Royal National Institute of Blind People

RNIB Wavertree House

Inspection report

Wavertree 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 comprehensive inspection took place on 9 October 2018 and was unannounced.

RNIB Wavertree 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 Wavertree House provides accommodation for up to 36 older people. On the day of our inspection there were 33 people living at the home. Wavertree House is a residential care home that provides support for older people living with sight problems, some of whom are living with dementia. Accommodation was arranged over three floors with stairs and two lifts connecting each level. Each person had their own flat and there were communal lounges, a communal dining room and gardens. The home is situated in Hove, East Sussex.

The home had 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.

In September 2017, the provider re-registered and changed its registered name to Royal National Institute of Blind People. The registered name of the service also changed to RNIB Wavertree House.

People and their relatives told us they had trust in the staff and felt safe and secure living at RNIB Wavertree House. Staff showed a good awareness of safeguarding procedures and knew who to inform if they saw or had an allegation of abuse reported to them. The registered manager was also aware of their responsibility to liaise with the local authority if safeguarding concerns were raised. One person told us, "It's safe, warm, comfortable, friendly. We are well fed and looked after."

The design, adaption and layout of the service had been completed to ensure that people who were living with different levels of sight loss could have their needs effectively met, to promote their independence and support them to move around safely.

Staff remained kind and caring and had developed good relationships with people. People's privacy was respected and staff supported people to be as independent as possible. People were involved in making decisions about their care.

Risks relating to people's care were reduced as the provider assessed and managed risks effectively. People's visual difficulties were taken into account when managing risk and people were encouraged to be as independent as possible. There were effective infection prevention and control measures in place.

People's medicines were managed safely by staff. People were supported by staff who had been assessed as suitable to work with them. Staff had been trained effectively to have the right skills and knowledge to be able to meet people's assessed needs. Staff were supported through observations, supervisions and appraisals to help them understand their role. The provider had ensured that there were enough staff to care for people. One relative told us, "Everybody is so available and efficient."

People continued to receive care in line with the Mental Capacity Act 2005 and staff received training on the Act to help them understand their responsibilities in relation to it. People's capacity to make decisions had been carefully assessed. 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.

People's needs continued to be assessed and person-centred care plans were developed, to identify what care and support was required. People received personalised care that was responsive to their needs. People received compassionate support from staff at the end of their lives.

People were encouraged to live healthy lives and received food of their choice. Positive changes to the catering system had been implemented by the provider in response to people's requests. People received support with their day to day healthcare needs and were encouraged to live healthier lives.

People were informed of how to complain and the provider responded to complaints appropriately. The provider communicated openly with people and staff. Staff worked closely with professionals and outside agencies to ensure joined-up support.

People and staff spoke positively of the leadership of the service. Quality assurance and information governance systems remained in place to monitor the quality and safety of the service. Staff worked well together and were aware of their roles and responsibilities.

Managers and staff learnt from feedback and took action to improve service delivery following incidents, accidents and audits.

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

People told us they were safe. They were supported by carers that understood their responsibilities in relation to safeguarding.

The provider had a robust recruitment process in place to ensure that they were safe to work with people. There were sufficient numbers of staff to keep people safe.

Medicines were managed, stored and administered effectively. This process was audited effectively by the provider.

Individual risks to people's safety had been assessed thoroughly and reviewed when needs changed.

Lessons were learned and had been used to drive improvement.

Is the service effective?

Good

The service was effective

Carers received the training and support they needed. They understood their responsibilities with regards to seeking consent and the Mental Capacity Act 2005 and supported people to make decisions about their lives.

Staff worked well together, and with other professionals, to ensure people received effective care and support.

Assessments were holistic and took account of people's diverse and complex needs.

People were supported to have enough to eat and drink and to access health care services when they needed them.

People's individual needs were met by the design and layout of the service.

Is the service caring?

Good

The service was caring

People were treated with kindness and compassion by staff who respected them.

People were supported to express their views and involved, as far as possible, in making decisions about their care.

People's independence was promoted and staff respected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive

People's care plans were holistic and person-centred. People were involved in creating their support plans. People were supported to access activities and maintain relationships that were important to them.

