

Extrafriend Limited Ravenswood

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?	Requires Improvement ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

This inspection took place on 23 October 2018 and was unannounced. At the last inspection we found the provider had met the previous breaches of regulation.

Ravenswood is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Ravenswood provides accommodation and personal care for up to 36 older people, some of whom are living with dementia. At the time of our inspection, the service was providing accommodation and personal care to 28 people.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are registered persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they were safe and happy living at Ravenswood. Relatives told us they felt their relatives received good care from staff who were competent and caring. Throughout our inspection we observed positive interactions between people living at the service and care staff. Staff spoke kindly to people and responded quickly to care needs. Staff knew people well and were able to describe their needs and preferences.

Medicines were managed safely and people received them at the appropriate times.

People were positive about the food and told us they enjoyed their meals. The dining room was busy and noisy during meal times but people could choose to eat in their rooms. Staff supported people to eat independently or assisted if needed. Staff checked that people had enough to eat and drink.

The environment had been adapted where possible to the needs of people living with dementia and people with compromised mobility. People had a choice of two lounges and there was lift access to all floors of the home.

The service provided a range of activities. Some of these took place outside of the service, such as trips to the garden centre or out for coffee. Some people chose not to participate in these activities and preferred to spend most of their time in their room.

People received person-centred care, however this was not always reflected in care plans. Some people's plans lacked information about how staff should support them if they became distressed. Staff did not always record capacity and best interests decisions in a clear manner.

The provider had a comprehensive governance system which was operated effectively. Shortfalls in the service were mostly identified and rectified. However, the audits for care plans and best interests decisions had not picked up these shortfalls.

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.

Risks to people were assessed and plans were in place to reduce them.

Staff understood how to identify and report any concerns.

There were sufficient staff safely recruited.

Medicines were managed safely.

The environment and equipment were checked regularly to ensure they were safe.

Is the service effective?

Good ●

The service was effective.

Staff received regular training and were knowledgeable and competent.

People were supported to have enough to eat and drink.

People had access to ongoing healthcare.

Capacity assessments and best interests decisions were not recorded in a clear manner.

Is the service caring?

Good ●

The service was caring.

People were supported with warmth, kindness and compassion.

Staff respected people's privacy and dignity and supported their independence.

Staff knew and respected people's preferences.

Is the service responsive?

Requires Improvement ●

The service was not responsive.

Care plans were not always person centred.

Care plans did not always contain information about how to support people who were distressed.

People were able to choose to participate in a range of activities.

People received good end of life care, however plans were not detailed enough.

Is the service well-led?

The service was well-led.

Relatives told us the registered manager was accessible and responsive.

There was an effective governance system in operation.

Staff morale was good and staff felt supported.

The provider sought feedback about the quality of the service.

Good ●

Ravenswood

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 23 October 2018 and was unannounced.

The inspection team consisted of two CQC 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.

Some people at the service were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home.

During the inspection we spoke with four people living at the home, three relatives and seven staff members, this included senior staff, and the registered manager. We reviewed 11 people's care and support records and four staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and complaints.

Is the service safe?

Our findings

People who were able to speak with us told us they felt safe at the service. We were told, "I am safe because there are people looking after me and they know me well," and, "I am safe because it is a nice place and they are doing their best." Relatives we spoke with were confident their loved ones were safe. Comments included, "My [Name] is safe here because there is no lack of attention; staff understand my [Name] and their needs and recognise if there is a problem, then respond immediately. There are always plenty of staff around to help and make sure they are never left on their own."

Staff had been trained to keep people safe from harm and understood when to report concerns. For example, records showed that staff had reported bruises of unknown cause to nursing staff. At least one member of staff was present in communal areas at all times, which reduced the risk of any altercations between people living at the service.

Care plans contained risk assessments for areas such as falls, skin integrity and malnutrition. When risks were identified, the plans provided some guidance for staff on how to keep people safe; however other information was not in place. For example, hoist and sling details were specified and how often to change people's position, but staff had not always documented information about what pressure-relieving equipment settings should be.

Air mattresses were set correctly and regularly serviced. Regular checks were carried out to ensure mattresses were set at people's weights. However, staff had not always recorded when they had changed a person's position. The nurse on duty said, "I check people throughout the day. My observations are that people do have their positions regularly changed." Mattresses were serviced regularly and recently four air mattresses had been replaced.

