Ravensdale Health Care Limited

Ravensdale

Inspection report

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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

Overall summary

This was an unannounced inspection carried out on 25 November 2015. Our last inspection took place on 22 May 2013 and we found the regulations we looked at were being met.

Ravensdale provides care and treatment for people with physical disabilities and/or mental health problems. The service can accommodate a maximum of 20 people.

At the time of this inspection the home had a registered manager. 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.

Staff knew about their responsibilities in safeguarding people. They were able to identify different types of abuse and knew where to report their concerns. They also demonstrated their knowledge of the provider's whistleblowing policy.

Staffing levels in the home were sufficient, although some gaps existed in the covering of shifts. The registered

Summary of findings

manager was in the process of recruiting to vacant posts. Risks and medicines were managed safely in the home. Staff inductions were thorough and completion levels for staff training were high. Some staff had not received regular supervisions and appraisals.

Staff were seen providing care which was kind, caring and unhurried. Staff and people exchanged good humour. People were treated with respect and dignity and visitors told us they were welcome at any time.

Staff worked with a range of health professionals to ensure people maintained good health. People were positive about the food on offer and they could request alternative dishes. The provider had a 'food forum' for people to have their say about menus.

The service was meeting its legal responsibilities to people under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and people had decision specific assessments in place.

People's care plans contained sufficient and relevant information to provide consistent, person centred care and support. People and their relatives knew how to complain and when this happened this was recorded and people received a response. Although the activities coordinator was fulfilling a different role in the home due to staff shortages, we saw people were supported to take part in activities inside the home and in the community.

Staff and the registered manager felt supported in their roles. Visitors felt the registered manager was approachable. Resident and staff surveys had been carried out, but where feedback was required this had not taken place. A range of audits were carried out to make sure the systems that were in place were effective. People living in the home had their own forum and where action was needed we saw this was taken to improve the service based on their feedback.

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?
The service was safe

Good

People were protected from abuse by staff who were knowledgeable about safeguarding and the provider's whistleblowing policy. Safeguarding incidents were recorded and the relevant authorities were notified.

Staffing levels were assessed using a dependency tool. Although there were some gaps in staffing, the registered manager was actively taking action to fill vacancies.

The administration and management of medicines was well managed by trained staff. The necessary records to support the administration of covert medicines were in place.

Is the service effective?
The service was effective

Good

We saw from the records staff had a programme of training and were trained to care and support people who used the service.

The service was meeting its legal responsibilities to people under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Records showed people had regular access to healthcare professionals, such as occupational therapists, speech and language therapists, physiotherapists and dieticians.

Is the service caring?
The service was caring

Good

Care plans were easy to follow and contained information about people's life histories and personal preferences. This information was used by staff to provide person centred care.

Staff knew how to respect people's privacy and dignity and the provider used a '10 Point Dignity Challenge' to promote this in the home.

Relatives told us they were made to feel welcome and could visit at any time.

Is the service responsive?
The service was responsive

Good

Care plans were detailed, personalised and identified the involvement of people and their relatives.

Staff demonstrated their knowledge of the people they were supporting and knew about life histories, likes and dislikes.

People were supported to engage with a range of activities both inside the home and in the community. Staff carried out meaningful activity audits to evidence people's engagement in activities.

Is the service well-led?
The service was well-led

Good

Summary of findings

Staff enjoyed working at the home and both they and relatives felt the registered manager was approachable.

Resident and staff surveys required analysis to identify action points and responses. People had their own meetings and the provider took action in response to concerns raised through this.

A range of audits were carried out to make sure the service was effective.

Ravensdale

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 25 November 2015 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist advisor in nursing and an expert by experience with a background in mental health. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

At the time of our inspection there were 19 people living in the home. During our visit we spoke with the registered manager, the clinical nurse manager, a unit manager and a further 10 members of staff. We spoke with eight people who used the service and two relatives. We spent some time looking at the documents and records that related to people's care and the management of the service. We looked at six people's care plans.

Before our inspections we usually ask the provider to send us 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. We did not ask the provider to complete a PIR prior to this inspection.

Before our inspection, we reviewed all the information we held about the home. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Good

Is the service safe?