Complaints procedures were in place and people told us that they would feel comfortable raising concerns if they had to. Complaints were used by the provider to improve the delivery of care.

People and their relatives were supported well at the end of their lives.

Is the service well-led?

Good

The service was well-led

Quality assurance and health and safety systems were effective and embedded into practice.

The management promoted an open and transparent service that encouraged feedback and discussion to drive improvement.

People and staff were actively engaged and involved.

The service worked closely in partnership with professionals, agencies and local authority teams to ensure joined up and effective support

RNIB 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 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.

The inspection took place on 9 October 2018 and was unannounced.

The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. This team member had experience supporting people with visual difficulties.

We used information the provider sent us in the Provider Information Return (PIR) to complete the inspection report. 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 looked at this and other information we held about the service. This included notifications. Notifications are changes, events or incidents that the service must inform us about.

During the inspection we spoke with nine people and seven members of staff. These included the registered manager, deputy manager, a care supervisor, three care workers and the chef. We also spoke to three relatives. During the inspection we spoke to two healthcare professionals about their experiences of the service. Following the inspection, we contacted a further five professionals, who had provided input to people at the service, to seek their views of the support provided by staff.

We reviewed a range of records about people's care and how the service was managed. These included the care records for seven people, medicine management, recruitment records for staff, quality assurance audits, complaints management, training programme, incident reports and records relating to the management of the service. We spent time observing care and support in the communal lounges and observed the lunchtime experience that people had. We observed a staff handover meeting, an activities session and the administration of medicines.

Good

Is the service safe?

Our findings

People told us that they felt safe living at RNIB Wavertree House. One person told us, "Yes, I do actually." Another person said, "It seems a safe, secure place."

Staff had received training, and demonstrated that they understood their responsibilities, with regard to safeguarding people. The provider had a comprehensive safeguarding policy in place and had a consistent and open approach to dealing with safeguarding issues when they occurred. All staff had undertaken raising concerns and whistleblowing training so that they were supported to confidently raise concerns about people's safety should they need to.

Risks to people had been identified and assessed. There were comprehensive plans in place to guide staff in how to provide care safely. People were living with partial and full visual impairments, as well as range of needs and conditions. Risk assessments reflected the complexity of people's needs. For example, each person had detailed assessments on the level of their sensory impairment, and the areas of risk associated with this level. Risks to people's safety had been updated in a timely and responsive manner when their needs had changed. For example, one person's moving and handling assessment had been updated to reflect minor changes in the person's mobility following discharge from hospital.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular checks on equipment and the fire detection system were undertaken to ensure they remained safe. Actions identified in fire risk assessments had been completed within agreed timescales to ensure continued compliance. Personal Emergency Evacuation Plans (PEEPs) were in place for each person, detailing the support they would need in the event of an emergency. Staff undertook fire response training and we saw evidence of regular fire drills that had been carried out successfully.

People continued to receive medicines in a safe and timely manner. People told us that they were provided with medicines when they needed them. Staff were trained to administer medicines and recording was consistent and accurate. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines. Medicine policies were available for reference within the medicine record books, while staff had access to medicine lists that detailed what they were used for and their side effects. Protocols for the administration of auditing systems were in place to ensure that the system for medicine administration worked effectively and any issues could be identified and addressed. People had individual guidance for receiving medicines 'as and when required' (PRN). This provided clear guidance for staff as to how to recognise when someone might require the medicines. It detailed the name of the medicine, the purpose, when the medicines should be administered, the duration of time required in-between doses and when to seek further advice from a healthcare professional. People's independence in administering their own medicines was promoted, whenever possible, by staff. People were aware of when they required support and when they could support themselves. One person told us, "Some medication I do myself, like my nasal spray. Eye drops, they do."

People told us that there were enough staff on duty and records confirmed that staffing levels were

consistently maintained. During the inspection we observed that staff were responding to people's needs in a timely manner. Staffing numbers to ensure that people's needs could be met safely were guided through the management's use of a dependency tool. A dependency tool is a method to calculate staffing requirements based on people's needs. People told us that their call bells were usually answered promptly when they requested support. One person told us, "If I need them, they are there."

