The Norfolk And Norwich Association For The Blind

Thomas Tawell House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 20 and 21 September, 2016. The visit was unannounced.

Thomas Tawell House is a residential care home which supports older people living with sensory impairment, for a maximum of 37 people. There were 35 people living in the home when we inspected. All of the people living there were visually impaired.

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. There was a registered manager who had been in post for several years.

Staff were trained in safeguarding and were aware of who to report any concerns to, and people felt safe living in the home. There were risks assessments in place for people with regards to their physical safety, and these provided guidance to staff on how to safely support them.

The home was making improvements to the recording around some medicines. Medicines were administered by staff who were trained to do so, and some people were supported to take their own medicines.

The home had safe recruitment practices in place so that only staff who were deemed suitable could work there. There were enough staff to keep people safe.
People felt that staff were competent in their roles. Staff had received training relevant to their role and felt confident. There was an induction procedure in place, which helped to train new staff. Staff asked people for their permission before delivering care.

The CQC is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and report on what we find. Although staff did not always have training in these areas, we found that they were following the principles of the MCA. We have made a recommendation around training with regards to people's mental capacity.

People were supported to eat a sufficient amount of food with a good choice of meals. There were drinks available at various intervals throughout the day, and people had drinks in their rooms.

Staff were compassionate towards people, and they encouraged people to be independent where they were able. They encouraged privacy when carrying out personal care with people. Staff supported people to maintain relationships with loved ones and involve them in their care. We did observe that there were some practices in place which did not always promote people's dignity.

Although staff were cheerful and kind to people, the interactions were task-led. People were not always

supported to participate in social events or activities which followed their interests. People did not always receive support to engage with others and follow their interests and hobbies.

Care records did not always contain clear detail and guidance about each individual's life, preferences, and personal health needs. This meant that staff did not always have consistent guidance about how to support people effectively.

Although people we spoke with felt that they were involved in aspects of their care, there were some decisions that were not supported. This included bath and meal times. We spoke with the registered manager about this and they said they would review flexibility of the service.

There were not sufficient auditing systems in place to assess, monitor and improve the service. We found that the registered manager had not picked up on areas that required improvement, including monitoring staff competency, checking health and safety and medicines administration.

You can see what action we told the provider to take at the back of the full version of the report.

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 were looked after by staff who were aware of safeguarding procedures.

There were risk assessments in place for people, which guided staff on how to mitigate risks to their safety. There were systems in place to maintain people's environment safely.

There were enough staff to keep people safe. They had been deemed suitable to work with people through having completed robust recruitment procedures.

Is the service effective?

Good

The service was effective.

Staff had received training relevant to their role, and felt confident in working with people. Staff sought consent from people before delivering care.

People were supported to eat a good choice of fresh meals. People had timely access to healthcare.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate towards people.

People felt they were involved with planning their care, and were supported to keep up relationships with their loved ones.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always supported to follow their interests.

People's care records did not always contain detailed information about the person, including guidance for staff on

how to support them as they wished.

The service provided was not always flexible in considering people's requests.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were no systems in place for assessing, monitoring and improving the service provided.

There was an open inclusive culture of the staff in the home, and they felt supported by management.

Thomas Tawell 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 was carried out by one inspector 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 was an unannounced inspection.

Before the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. Prior to the inspection, the provider also completed a Provider Information Return (PIR). This 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.

During the inspection, we spoke with eight people living in the home and three regular visitors. We also spoke with seven members of staff as well as the registered manager. The staff we spoke with included the catering manager, an administrator and the head of care. Other care staff we spoke with included two care workers, two senior care workers and a regular agency care worker.

We looked at care records and risk assessments for three people who lived at the home and checked five medicine administration records. We reviewed a sample of other risk assessments in relation to the home itself and health and safety records. We looked at staff training records and reviewed information on how the quality of the service was monitored and managed.

Good

Is the service safe?

Our findings

There were systems in place to reduce the risk of people experiencing abuse or avoidable harm. One person living in the home said, "I do feel safe here because of the helpful staff. I only have to ask for something and it's attended to." Another said they felt safe, they told us, "I don't have to worry about intruders or a fire starting because the staff are very good with security in my opinion." These comments were reflected by everyone that we spoke with. The staff we spoke with had good knowledge of how to keep people safe. They were able to tell us what types of abuse could happen to people and who they would report any concerns to. We saw that they had received training in safeguarding. This contributed to keeping people safe within the home.