Our findings

We spoke with people who told us they felt safe and secure in the home.

Safeguarding incidents and the recording and reporting to both local authority and the Care Quality Commission (CQC) were found in the safeguarding records reviewed. The staff we spoke with were all able to describe the process they would follow if they suspected abuse was taking place. Staff were aware of the whistleblowing policy and would not hesitate to raise concerns.

We looked at the records of safety checks carried out in the home. These included maintenance records, fire records and water safety checks. There was evidence these were carried out regularly and any actions identified were clearly documented to show they had been addressed to improve the service and ensure safety.

There were systems in place to monitor accidents or incidents and we saw the service learnt from incidents to protect people from harm. This indicated there was a commitment to continuously improving safe practice in the home. For example, a person who used the service had been identified as at risk from increased falls; the care records showed their risk management plans had been reviewed in response to this.

There were systems in place to make sure equipment was maintained and serviced as required. There were certificates to show gas and electrical safety tests were carried out at the correct intervals. There was documentation to show all moving and handling equipment, fire safety equipment and the passenger lift was serviced as required by the manufacturer.

The care plans we looked at showed a number of risk assessment tools were used to ensure the level of risk was minimised and maintained people's independence. For example, falls, nutrition and pressure care were assessed.

The registered manager told us staffing levels were assessed on an individual basis depending on the needs of the people who used the service. We saw documentation which showed us how this was done. We saw need and dependency was assessed in a number of areas which included consideration of a person's behaviour, mobility, clinical and social support needs. The registered manager said they were satisfied the current staffing arrangements met people's needs. They said they kept this under review and could increase or decrease staffing levels dependent on people's individual needs. One person told us, "Staff are alright, but they keep changing. They stay three months and move on." One staff member told us, "Staffing is fine and we can ask for help from another home."

The registered manager had reorganised the deployment of staff across the two floors. This was designed to help staff become more familiar with people and their care needs. One staff member told us, "I'm warming to it."

Our review of the rota over the last month showed the registered manager identified on a daily basis the staffing levels required in the home. We saw for the majority of the time, staffing levels were provided as planned. However, on 14 out of 56 shifts the rota showed the staffing levels were one staff member below what was planned. The registered manager was aware of this situation and said it was due to staff vacancies. They said due to the needs of people who used the service it was more beneficial to work like this than use agency staff who were not familiar with the needs of people who used the service. The registered manager and operations manager told us what they were doing to try and drive recruitment and fill their current vacancies. This included attendance at job fairs and local university events. We saw evidence which showed applications were being processed and people had been invited to attend an interview.

We looked at the recruitment records for four staff members. We found the recruitment practices were in general appropriate and relevant checks had been carried out prior to staff starting work at the home. This included obtaining references and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. However, we noted risk assessments were filled out, but not authorised by the operations director when DBS disclosures were identified. The registered manager told us they would follow this up with the operations director.

The registered manager told us disciplinary procedures were in place and were implemented to ensure standards were maintained and people were kept safe.

During the medication round we observed staff administering medicines in a calm and unhurried way, with lots of positive interaction between people and staff. We

Good

Is the service safe?

looked at the staff training records and found staff who were responsible for administering medicines had received up-to-date medication training. We reviewed the medication records for four people and found the practice of administering medication was safe.

Storage temperatures for refrigerated medicines were checked and recorded on a daily basis to ensure medicines were kept within required temperatures. We looked at stock held including the contents of the controlled medicines cabinet and found this matched the information recorded on medication administration records and in the controlled medicines register. We found there was no record of body maps for staff to indicate where pain relief patches had been administered. We discussed this with the registered manager who agreed to look at this.

We looked at the use of topical creams and lotions and found these were recorded when they had been applied.

The covert administration of medicines occurs when a medicine is administered in a disguised format without the knowledge or the consent of the person. The records we looked at showed three people received their medication covertly. The decisions to give medicines covertly were supported with mental capacity assessments and records of 'best interests' meeting which were attended by a range of professionals and family members. Best interest meetings are recommended by the National Institute for Care Excellence (NICE) in their guidance for medicine management in care homes. They should evidence the involvement of a family member or other appointed advocate who can communicate the views and interests of the person.