Some people had bedrails in place to keep them safe whilst in bed. In these instances, bed rails risk assessments had been carried out. Regular checks of rails were carried out to ensure they were being used correctly.

There were enough staff on duty to meet people's needs. The clinical lead said, "Our staffing levels have increased. We always have enough. Our safeguarding incidents have gone down because we have more staff around to prevent things happening." Staff we spoke with told us there were enough staff on each shift. We observed staff had time to respond to people's needs and to sit with them.

The provider followed a recruitment procedure to reduce the risk of employing unsuitable staff. Staff files showed the provider had carried out checks before employing new members of staff. All contained a Disclosure and Barring number (DBS). This is a check that is made to ensure potential staff have not been convicted of any offence which would make them unsuitable to work with vulnerable people. Staff files also contained proof of identity, an application form, a record of their interview and two references.

Senior staff explained how they monitored staff performance by observation and that they would

immediately address any poor practice.

At our previous inspection we found that medicines were not managed safely, because medicines were not always administered in line with the Mental Capacity Act 2005. At this inspection we found that improvements had been made and legislation was being followed. Some people were having their medicines administered covertly. This is when medicines are disguised in food or drink. People's capacity to consent to having their medicines administered this way had been assessed. When people lacked capacity, best interest decisions had been made with input from their GP and the pharmacist. This was documented and showed how the decision had been reached and who had been involved. The pharmacist had documented which medicines were safe to crush and when liquid medicines were available as an alternative.

Some people had been prescribed additional medicines on an as required (PRN) basis. There were PRN protocols in place, but these provided staff with limited information on when and why people might require them.

Additionally, the steps staff should take to try and alleviate the agitation prior to resorting to the use of medicines had not been documented. However, staff were able to describe what steps they took when a person was becoming agitated which included tactics such as retreating and returning a few minutes later or sending a different member of the team. Staff had written when these medicines had been administered on the reverse of the medicine administration records (MARs), but had not always documented the outcome.

Alongside this, daily records did not always refer to people being agitated or that medicine had been administered. We discussed this with the nurse on duty who said, "If the staff tell me someone is agitated I will go and check on the person. Mostly I will suggest we try other things rather than give medicine. We have been told to make sure we document when people are agitated. I know we need to write it in the daily notes."

There were photographs at the front of MARs and these were dated to indicate they remained a true likeness of people. People's preferences had been documented, but these were not always up to date. For example, one person's preferences were documented as "I am compliant with taking my medication", and the same had been written in their care plan, yet there was documentation in place indicating their medicines were to be administered covertly. We discussed this with the clinical lead who said they would update the information.

Medicines were stored safely, including those that required additional storage. At our previous inspection we found the temperature monitoring of medicine storage was not robust. At this inspection we found improvements had been made. Records showed the temperature of the medicines room was monitored and was maintained within safe levels. The temperature of the medicines fridge was also monitored. Medicines that were no longer required were disposed of safely.

Some people had been prescribed topical medicines such as creams or lotions. Although there were topical charts in place for staff to sign when they had applied these, they had not been consistently signed. For example, one person was prescribed a barrier cream to be applied, "two to three times daily." Although there was a body map and instructions in place, the chart had only been signed on seven occasions during October.

The environment was clean and free of odours. A relative told us, "I come in at all times and the place is

always clean, my [Name's] room is always clean and tidy, there are never bad smells." Staff had access to personal protective equipment such as gloves and aprons. Staff we spoke with understood how to reduce the spread of infection and were clear about the safe management of laundry. We saw that staff wore aprons when assisting people with their lunch. The registered manager undertook regular infection control audits. Where shortfalls were identified action was taken.

Equipment in the service underwent regular maintenance. The provider carried out checks of hoists and slings in line with guidance. The lift was serviced regularly. The provider carried out electricity safety checks and regular fire equipment checks. Regular health and safety checks were carried out to manage environmental risks within the service. For example, there were checks that radiators were covered, water temperatures were within a safe range to reduce the risks of scalds, and window restrictors were in place to prevent falls from a height.

Is the service effective?

Our findings

Relatives told us staff were competent. One relative told us, "As far as I am concerned they are well trained and very competent. For example, they knew there was something wrong with my [Name] who is unable to tell them. They called the doctor who sent her to hospital."