Staff had a firm understanding of infection control procedures. They were observed to be using appropriate protective equipment during the inspection when supporting people and records confirmed that a regular cleaning regime was in place. The provider undertook regular and comprehensive infection prevention audits throughout the year, and records confirmed that resulting actions had been completed. People's environmental care plans recorded people's preferences on the frequency and timings of domestic support for their rooms.

The provider ensured that people's safety was consistently maintained following incidents and accidents that had occurred. Incidents and accidents were recorded and monitored through the providers own recording systems. Analysis included identifying possible triggers for incidents and evaluation of strategies to assess their effectiveness in supporting people. Care plans and risk assessments were updated to reflect any changes following analysis of incidents and accidents.

Good

Is the service effective?

Our findings

People's needs and preferences were assessed in a holistic way and comprehensive care plans were developed based upon these assessments. People had received assessments before they came to the service and that their care and treatment was delivered according to their needs. People's needs were assessed in areas such as nutrition, oral care, and mobility, while religious and cultural preferences were obtained to ensure that people received holistic assessments. People's needs had been reassessed effectively when their care or clinical circumstances had changed. For example, staff had updated a person's moving and positioning guidelines following a hospital admission. Another person's care plans had been comprehensively updated after being reassessed as requiring bed care. The person's nutritional and hydration needs were amended, while preventive measures were identified in the person's personal care regime that looked to preserve skin integrity.

People were cared for by staff that had the appropriate training, skills and experience. New staff undertook comprehensive induction programs during which they received training in areas relevant to the support they would deliver, such as sight loss, dementia, moving and handling and safeguarding. New staff worked towards achieving the Care Certificate. The Care Certificate is a set of standards that social care and health workers work in accordance with. It is the new minimum standards that can be covered as part of the induction training of new care workers. Staff also shadowed established care staff to understand the role and care they would need to provide. Staff were then supported with a programme of ongoing essential and specialist training. This equipped them with the skills and knowledge to provide safe and effective care for people with sight problems. Staff told us that the sight loss training was very effective in demonstrating the challenges that people faced. Staff described training scenarios where they would try and function with adapted eye glasses that showed them the difficulties people experienced with varying levels of sight loss. One staff member told us, "It puts you in the residents' position and shows you why and how you need to guide people." People told us that they were cared for in the way they preferred and liked. One person said, "Yes, that is what I am here for. Yes, they do (look after me the way I like)."

Staff told us they felt supported in their roles. Supervision is a mechanism for supporting and managing workers. It can be formal or informal but usually involves a meeting where training and support needs are identified. It can also be an opportunity to raise any concerns and discuss practice issues. Records confirmed that staff were receiving regular supervision.

People's consent to care and treatment was sought in line with guidance and legislation. People had signed care plans and risk assessment agreements. Where people has been unable to visually confirm these agreements, they had been supported by staff to understand them, after which they had provided their consent. 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 to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application

procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. These safeguards will have been authorised by the local authority to ensure that the person has been protected from harm. The registered manager understood fully however the importance behind best interest decisions and the need to ensure that these decisions should be recorded accordingly. Staff demonstrated a good working knowledge of the issues around capacity and decision making. Staff informed us that people should be supported to make their own decisions as much as possible. We observed staff using their knowledge of people's preferences and communication methods to ensure this best practice was applied.

The design, adaption and layout of the service had been completed to ensure that people who were living with different levels of sight loss could have their needs effectively met, to promote their independence and support them to move around safely. Contrasting paint colours had been used to differentiate doorways and communal areas. Contrasting coloured and textured flooring had been used on flat areas between stair flights and outside lifts doors to assist people with depth perception. There was good use of different floor coverings to direct people to the dining area, the lifts and their own rooms. There were clearly marked, large signs and notices on the walls to inform people of the latest activities, food menus, fire exits and to identify where they were in the building. Many of the signs also had a raised 3-D effect on them to allow people to feel where they were. People's rooms were decorated in light colours with a darker coloured surround on plugs and light switches to highlight them. Environmental care plans were completed that detailed people's individual lighting requirements for their rooms, in order to 'maximise the usefulness of my sight'. Essential maintenance and decoration work was being completed at the time of the inspection within some communal areas of the service. The provider had ensured that people had been kept informed of this work and discussed any potential disruption that they may experience. The registered manager had fully risk assessed the ongoing work to ensure that the people remained safe and would continue to be supported effectively.