Good

Is the service effective?

Our findings

We asked a staff member about their induction and they told us, "It was quite good." Another staff member commented, "I really enjoyed it." Staff received an induction which consisted of seven days training at head office. Staff were then given a further three days of training in-house which in part consisted of shadow working. The registered manager told us staff started the Care Certificate as part of their induction. The 'Care Certificate' is an identified set of standards that health and social care workers adhere to in their daily working life.

We looked at the staff training records which showed staff had completed a range of mandatory and non-mandatory training. These included fire safety, equality and diversity, infection control, use of bed rails, person centred support, first aid, safeguarding and moving and handling. We saw staff training completion levels were high.

The registered manager told us the provider had a policy for all staff to receive one to one supervision meetings six times per year. They said they were currently behind schedule on this and were aware it was an area they needed to improve on. They told us the vacancies in the home had contributed to this and they hoped as more nurses were recruited they could get 'back on track'. One staff member we spoke with told us supervision meetings took place every four weeks, whilst another member of staff informed us supervisions were held every eight to 12 weeks. Staff files we looked at showed supervision meetings were conducted. However, we saw one staff file showed no supervision meeting had taken place since they started in the middle of 2015.

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 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 asked staff about the MCA. They were able to give us an overview of its meaning and could talk about how they assisted and encouraged people to make choices and decisions. Examples they gave were making sure people were supported and given time to make decisions such as what to wear, what to do and what to eat and how they did this. One staff member told us, "Most people have the same breakfast every day, but we always ask what they want."

There were a number of people who were subject to Deprivation of Liberty Safeguards (DoLS) authorisations in the home. The care plans we looked at included detailed mental capacity assessments for those people who lacked the capacity to give consent. For each decision a separate assessment and best interest process was in place. Assessment areas included, care and treatment, financial decisions and covert medication.

There was a monthly audit of DoLS documentation. The audit checked if a DoLS had been authorised, if CQC had been notified and if there were any conditions. The audit ensured expiry dates and re-application dates were highlighted and there was a care plan in place for the person who used the service.

People we spoke with were positive about the quality of the food and they confirmed they were given choice. People told us, "The food is not bad. I do get snacks brought in by my mum." Another person said, "The food's great, but there's no cook at the moment." Other people we spoke with commented, "Food is not bad" and "Yes, the food is good."

We asked a staff member about food and they told us, "I'd say it's average." Staff were aware of people's dietary requirements including which people had been prescribed thickening fluids. We saw the five week menu planner which showed there were options designed to give people a balanced diet. During the morning we observed a person and a staff member discussing having a change from what was advertised on the menu planner for that day. One staff member told us people can have their say on the menu through the 'food forum' and they can also talk to the staff.

During our inspection we saw cakes and snacks were available throughout the day and drinks were on offer to people.

We observed the lunchtime experience and saw the food was served hot and looked appetising. Staff assisted some

Good

Is the service effective?

people who needed support with their meal. This was done with kindness and the support they gave was unhurried. We saw staff remained in the dining area throughout lunch as some people were at high risk of choking.

People's nutritional assessments were carried out and recorded in their care plans. Quality management records showed there was a monthly audit of weights of people who used the service. The home responded to any significant changes in people's weight and made referrals to appropriate health professionals such as GP's dieticians and speech and language therapists. Resident surveys we looked at showed a high degree of satisfaction with the food and menus in the home.

Within the care plans we looked at we saw evidence of the involvement of other support professional including occupational therapists, speech and language therapists, physiotherapists, dieticians, consultant psychiatrist, GP's and dentists. Health professionals recorded the care they provided into a section entitled 'People Involved in My Care'.

Good

Is the service caring?

Our findings

People and their relatives were positive about the staff who they said were kind, caring and compassionate. One person we spoke with told us, “Staff are great. Thumbs up.” Another person told us, “Yes, I’m happy here.” People we spoke with told us their relatives and friends were welcome to visit them at any time. Family members we spoke with were able to confirm this.

Some people who had complex needs were unable to tell us about their experiences of the service. We spent time observing the interactions between the staff and the people they cared for. We saw staff approached people with respect and support was offered in a sensitive way. We saw staff were kind, caring and compassionate.