Risks to people's safety had been assessed and were being managed well. There were risk assessments in people's care records for various aspects of their care, such as manual handling and falls. The risk assessments for manual handling provided guidance to staff on how best to mitigate risks, for example risks associated with using equipment to support people to move around. Where people were identified as being at risk of pressure areas, staff were able to tell us what they would be concerned about, for example, skin redness. Where it was required, people had specialist pressure relieving equipment in place such as an air mattress. Some people were also supported by staff to reposition regularly. Both of these interventions had been put in place to prevent the risk of people developing pressure ulcers. Staff were able to tell us about individuals who required this support, and how they delivered it safely. This was accurately reflected in a care record for one person we looked at, who required assistance to reposition using equipment.

Risks to the environment such as legionella, gas and electricity had been managed. There were records of regular checks carried out on the fire equipment such as emergency lighting, extinguishers and fire doors. Regular flushing and water temperature checks took place in order to maintain water safety. We found that the yearly check for lifting equipment, such as the lift, stand aids and hoists, was nine months out of date. The provider had therefore not complied with the relevant legislation. However, the equipment may not have been in good working order which could pose a risk to people's safety. When we spoke with the registered manager about this, they organised the checks to be done immediately.

There were enough staff to meet people's basic needs and keep them safe. People told us that they did not feel they had to wait long for support from the staff when they needed it. One person told us, "I've never had to use my call bell so I don't know how quick they would come, but they look after me and I don't really have a need to use the bell in my room." Staff told us that if they had to keep someone waiting, they would always go and tell them first and check that this was alright and that the person was safe. Staff told us there were enough staff to keep people safe, and we observed that there were staff around the home during our visit. We saw the rotas and saw that the number of staff working was as the registered manager had told us, and that this had been consistent. The registered manager used a dependency tool to work out how many hours of care they needed to provide, which helped them to decide how many staff were needed.

There were systems in place for recruiting staff that were deemed suitable to work with people who lived in the home. The home carried out various checks prior to staff starting to deliver care to people. These

included character references and criminal record checks, which contributed to keeping people safe.

People received their medicines safely as prescribed. We looked through some medicines administration records (MARs) and found that all medicines had been signed for as prescribed. The front page of each person's MAR had information about whether people had an allergy, and their photo. This minimised the risk of people being given wrong medicines. The pharmacy had carried out a recent audit and made some recommendations which the head of care was implementing. These included adding protocols for 'as required' medicines. We looked at medicines which required extra checks as they carried a higher risk. These had been managed appropriately for the safety of the people who lived in the home, and signed for by two members of staff.

Some people in the home had been encouraged and supported to look after and administer their own medicine. One said that this was safe, telling us, "I'm self-medicating and they watched me to make sure I was okay and then agreed to let me look after myself." Other people also told us how they administered their own medicines, at times with supervision from staff.

Good

Is the service effective?

Our findings

People said that staff were competent in their work, and the visiting healthcare professional we spoke with also confirmed this. The staff received training in areas such as first aid and manual handling, and some specialist training in visual impairment. Staff explained how this had been helpful to them in learning how to guide people properly. They also said it increased their understanding and empathy. Most of the training staff received was via watching a video, and included infection control and safeguarding. They also did classroom based first aid and manual handling training. Staff said that they felt competent to perform their roles.

There was an induction process in place, which consisted of new staff shadowing more experienced staff until they felt confident in the role. Staff were subject to a probation period of three months which meant that they would be supervised for this time and signed off at the end of it if they were deemed competent.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

People we spoke with said that staff asked them for consent before delivering care to them. One person living in the home told us, "They [staff] always ask permission to do something." A visiting healthcare professional told us they felt staff had a good awareness of people's decisions and levels of capacity. The staff we spoke with did tell us about some people in the home who had variable capacity, and were living with dementia. They demonstrated to us that they knew how to follow the principles of the MCA, such as offering choice and assuming capacity. However, staff had not received training in the MCA, and were not clear on when a mental capacity assessment may need to be done or a DoLS applied for. Further training would further prepare staff for this eventuality should it arise.