People were supported to eat and drink enough to maintain a balanced diet. The provider and kitchen staff planned the menus based on people's nutritional needs and preferences. People could make their selections on the day and alternatives were provided if the main meal choices were not preferred. People were generally happy about the quality and variety of the food. One person told us, "I have no complaints." Care staff and kitchen staff worked together to ensure that people's need and preferences were acted upon. For example, staff used the kitchen communication book to pass on information. One person had requested pate for their evening meal and the chef was able to prepare their meal that evening, as directed within the communication book. Kitchen staff were informed of people's special culinary requirements which included information for people who required a pureed soft diet as well as information on allergies to specific foods. We observed people's experience during the lunchtime meal, although many chose to eat in their own rooms. Tables were set out to allow maximum space and ensure that people with sight loss had an area around them. They were decorated in blue table cloths with contrasting red place mats, to assist people with finding their meals.

Staff described effective working relationships within the home and with external health and social care professionals, such as GP's, falls specialists, speech and language therapists and dieticians. One staff member said, "I get on well with other team members", while another told us, "You couldn't ask for a better team." People and their relatives told us that staff were observant and sought advice from health care professionals when needed. A health care professional told us that staff were good at, "Giving us information that we needed." Another professional said, "I have found both staff and managers welcoming and accommodating to me but also supportive of each other.

Good

Is the service caring?

Our findings

People and their relatives told us that staff provided kind and compassionate support. One person told us, "Staff are pleasant, helpful and friendly." One relative told us that, "They've been absolutely marvellous. They've just been so caring."

People were given emotional support when they needed it. One person we spoke to told us how staff had supported them compassionately through the recent grieving process following the passing of a loved one. The person told us that staff were, "More like family and friends." The person's relative also spoke of kindness of staff towards them and told us that their response had been, "Absolutely incredible."

People and relatives told us they could express their views and were involved in making decisions about their care and treatment. Consent was always obtained by staff who ensured that people understood the information they needed to make a decision. People's independence was encouraged and promoted through their involvement with detailed care planning of their needs. People's visual difficulties were assessed in detail and ensured that people's abilities were factored in to their support as much as possible. The adaptions made to the service were to ensure that people had as much control and support to mobilise around their home as independently as they could.

People's diversity and cultural differences continued to be respected and promoted, according to their wishes, and staff supported them with these. For example, one person had specific foods that they were restricted from eating due to their religious faith. These considerations were known to staff and they were strictly adhered to when preparing meals for that person. People were supported to practice their chosen faith when they wished and staff could arrange for people to be supported at the service. With regards to accessing this, one person told us, "I haven't done that, but I could do."

Throughout the inspection we observed many kind and caring interactions between people and staff. During the lunchtime experience, the atmosphere was happy and inclusive. Staff maintained good eye contact with people throughout their conversations and there were frequent jokes and laughter between people. Staff ensured that people were satisfied with their meals and were asked what they wished for throughout. Staff assisted people carefully and considerately out of the dining area when they were ready to leave. We observed close interactions initiated by both people and staff. One person beckoned a staff member she had not seen for some time to her chair and rested the staff members arm against her own face affectionately while they talked. One person actively approached the inspection team during the site visit to present a poem they had written praising the staff for the care they received. The comments within the poem told us, "CQC arrived here today here at RNIB, I know that they will leave surprised at all the good things they see. Each week we get an itinerary to keep our memories on the go, and the happy faces all around shows our happiness you know."

People's privacy was respected. Staff were observed knocking on people's doors and waiting for a response before entering. People confirmed that staff protected their privacy when being supported with personal care needs by ensuring that doors were closed throughout. Staff ensured that the confidentiality of people's

information was maintained. Carers had undertaken training in the new General Data Protection Regulation (GDPR) and were aware of their general principles. This regulation requires providers to maintain and demonstrate evidence of data protection compliance. People's files showed that the provider had updated privacy statements that confirmed what personal information they held, how this information was to be used and who they wished to share the information with.

