confident and experienced workforce.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. People gave very complimentary feedback about the caring nature of the staff. One person told us, “They treat me with respect. They are very helpful.” Another person told us, “Can't fault the staff. They are so kind.”

The atmosphere in the home was calm and relaxing. Considerable thought had gone into making the home caring in nature and promoting the needs of people with a visual impairment. Flooring throughout the home was designed to orient people. For example, the texture of the flooring changed to help people feel when they were approaching a slope or steps. Different colour flooring was used to help people identify where the lift was and create a pathway to help orient people to the dining room. Signage was used throughout the home with braille as well to help empower and enable people. Bannisters were painted a different colour to the walls to help people identify something to hold onto when walking along the corridors. One member of staff told us, “The home is designed to help people retain their independence.”

There was a strong ethos of promoting people’s independence. One visiting relative told us, “My mum has suddenly recovered the confidence to be independent again since she has joined the home.” Staff members clearly recognised the limitations of each person and empowered people to be as independent as possible within their limitations. One staff member told us, “We know what each resident can and can’t do and we always try and support them to do as much for themselves as possible.” One person told us, “I can do a lot for myself but I know staff are there for when I can no longer do it.” The lighting in each individual flat had been considered and assessed what lighting was required to maximise the vision for the person. Where required, specific light bulbs were sourced for people which maximised their vision and subsequently their level of independence.

Friendships between people had blossomed while living at Wavertree House. Throughout the inspection, people were seen sitting interacting together. Laughter was heard throughout the inspection and at lunchtime, people were observed sitting in groups with people with whom they had developed friendships. Two ladies were seen walking arm in arm along the corridors while one gentleman and lady were observed going for tea in the afternoon in one of their flats.

People were encouraged to treat their flat as their own space. People were encouraged to bring items into the flat which enabled them to personalise the flat. We saw evidence of this in people’s bedrooms, with items of personal value on display, such as photographs and items of furniture. With pride, one person spent time showing us which furniture they had brought with them and what they liked about their flat.

Approximately ten years ago, a stray cat arrived at Wavertree House. People at the time asked if no one claimed the cat, could they keep the cat. 10 years later, the cat still resides at Wavertree House. People spoke positively of having a cat around to stroke and pet. Throughout the inspection, the cat was seen coming in and out of people’s flat and it was evident that people enjoyed the companionship and warmth the cat brought to Wavertree House.

People’s dignity and right to privacy was protected by care staff. People were assisted to their bedroom, bathroom, or toilet whenever they needed personal care that was inappropriate in a communal area. This support was discreetly managed by staff so that people were treated in a dignified way in front of others. Staff members also made sure that doors were kept closed when they attended to people’s personal care needs. People’s individuality was respected by staff members. Some ladies took great pride in their appearance. Wearing make-up, jewellery and clothing which reflected their lifestyle preference. This helped communicate to others a very clear sense of their values and priority to look after themselves.

Staff acted in a kind and caring manner throughout our inspection. It was clear staff had spent considerable time building rapports with people, getting to know their likes, dislikes and personality traits. One member of staff told us, “I love my job and the people living here.” When talking to people staff directed their attention to the person they were engaging with and not being distracted or talking unnecessarily with someone else in their vicinity. They used the person’s preferred name, maintained eye contact and people responded to staff with smiles. One person told us, “Life is perfect here. The staff are very good.”

Good

Is the service caring?

People were consulted about the care and treatment they received and what they wanted to do. People told us they felt involved in their care and could always approach staff or the management team with any questions. One person told us, "I am aware of my care plan. If I am anxious, they spare time to talk issues through with me." Another person told us, "I am always being consulted. I am very much in control." One staff member told us, "We spend time with people and due to their vision impairment, we often read the care plan to the person to make sure they feel involved and are happy with it." Relatives were also provided with opportunities to read their loved one's care plan (with permission from the person) and make any further remarks or comments. Relatives said they were always informed about their loved one's changes or updates.

Relatives told us they were free to visit and keep in contact with their family members. They said they were made to welcome when they visited. Throughout the inspection, we saw relatives coming and going, spending time with their loved ones in the communal areas or the person's own flat. Staff also provided support to people to maintain contact with their loved ones. When required, staff assisted people to use the telephone in their flat to phone relatives. One member of staff told us, "We are looking at getting an iPad for one person so they can Skype their relative."

Good

Is the service responsive?