We observed staff interacting with people on a one to one basis and in groups. Staff were chatting with people and we saw there were good humoured exchanges. We saw staff spending time to discuss people’s needs and staff demonstrated they knew what people liked and disliked as well as their life history. Staff were observed asking people what they would like to buy their relatives for Christmas.

We looked at the care files for six people who used the service. They contained life histories and information about people’s preferences. We saw staff supported people with different language needs which helped them to express their needs. We saw the registered manager was actively exploring the use of technology to help aid communication.

Family members told us they had been involved in developing and reviewing their relative’s care plans. One relative told us they were actively involved in their family member’s care and they felt fully involved and informed about their wellbeing.

We saw some people were dressed in casual clothing such as t-shirts and shorts. We spoke with staff who told us the condition some people have meant they find it difficult to regulate their body temperature. We found the temperature in the home was very warm although staff did open windows to cool people down when needed.

There was emphasis on dignity and respect in the home. We saw there was a ‘10 Point Dignity Challenge’ on display in the home which reminded staff and people who used the service what dignity and respect meant in practice. This included a zero tolerance approach to any forms of abuse, to treat people as individuals, to enable people maximum choice, control and independence and to act to alleviate loneliness and isolation. There were three staff members who acted as dignity champions in the home. The dignity champions were expected to demonstrate good practice and challenge any bad practice with regards to respecting people’s dignity at all times.

We asked a staff member about how they respected people’s privacy and dignity and they told us, “The way I see it, you knock and you knock gently.” Another staff member told us they closed the curtains when they were providing personal care. We observed staff hoisting people and saw this with carried out with care and dignity. Staff explained the process to the person they were assisting as they carried out the transfer.

One staff member told us about a person who had been reluctant to manage their own personal care. With encouragement over time they managed to persuade this person to have regular showers. A staff member said, “It’s every week now. Sometimes [name of person] asks us.”

When we looked in people’s bedrooms we saw they had been personalised with pictures, ornaments and furnishings. Rooms were clean and tidy showing staff respected people’s belongings.

Good

Is the service responsive?

Our findings

Records showed people had their needs assessed before they moved into the service. This ensured the service was able to meet the needs of people they were planning to admit.

People we spoke with told us they were able to see their care plan and express their wishes.

We spoke with a relative who told us, "We have been happy about the service for [name of person] and we do get feedback from staff and also they call us if there are any issues."

Another family member told us they were involved in their relative's care planning. We asked a staff member about people's reviews and they told us, "Family members are always invited."

Care plans we looked at were written in a way that showed the involvement of people who used the service. Care plans were detailed and contained evidence of a personalised approach to care. The care plans we looked at had clear sections including 'This is me', which contained a lot of information related to people's preferences and care needs.

Staff showed an in-depth knowledge and understanding of people's care, support needs and routines and could describe care needs provided for each person. This included individual ways of communicating with people, people's preferences and routines.

Staff told us the activities coordinator was fulfilling a different role in the home due to staff shortages. One staff member told us, "We could do with more activities." Another staff member told us, "We've got no drivers." On the day of our visit some people expressed they were bored at times, although they did say they enjoyed the trips out. We saw staff asking people about activities and suggesting ideas as well as people making their own suggestions.

We saw people had been involved in creating a picture of their favourite pastimes which had then been placed on the door of their room. The home had a sensory room which was used by the activities coordinator to do nails and some pampering for people. This was confirmed by people we spoke with who told us they enjoyed this. On the day of our inspection we saw a pampering session which took place in the sensory room and later two people went to the supermarket. Staff told us the day before our inspection they had taken a group of people to the cinema. We saw people had access to board games and DVD's in the lounges as well as arts and crafts available in the activities room.

We found one person had recently been taken to the Yorkshire Rail Museum and another person who enjoyed football and had been assisted to attend matches. Special events such as a French day were held where the home added decorations such as French flags on windows and changed the menus to include French cuisine. During our inspection we saw staff were making preparations for an 80's themed event.