Good

Is the service responsive?

Our findings

People continued to receive personalised care that was responsive to their needs. Care plans were based upon people's assessed needs and preferences. People and their relatives had been involved in developing care plans which included details of the person's diverse needs, their background, social and religious needs and preferences. Care plans were detailed and personalised, they gave a clear sense of the individual and included people's interests and the things that were important to them.

People were supported to follow their interests and take part in activities that were socially and culturally relevant to them. People told us they could choose how they wished to spend their day. At the start of the inspection we observed people happy and engaged in designing and creating pom-poms. The majority of people we spoke to said that they participated in the activities within the service. One person told us, "I went to skittles and bingo yesterday." Another person told us, "The person I look forward to seeing is the one from Blind Veterans UK. They are fantastic, they come each week." One person at the service had been encouraged to pursue their gardening hobby and worked alongside the provider's gardener to maintain an internal garden at the service. One family member told us about their loved one, "He loves all the activities at Wavertree."

People used different technology to support them to overcome their visual impairments and to participate in activities and hobbies. One person told us, "I like listening to the radio and using the Daisy machine." A Daisy machine, or digital accessible information system, is a means of creating digital talking books for people who wish to hear, and explore, written material presented in an audible format and is used predominantly by people living with blindness and visual impairments. One person had a voice recorder which staff used to record what activities that person was undertaking that day. Each person had access to a telephone with large key pads in their rooms and had speed dial access to staff in reception should they need them.

People's individual preferences were respected and delivered in other areas of their support. For example, the staff member completing the medication round told us that they completed up to five or six separate rounds per day to accommodate the times when people had requested to have their medication. Staff had ensured that these requests did not conflict with any clinical requirements or conditions and had delivered medication, where possible, at times that people preferred. For example, one person liked to have their medicines after watching their regular evening television show and staff would wait until this had finished to support them.

People living with dementia were also supported to participate in meaningful activities. Staff worked closely with the care home in reach team to support them in developing strategies for meaningful occupation for those living with dementia. Some people had been supported to create life stories. People living with dementia often require support to communicate their identity, background and interests as a result of memory loss. Life story works are activities where people are supported by staff to gather information about their past lives and build a 'story' to reflect on these experiences. We observed people using dementia 'gloves' to promote sensory triggers and tactile stimulation. We also saw people gaining comfort from using

an interactive toy cat. For people with dementia, these toys enhance social skills, promote sensory awareness, trigger memories and provide occupation and comfort. One person had used this toy as emotional support following the passing of a loved one.

People had been supported by staff to participate in a community based activity called 'Cycling without Age'. The group provides open air cycles called trishaws that support people to experience their local area safely and regain social connections. We saw pictures of a number of residents enjoying this experience and comments from people about how much they enjoyed the group. Due to the success of the initial trial of this activity, the provider asked people how they wished to spend funds that had been raised through the use of the services library. People overwhelmingly requested for this to be put towards continuing the cycling group, which the provider agreed.

The provider was proactive in ensuring that the communication needs of people were identified and that they received information about their care and support in a way that took their needs into account. We looked at whether the service was compliant with the Accessible Information Standard (AIS). From August 2016, all providers of NHS care and publicly-funded adult social care must follow the AIS in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs relating to people with a disability, impairment or sensory loss. People had access to a magnifying raised board in the main communal lounge that allowed people with visual impairments to read correspondence and information more effectively. Staff were aware of people' requirements as to which font size they required text to be enlarged to. The provider could provide people with compact discs to provide information in the spoken word. One person, who lived with arthritis in their neck had been supported to research clinical information relating to posture support and neck pain. Records confirmed that staff had enlarged the text of this information so that the person was able to read it themselves. Staff also read the document to the person, at their request, to ensure that they were as informed as possible about the condition. People also received newsletters, in formats that met their needs and preferences, that informed them of upcoming events in the service as well as other celebratory information about other activities.