Our findings

People spoke positively about the opportunities for social engagement and the activities offered. People spoke positively of a recent trip to the veterans VE day evening dance, where they danced the evening away. One visiting relative told us, "I love the way they have integrated Mum into the community here and I really love the activities they do here."

The provider employed two activities coordinators. Between the two of them, activities and opportunities for social engagement were offered seven days a week. A weekly timetable was displayed throughout the home and delivered to each person (in large print). The activities coordinator told us, "Some things are fixtures. For example, seated exercise morning and a tactile craft group. Changes are made to programme to suit weather or residents' wishes, especially substituting outdoor activities for indoor in event of good weather, such as walks to local park or seafront, or groups in summerhouse." People spoke positively of the activities coordinators. One person told us, "They are very good at organising trips for us." The registered manager told us, "Later this week we are taking some people to Buckingham palace to attend a garden party."

Wavertree House had a real focus and emphasis on organising trips out for people. The activities coordinator told us, "Regular trips are also a good way of retaining and promoting people's independence." A fortnightly shopping trip was offer and in the intervening weeks, trips to the country side, garden centres and other places of interest were offered. Twice a year, they held a holiday week, whereby day trips out or bbqs are held every day. People commented that the holiday week provided to be popular and they enjoyed the atmosphere of the home during holiday week.

People and activities coordinator commented that crosswords and quizzes are both very popular. The home linked with another local care home for competitive quizzing and the registered manager commented that it does get very competitive. The activities coordinators expressed a commitment to involving people in the organising and running of activities as much as possible.

The activities coordinator told us, "We have seated exercise classes which have been developed to include music; we have one person with relevant experience who now sources the music for us."

Activities coordinators recognised that not everyone wished to engage with group activities and some people preferred one to one activities. The activities coordinator told us, "We see everyone on a one to one basis at the weekend and talk about what activities they may like to do." For people living with dementia, work was being undertaken to ensure meaningful activities are available. Keeping occupied and stimulated can improve quality of life for the person with dementia. One person's passion was listening to a certain radio station. When the inspection team visited the person in their flat, they were sitting listening to the radio which had been put on by staff. The registered manager told us, "We have organised for our activities coordinators to attend dementia training and promote further meaningful activities."

On the day of the inspection, a game of indoor bowls took place. People taking part were seen to be enjoying the game and it had generated a range of conversations between people taking part. The activity coordinator provided support to each person individually when throwing the ball, whether to throw it more to their left or right to enable them to hit the target.

Staff members were responsive to the individual needs of people. Staff recognised the psychological impact sight loss had on people and encouraged people to liaise with the RNIB helpline to receive additional emotional support. One staff member told us, "We have some younger people living here and we always try and promote their quality of life." Where people were identified as spending considerable amounts of time in their rooms, staff spent time trying to ascertain what could be done to prevent social isolation or ensure their social needs are met in their flat. Staff members spoke positively about the use of the geriatric depression scale tool. The geriatric depression scale is a screening tool to help identify depression. Where staff members had concerns over someone's low mood, the scale was implemented and helped staff work with the person to implement an action plan and ascertain the person's feelings and wishes. One person had expressed feeling low but felt being able to go out more when the weather improved would help them.

Good

Is the service responsive?

Staff recognised that people's religious needs should not be overlooked and people required on-going support to maintain their beliefs. Ministers, Reverends and Priests visited the home providing services for people who may not be able to attend the local service. Every Sunday, a handful of people walked to the local church together. One staff member told us, "We use to assist people to the local church but currently no one requires this level of support but if we needed would provide this support." End of life wishes were considered and reflected in each person's care plans. Consideration had been given as to what to do in the event of the person's health deteriorating and people expressed a preference to pass away at Wavertree House.

People and their relatives were provided with the information (in the appropriate form which included braille) they needed about what do if they had a complaint. People and relatives we spoke with confirmed they felt able to approach the management team with any concerns or queries and felt they would be responded to appropriately.

Since November 2014, Wavertree House had received 12 complaints. The complaints were primarily in regards to the provision and quality of food. Each complaint included a complaint form which incorporated the nature of the complaint, who made the complaint and the actions taken. Complaints were responded to in a timely manner and formal feedback was provided to the complainant. In light of honesty and transparency, where regular complaints were received regarding the same issues, the complaint was overseen by a separate person within the organisation to provide further clarity and resolution. A recent complaint was brought to the attention of the registered manager whereby a person felt distressed and their nutritional needs were not met. An investigation had taken place which included talking to the person concerned, talking to other people living at the home, catering staff and observations of the lunchtime meal. In light of the complaint, 22 recommendations were made to the home. These included a dedicated key-worker and additional lighting in the person's bedrooms to reduce the risk of falls.