A recent audit of meaningful activity had been carried out by the home's occupational therapist. This was done through review of social activity notes. The audit showed a 100% compliance score within the provider's quality assurance system. It was not clear from the results if people who used the service had been asked to comment on their satisfaction with activity in the home. The registered manager said the views of people who used the service and staff's comments were included as part of the check.

The home had procedures in place to deal with concerns and complaints, which included providing people with information about the complaints process and a complaints policy. We saw the procedures on how to raise concerns or make complaints were displayed in a number of places around the home. The registered manager maintained a log of complaints received about the home. We looked at records of complaints and concerns received recently. It was clear from the records that people had their comments listened to and acted upon. This included written responses to people's concerns and apologies for any shortfalls in the service provision.

People we spoke with who attended the 'resident' meetings told us the staff were listening to them and responding to the concerns they had. Relatives told us they felt they were listened to if they had concerns.

Good

Is the service well-led?

Our findings

Relatives told us they thought the service was well managed. They knew the registered manager who they said was approachable.

We spoke with a member of staff who told us, "I love working here." Another staff member said, "They're the best management team we've had in years." Another staff member commented on the registered manager, "You can always go and see him." A fourth staff member said, "I think we're pretty well run." We asked the registered manager about the support they receive from the provider and they told us, "There's a lot of expertise I can access."

People who used the service and their relatives were asked for their views about the care and support the service offered. The provider sent out annual questionnaires for people who used the service and their relatives. These were collected and analysed to make sure people were satisfied with the service. We looked at the results from the latest survey undertaken in 2014 and these showed overall a high degree of satisfaction with the service. A comment from a relative included; 'My relatives are cared for to a high standard and this is due to the hard work and dedication of the nursing staff at Ravensdale who are both professional and caring. You should be very proud of the staff at Ravensdale.'

The survey showed a person who used the service had raised concerns about several areas of support they received. There was no evidence to show how these concerns had been addressed. The registered manager said they were aware they had not completed an action plan following the survey, but had introduced feedback forms for people who used the service. They told us they were about to send out surveys for 2015 and would ensure there were action plans for any shortfalls identified to ensure ongoing improvement in the service.

We saw people held a regular 'resident' meeting which had started earlier in 2015. This meeting was chaired by a person living in the home. People told us this was important to them and we saw from the minutes this gave people an opportunity to formally discuss issues such as staff not wearing identification badges. During our inspection we noted most, but not all staff were wearing identification.

We also saw evidence of a 'carer's forum' being developed and found the provider had a display in the service titled 'You said, we did'. This recorded feedback from people and what action the provider had taken in response. For example, people found when their visitors were at reception, it took some time for staff to respond to them. In response to this, bells were installed on each floor to alert staff to people waiting. The levels of attendance at the forums was low, but the staff were working to ensure as many people attended as possible, by changing meeting times for example. People living in the service also identified they were struggling to recognise new staff. The registered manager responded by placing a wall chart on display which showed the name and a picture of each member of staff, although we noted this was on display in an area not generally accessed by people.

Staff surveys were conducted to give staff opportunity to comment on the service. The responses had been received by the provider. However, no action had yet been taken to address issues raised. The registered manager was aware of the need to develop an action plan.

Feedback on the service was also gained from outside agencies such as health professionals. We looked at the survey analysis from 2014 and saw the results were positive. The surveys said the staff and manager were helpful, followed instructions well and were knowledgeable about people who used the service.

The registered manager told us they had a system of continuous audits in place. We saw this was drawn up in a schedule to show the frequency of audits. This schedule had been followed and was up to date. These audits included care records, medication, health and safety, cleanliness, meals and mealtimes, training, leadership and management. We looked at a sample of audits and saw action plans were in place which showed any issues identified were addressed. For example, a medication audit identified the need to set up a meeting with the supplying pharmacist. We saw this took place on the day of our visit. A health and safety audit identified the home's air conditioning unit needed to be serviced. Records showed this was completed the day after the audit.

We were told senior managers visited the home regularly to check standards and the quality of care being provided. The registered manager and staff said they spoke with

Good

Is the service well-led?

people who used the service, staff and the manager during these visits. We looked at the records of recent visits and saw any actions identified were acted upon to ensure continued improvement in the service.