The provider had a system for managing complaints. People knew how to make complaints and told us that actions were taken to address any concerns they had. The complaints procedure and policy were accessible for people on display boards in the service and complaints made were recorded and addressed in line with the policy. We saw evidence of responsive and timely acknowledgements to people who had raised concerns. The provider also used learning from complaints to improve the quality of care it subsequently delivered. For example, one complaint resulted in the implementation of fluid charts for one person in order that family members could see the hydration intake of their relative.

People received compassionate and dignified end of life care that respected their wishes. The provider's support for people at the end of their lives extended to family members and those closest to the person. People were given the opportunity to discuss their end of life care and this information was documented in people care plans, which recorded the person's wishes for how they wished to be cared for. We saw records that guided staff on what actions they should take in the event one particular person passed away during the night. Detailed and respectful guidance was provided on how the person's religious wishes should be carried out, what relatives to contact and detailed arrangements for personal care needs that maintained the person's dignity prior to the arrival of family members. End of life boxes had been created by staff that held items for them to provide more individualised personal care at the end of people's lives. These had been well received and the service has been asked by the local hospice to demonstrate them at future training sessions to share with other services. Staff have accessed additional emotional and practical support with the anxieties of supporting people with end of life care through links with nurses at the local

hospice.

Good

Is the service well-led?

Our findings

People, relatives and staff told us that they were happy with the management of the service. One person told us, "On the whole we are very well looked after." A relative told us, "The management are excellent."

The home had 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.

People and their relatives told us they felt included and involved in the home and described attending and contributing to regular resident's meetings. A family member told us that the staff team were, "Responsive if I've got anything to say." Another relative confirmed that management were, "Very good at communication. You can ask anything at any time." Residents could provide feedback through satisfaction surveys and comments observed were almost wholly positive about staff's approach and the management of the service. People's views had been acted upon to drive improvement in the service. Through the feedback they had provided about the quality and delivery of food at the service, the provider had taken action to change the catering suppliers, a change that had been positively received by people we spoke to. The provider had implemented a 'You said, we did' board in the main reception where people could see the improvements and changes made by the service in direct response to people's feedback and suggestions suggest positive changes they wished to see in the service.

The registered manager and provider were proactive in ensuring that a transparent and open culture existed, and that its values were embedded across the scheme. One staff member told us, "You can go to them about anything." Another staff member said, "I couldn't ask for a better team, so supportive like a family." Staff were encouraged to reflect on their own practices and those of the service as a whole and document them for other staff members to learn from. We saw reflections by a staff member who had questioned their own performance when speaking to someone on the telephone and what changes they proposed to take with their professional approach in the future. Another staff member had reflected on whether staff's response to a person's fall had been sufficient. The staff member had then looked at the actions by the service to mitigate risks, such as specialist referrals and had reflected, "All staff are happy with the decisions we made as a team and they are checking to ensure this is still working." The impact of this practice was that it promoted transparency within the staff team and encouraged staff to continuously check their own skills and decisions for the benefit of people who used the service.

The provider used a number of systems to monitor and evaluate the quality and effectiveness of the service. For example, audits were regularly carried out to ensure compliance and quality in areas such as medicine management, care planning, environmental and fire safety. Care plans were reviewed monthly by staff and we saw evidence that changes in people's needs had been recorded effectively. The service had also received quality assurance reviews from the local authority, from which the leadership team had completed any actions and improvements that had been identified. Throughout the inspection the registered manager and staff team were well- organised and demonstrated that they understood their responsibilities. The

service showed a commitment to sustained improvements by having care champions in place in areas such as end of life care, health and safety, infection control, falls and nutrition amongst others. The registered manager stated that the service plans to expand this area. The provider displayed certificates of awards that it had achieved runners up status or been nominated for around the service, including the Great British Care awards.

Staff worked in partnership with external agencies and had made links with organisations in the local community such as a local hospice, low vision aid clinics and East Sussex Association with the Blind. The service had formed links with care homes that didn't specialise in providing sensory support to people. These other homes had requested for RNIB staff to provide them with guidance and training to their own staff to improve their skills in supporting residents with some visual difficulties. The service had links with Blind Veterans UK who visited to engage people in quizzes and to support them with events.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The registered manager had informed the CQC of significant events in a timely way and had sought guidance and advice when required. This meant we could check that appropriate action had been taken. The registered manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.