Care staff told us they received regular training and updates. Some training was online and other was face-to-face. Staff told us they had time available to do the online training. Staff we spoke with demonstrated clear knowledge about the training they had received. There was regular supervision of staff which was a mixture of group and individual. Supervision is where staff meet with a senior staff member to review and discuss work or any other issues affecting the people who use the service."

Nurses said they had access to training and development in order to carry out their roles. For example, one nurse said, "I've done catheterisation, venepuncture, dementia and all of the mandatory training." Nurses said the training enabled them to meet their professional registration requirements and that if they identified training courses of interest they were supported to attend these.

The clinical lead and the nurse on duty both said they felt well supported. They said they had regular supervision sessions. The nurse told us, "[Name] does a supervision with me every few months or so. I've learnt a lot from [them]."

People were supported to have enough to eat and drink. People were assessed for the risks of malnutrition and people's weights were monitored. When required, specialist advice and support was sought. For example, records showed people had been reviewed by the speech and language therapy team and their recommendations had been included within care plans. The plans detailed the level of support people needed when eating and drinking. For example, plans included details of how people should be supported to eat independently where possible, such as the use of plate guards.

We looked at the plan for one person who was receiving some of their nutritional intake via percutaneous endoscopic gastrostomy tube (PEG). The plan included the person's artificial feed regime and how the PEG site should be cared for. The person's additional nutritional requirements were also documented and weight records showed the person had gained weight as planned.

Some people were having their food and fluid intake monitored. We saw that records had been maintained and that fluid intake was totalled each day. Care plans had target intakes documented and we saw these had been met or exceeded.

People were positive about the food at the service. One person said, "I like the food here, they know I don't eat meat so they give me what I want." We observed the lunchtime experience. Where people needed support to eat their lunch, this was done in an unhurried way, with staff checking when they were ready for the next spoonful and often asking if they were enjoying it. However, one member of staff took a phone call whilst supporting someone, then leaving them to collect a file from the office before continuing with the

meal. Many people ate in the communal dining room. However, the noise level was high, and this did not make for a relaxing and sociable experience.

The environment had been adapted, where possible, to support people with dementia and people with mobility issues. Communal areas were wheelchair accessible and there was a lift. People had a choice of two lounges, one of which was designated the 'quiet' lounge. Toilets and bathrooms were clearly signposted. There were pictures on the walls in the lounges of snacks to prompt people to ask for these. People who were at risk of falling had pressure mats and sensors by their beds or armchairs to alert staff to their movement.

People had access to ongoing healthcare. The GP visited weekly and there was a book for staff to record which people needed to be reviewed and the reasons why. Records showed people had also been reviewed by social workers, physiotherapists and advocates. Physiotherapists had shown the Activities Co-ordinator a series of chair exercises to use with specific people. The clinical lead said, "We invite relatives to come along for the GP rounds if they want to."

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

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

People's capacity to consent to aspects of their care had been assessed; however, best interest documentation did not always detail how decisions had been reached. For example, although best interest decisions for the use of covert medicine administration explained why people needed to have their medicines this way and what alternatives had been considered, decisions in relation to the use of bed rails did not. We looked at the best interest documentation for two people who had bed rails in place and in both cases there was nothing written to explain if any less restrictive options had been considered or why these had been rejected. In one person's plan it was documented, "[Person] lacks capacity to maintain own safety and has been assessed to require bed rails for safety when in bed."

Other capacity assessments had been carried out and recorded on the electronic care plans. However, the best interest decision was not always documented clearly and in some cases stated the person did not have capacity before the questions to ascertain this had been asked.

We recommend the provider review the recording of capacity and best interests assessments.

In other instances, documentation was clear. For example, one person had been assessed as being at risk of choking due to difficulties with swallowing. They had been reviewed by the SALT team and it was recommended the person should have a soft diet. The person had informed staff they wanted to eat biscuits and they had been assessed for their capacity to understand the risks associated with this. Staff had concluded the person was aware of the risks and should be supported to eat biscuits if they wanted to, with staff supervision.

Is the service caring?

Our findings

Staff interacted with people in a natural, friendly, caring and compassionate manner; it was apparent that staff knew the people they cared for well and their likes and preferred choices. They were aware of how individual people were feeling from their body language and took appropriate action to prevent problems, for example by talking to them and or escorting them to another area.

One person said, "I like to have a laugh with the staff." They told us they liked to joke with staff and that it "brightens my day to have a joke." A relative told us, "My [Name] receives loving care, they understand them; I cannot speak highly enough of the way they are looked after."