We therefore recommend that the provider find out more about training for staff based on current best practice in relation to consent and capacity.

People received a choice of nutritious, home cooked food. One person told us, "One of the staff overheard me saying I'd like some fruit but because of my teeth I couldn't eat a lot of fruit. Without asking someone went into the kitchen and pureed me some strawberries and they do this all the time now." People confirmed that they could ask for food any time, saying "I can get food outside of mealtimes and I just have to ask. Things like crisps, biscuits and fruit are available." Another told us, "The choice of food is very good

and the portions good too. I've never had to ask for extra food or drink."

We spoke with the catering manager and they were able to tell us about different individual's dietary requirements and how they accommodated them. They said that if people did not like what was on the menu, they would make something else. They also said that where people made specific requests, they accommodated these where possible. They gave an example of where they had bought in specific soups for one individual to have regularly. Where people ate a softer diet, the kitchen staff catered for this effectively. The staff and the registered manager told us how they supported people who required physical assistance, to eat enough. People had specialist crockery and cutlery which helped people with visual impairment to eat their food. The home had recently received five stars for their food hygiene.

Although people said they had drinks regularly, some people said they had to wait for staff to bring the hot drinks around during scheduled times, in order to have a drink. We observed one person ask a staff member outside of this time for a drink in a communal area, which they got for them. We discussed this with the registered manager, and they said they would review this immediately so that people had constant access to drinks when they wanted, and would always have one within reach. Everyone we spoke with in their rooms had a cold drink within reach. We discussed records of fluid and food intake for those who were at risk of not eating and drinking enough. The registered manager told us that staff knew when people required assistance, and would hand over the relevant information between shifts. They said that staff also recorded information about food and fluid within their daily notes. They said they would record more details of food and fluid following the inspection, in order to better monitor what people were eating and drinking where appropriate.

People had timely access to healthcare if they needed it. We spoke with a visiting healthcare professional who told us, "In terms of liaising with us [staff] are very efficient at all times. They know people exceptionally well." They said that they did not have any concerns about people living in the home because they visited regularly, and staff always kept them informed about people. We saw that people had access to a chiropodist and were supported to go to hospital appointments when they needed.

Good

Is the service caring?

Our findings

All of the people we spoke with said that staff were kind and caring towards them. One said, "I find the staff here friendly and helpful and you only have to ask and they will do it." One person said, "You can tell they do care about us and you can tell they are nice people and will listen to me." One member of staff said, "I wouldn't work anywhere where I wouldn't have my own family." We observed that staff spoke to people with respect and kindness.

A visiting healthcare professional that we spoke with said, "[Staff] have a very personal touch with people." They also gave an example of a person who had recently come to the home, and said that they had seen a real improvement in the person's health. The staff we spoke with, many of whom had worked in the home a long time, said that they knew people very well. One person told us how staff had reassured them and made them feel more comfortable during personal care. Staff we spoke with were also able to tell us about this person and their feelings about personal care. This meant that staff knew individuals well, which helped them provide care in a way they wished, and provide reassurance where needed.

Staff were able to tell us how they assisted people in a way that promoted their independence. This included assisting people with personal care whilst encouraging them to do as much as they could themselves. They told us how they encouraged people to make choices about what to wear, talking them through what clothes looked like if they were unable to see. However, we asked if there was any provision for people who were able, to be supported to make their own drinks and this was not available.

The home supported people to maintain their relationships with their loved ones. One visiting relative said, "Visitors here are free to come and go at any time and on visiting I can see the staff do care about the residents." There was also a private room with a telephone which people could use, or their relatives could contact them on that telephone.

People and families felt that they were involved in their care planning. One person explained that they did feel they could ask for how they wanted their care to be delivered, saying, "[Staff] will listen to me when I need something." One visitor told us, "My [relative] is quite capable of making decisions, but the home will discuss issues with me and I've certainly talked about the care plan with them, which we are both in agreement with." Another relative gave us an example where the staff obtained a more comfortable chair for their relative to spend time in. This showed us that people were supported to make decisions about their care, and the home had listened to individual wishes.