Good

Is the service well-led?

Our findings

People commented on the leadership and management of the home. One person told us, "I just think that the manager and her team do a brilliant job." Another person told us, "The management team are very good."

The atmosphere at the home was calm and relaxed with a homely feel where people were supported to live the lives they wanted. The registered manager told us that their priority was to make every day better for people with sight loss. They demonstrated that that they knew the people who lived at the home well and their individual needs and preferences. Staff spoke positively of the leadership style of the registered manager confirming she held an open door policy and was approachable. One staff member told us, "I feel like I can approach the manager."

The registered manager recognised and understood the importance of an open and honest culture within the work place. The registered manager told us, "I feel that my leadership style as a registered manager is open and honest and I lead by example. For example, if something needs doing, I'll work with the staff as well." Consideration had been given to the Duty of Candour regulation which was introduced on the 1 April 2015 by the Care Quality Commission (CQC). Under this regulation, the CQC expects organisations to be open and honest when safety incidences occur. The provider had implemented a Duty of Candour policy and the registered manager understood their responsibilities under the regulation.

Engagement and involvement of staff and people was encouraged and their feedback was used to drive improvements. Staff and 'resident meetings' were held on a regular basis and were used as a forum to share ideas and discuss with staff and people changes or plans for the service. The last resident meeting was held in April 2015. People discussed ideas for the summer fete, victory dance and menu choices. Minutes from the last staff meeting held in April 2015 confirmed the Duty of Candour was discussed, MCA, DoLS, staffing levels and the Care Act 2014. Staff commented they found the forum of staff meetings helpful and felt they contributed to the running of the home.

The registered manager had a clear understanding of the challenges facing the service. They explained that in the medium term their objective was to make improvements to the premises and environment, enhance the activities and social opportunities available for the person using the service. They also added on how they wanted to improve links with local eye group and sign all staff up for the care certificate.

There were a range of systems in place to assess and monitor the quality and safety of the service and to ensure people were receiving the best possible support. The registered manager completed a monthly monitoring form which was sent to the provider at the end of each month. This considered the running of the home, looking at care plans, medication, fire safety, infection control, staffing, staff training and recruitment. Action plans were developed where needed and followed to address any issues identified during the monthly monitoring form. External audits were also completed by the provider, these included visits by the regional director, health and safety officer and monitoring officer. Action plans were generated and changes implemented following their visits. The registered manager told us, "Following a recent health and safety visit by the provider, it was identified that the kitchen needed a deep clean which we have now done."

The registered manager had sent us statutory notifications about important events at the home, in accordance with their legal obligations. The provider kept us regularly informed of the progress and outcome of investigations they completed when issues or concerns were raised.

Wavertree House belongs to the provider RNIB. RNIB is a leading charity for anyone affected by sight loss. The charity produces a five year strategy which governs the ethos and running of RNIB and RNIB care homes. RNIB is committed to 'making every day better for everyone affected by sight loss.' This philosophy was understood by staff members and embedded into the day to day delivery of care. One staff member told us, "We want to make every day better." Another staff member told us, "We have a five year strategy in place which we discuss at our appraisals." A set of values and behaviours were in place to help RNIB achieve their five strategy. These included deliver results, engage customers, engage others, set direction, lead and inspire and personal impact. The registered manager told us, "We use the forum of appraisals and supervisions to assess staff against the values and behaviours and support staff in continually demonstrating these behaviours."

Links with the community were promoted and strived for. Local school children visited the home every two weeks, spending time with people and engaging with activities.

Good

Is the service well-led?

One person told us, “I enjoy it when the children come and visit us, makes me feel young again.” Strong links with volunteers and volunteer groups were held. One staff member told us how Lloyds TBS group did some volunteering in the garden. The registered manager told us, “We feel it’s important to engage with volunteer groups. We recently had a group of young people volunteering in the garden and an insurance company also came and did some volunteering.” Seven volunteers had been recruited by the home to provide one to one support to people alongside group activities. Alongside the home’s volunteers, people received volunteers from a local blind association and the RNIB emotional helpline. There was a strong emphasis on the promotion of volunteers within the home and recognise the contribution volunteers bring and the level of support they provide for people.