We found some practices within the home compromised people's privacy and dignity. For example, people's names and dietary requirements were written on the white board in the dining room. This was in full view of any visitors to the home. We spoke with the registered manager about this and they said they would review whether this was necessary or not. They told us following the visit that this had been removed. We saw that medicines were administered in the dining room during lunch time, which could interrupt people and compromise their dignity through taking medicines in a public area. We spoke with the registered manager about this, and they said they would look at considering altering the lunch time

medicines round to better accommodate people's privacy.

There were hot drinks and biscuits brought around several times a day on a trolley. We saw that the biscuits were left directly on people's tables, or given to people in their hand, rather than on a plate or a napkin. Not only was this a compromise to hygiene, it did not always respect people's dignity. We found that although staff always spoke to people with respect, some practices did not maintain dignity.

Requires Improvement

Is the service responsive?

Our findings

We found that the service was not always responsive to people's individual needs and preferences. The staff appeared cheerful and engaged with people well, however the interactions were limited to focus on tasks rather than conversational and individual. One person told us, "I was told when I came here they don't have enough staff to give showers to everyone every day and certainly not baths, so we get one bath a week." Another person we spoke with told us, "I used to have a bath once a week, but that wasn't enough so I asked for my feet to be washed and [staff] did agree. I'd love a bath more often." The staff we spoke with told us that whilst at times extra baths or showers could be accommodated, there usually would not be enough staff to allow extra time for baths. One member of staff said, "People can choose to a certain extent when to get up and go to bed. They mostly fit in with us. Baths are organised for the same time each week." This meant that different aspects of people's care was not always individualised. People did not always get a choice of when to have a bath and there was limited response to people's requests.

There was a survey in place for people to give feedback on the service. We found that where people requested something to be altered, this was not always considered. One person had requested to have a main meal in the evening instead of lunch time. This was not considered because the main meal was always served at lunch time for everyone. This meant that people did not always receive responsive care that was individualised to people's preferences, with flexibility.

The care records were not always detailed and individualised. Some people's care records had identified them as being at risk for low mood or anxiety, however there were no risk assessments or guidance for staff with regards to managing this in the best way for the person. We also saw in some people's care records that they had variable continence. There was no further information, risk assessment or guidance about how best to support them. Where some people had a catheter in situ, there were no risk assessments in place with regards to potential problems with them. Staff told us that they knew how to work with people's catheters and other equipment they had, however there was no guidance in place for new or agency staff.

Some people's care records we looked at contained information about their life history, and some did not. The registered manager told us that some people had refused to give this information. We spoke with the registered manager about information that would help staff get to know people and their individual preferences. They told us that because most staff knew people well, they supported them as they required. They said they would review the information in care plans to ensure people were asked for information where possible. During the second day of our inspection, the registered manager had started working on this. They had also developed a further risk assessment for people's continence needs.

Visiting agency staff or new staff did not always have clear, concise guidance to follow about people's care within the records. One senior care worker told us that at times they would have to direct agency staff a lot, which could at times interrupt their medicines round. We spoke with the registered manager about this and they said they would create a more detailed care needs summary for each person which would help support staff.

We received mixed feedback about whether staff felt people had time for one to one attention and conversation. Some staff members who we spoke with told us that they felt they did not always have extra time to spend with people to have conversations and one to one time. One visitor told us, "I do get the feeling sometimes that they are short staffed, but I haven't seen any problems when it comes to dealing with immediate needs." Staff said this was more the case in the mornings as they were busier. One staff member also told us about how they made the extra effort to spend more time with people who did not have family visiting regularly, when they could. This helped to reduce their risk of social isolation. The registered manager said that they felt there was not enough provision for one to one time and activities.

One person said, "I suppose it would be nice to have things to do", with regards to the provision of activities within the home. Another said, "I do spend the day how I want and I take part in quizzes, plus I go to other events here and they [staff] do encourage that." The registered manager told us that there was not a member of staff at present dedicated to activities, but that there were some volunteers who visited. One member of staff said, "I think people could do with a bit more." People were not always supported to follow any interests or socialise. Where they could, people went out to the activities centre on site which was owned by the organisation, the Norfolk and Norwich Association for the Blind. They participated in various groups doing activities such as crafts and basket making here. However, we found that where people did not want to participate in a group or were not able to go out, there were not enough opportunities for people to engage in activities interested them. The registered manager was planning to make some improvements, such as starting a cookery group this year.

There were no activities, and limited equipment, in place to respond to the needs of those who required additional sensory input. People were not actively supported or encouraged to go outside and spend time in the garden, which could help promote wellbeing. We saw that people had televisions in their rooms, some of which could receive the broadcast 'Audio Description Facility', aimed at the blind or partially sighted. None of the people we spoke with had been told about this facility.

The home had not received any complaints recently, however we could see that previous complaints had been investigated appropriately. People and visitors said they felt the registered manager was approachable if they needed to raise any concerns. There was also a summary of the complaints policy in the reception area, so that people had easy access to it, and it was available in Braille. One person said, "[The manager] is also very good at sorting out minor problems."

Requires Improvement

Is the service well-led?

Our findings

We found that the service did not have adequate audits in place to monitor the quality of the service. A recent pharmacy inspection had led to several recommendations being made with regards to improving medicines administration and remaining up to date with protocols. There had been no existing audit done in the home which had picked these up previously, or looked at medicines in terms of storage, recording and administration.

There were limited systems in place to identify potential problems if they arose with regards to medicines administration. We discussed the development of additional risk assessments with the registered manager, and they said they would start working on them immediately. We found that improvements were necessary to add to the safety of monitoring and administering certain medicines, as well as ensuring risk assessments were in place for those managing their own medicine. We discussed these concerns with the registered manager. They immediately began developing further risk assessments to add to people's MARs, and said that they would seek further advice from the pharmacist if they needed. At the time of the inspection, the head of care was working on improving the MARs, following a recent pharmacy visit.

We found that in some bathrooms, equipment such as appropriate bins were not in place. This had not been picked up because there were no audits with respect of infection control. This meant that the registered manager did not know if equipment was in place as needed, and where improvements were needed. We found that the yearly lifting equipment checks were nine months out of date. There was no health and safety audit in place, so the registered manager had not checked where improvements were required. Where there were gaps or contradictions in care plans, there had been no way of checking them. We discussed audits with the registered manager, and how they could be used to improve and monitor the service. They agreed to put these in place and have developed an action plan to do so.

There were no formal competency checks in place for staff to monitor their practice, or records of regular supervisions having taken place, or spot checks carried out. We saw that there had been some concerns regarding staff competency and attitude during a probation period. The registered manager had not recorded any supervision following this, although they told us they had spoken to the member of staff. They had not checked and recorded the staff member's competency, but said that they relied on other staff to tell them if there were any concerns. This meant that the registered manager was unable to show that they checked whether care was always delivered to a high standard by staff of suitable character. We discussed recording more staff competency and disciplinary actions, and how this contributed to keeping people safe and delivering good care. The registered manager said they would review this.

Other improvements that we discussed with the registered manager included more concise recording of food and fluid when people were as risk of not eating and drinking enough and required full assistance. Recorded information may be required by other health care professionals and help them to more closely monitor people's health.

The above concerns constituted a breach of Regulation 17 in the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

The registered manager had kept some links with their local community, as people regularly visited the activities centre on site, run by the home's organisation. The registered manager said they had regular contact with others throughout the organisation as people living in the home used the different services. The organisation's trustees provided support to the registered manager by visiting regularly and giving their feedback about the service. However, we found that the registered manager had not kept up to date with current best practice. Best practice ensures that providers of care services can keep up to date with current legislation and developments in providing care.

There was good leadership in place. Without exception, all of the staff we spoke with felt that they were supported and could go to the registered manager any time if they needed to. Staff told us that there was an inclusive, open culture within the home, where they worked as a team. They also said that everybody worked well, without a feeling of hierarchy between staff. We observed staff working well together during our visit. People who lived in the home, as well as staff, also felt that the registered manager was approachable to speak with.

There were staff meetings, although the staff we spoke with said that they rarely went, as it did not always fit in with their shift times. They did say that they felt the staff team communicated information well during handovers between shifts, and important information was shared this way.

People told us that they had a choice whether to attend meetings for people living in the home, and that it provided an opportunity to share any ideas and that the home staff would inform people about any changes they were planning to make. This demonstrated to us that the home were encouraging people and families to be involved in the running of the home.