Staff were very patient, they spoke to people using appropriate volume and tone of voice; terms of endearment were used appropriately with positive reactions. For example, we witnessed a person who had been very unwell and was being cared for in bed smiling and gently blowing kisses to their carer who had just given them a drink. Another person was enjoying chatting with a carer discussing football teams, and talking of their experience of meeting the Beatles, which ended with the carer singing a Beatles' song.

Staff told us some people just want physical contact, so they sit with them and hold their hand. The nurse on duty said, "It's good care here. I know it is because I observe the care staff and I can see they do a very good job," and, "the staff are all very friendly, it's like a family here." A senior member of staff said, "I train the staff to treat people living here the way they would want their relative treated."

Staff used a picture communication board with one person who was unable to express themselves verbally.

We saw staff constantly checking on people who preferred to stay in their rooms and keeping other staff informed of their condition. Whilst most people appeared to be well kempt, others appeared to be dishevelled; we were told that this was because they had either refused personal care, or that it was how they wished to look, which was respected.

People were encouraged to be as independent as possible, one person told us, "Everybody is okay, they encourage me to do what I can." Staff told us they knew from people's care plans what they could do for themselves such as going to the toilet independently or washing.

Staff respected people's privacy and dignity. A relative told us, "They are extremely kind to my [Name] who likes them; they always knock before entering [Name's] room, and are very respectful." All staff we spoke with were able to describe how they respected people's privacy and dignity, such as closing doors, asking permission and explaining. We observed staff knocking and calling out before entering people's rooms and staff discreetly telling people they were going to help them to the bathroom before their meal.

Is the service responsive?

Our findings

Care plans were person centred in part but this was not seen consistently. The service used an electronic care planning system and in some cases we saw that generic statements had been used, rather than personalised information. For example, end of life plans for two people had the same objective, "To ensure [name] is pain free, comfortable and is dignified." Other information within plans sometimes conflicted. For example, in one person's plan it was written that they were at risk of falling from their chair. The plan stated the person should not be left alone without supervision when sat in their chair, but later within the same plan it was written that staff would monitor the person "hourly to two hourly."

Plans in relation to the types of behaviour people sometimes displayed were not always detailed and did not always inform staff of any known triggers or actions staff should take to de-escalate situations. For example in one person's plan it was documented, "Can be restless, vocal, agitated and disinhibited and rude/cheeky." There was nothing to inform staff what, if anything might cause the person to act in this way, or if there were any steps they could take to reduce the likelihood of this. Instead, the guidance for staff was limited to, "Staff should walk away and come back later. Staff can reposition me in another room when I'm making others angry." In another person's plan however, it was written that certain things could trigger the person to become verbally aggressive. The actions staff should take to alleviate this and to help the person to become calm again were listed.

Care plans were reviewed regularly. People and their relatives were invited to care plan reviews. However, when people's needs changed, plans had not always been updated. For example, we looked at one person's mobility plan. It was documented the person was "immobile." However, in another section of the plan it was written the person could walk, albeit only with two physiotherapists. The nurse on duty confirmed the person was now able to mobilise when the physiotherapists supported them, but the plan had not been updated to reflect this.

There was a folder available which described what could cause people to become upset or agitated and actions staff should take in these instances, but this was not comprehensive and the information within was not always documented within people's care plans. This was also noted during the previous inspection.

Plans in relation to people's health needs were also of a variable standard. We looked at the plan for one person who was an insulin dependent diabetic. It was documented, "My blood sugar is very erratic." However, the guidance for staff was limited to, "Nurse to be aware of signs and symptoms of hypo/hyperglycaemia." The signs and symptoms for care staff to observe for were not listed which meant there was a risk they would not be aware if the person became unwell. We looked at the plan for one person who was at risk of seizures. Although the plan informed staff what to do in the event of a seizure, it did not inform staff what a seizure for that person might look like.

Communication plans were also variable. The plan for one person who was registered blind informed staff to touch their hand when speaking to them, so they would know staff were talking to them and to tell them where food and drink was so that they could eat independently. However, the plan for another person who

had limited speech informed staff to, "Assess for non-verbal communication and body language to ensure choice has been given" but did not specify what staff should look for.

Wound care plans were detailed. They contained information for staff on the which dressings to apply and there were photographs in place to help staff to assess for signs of improvement or deterioration.

People's life histories and preferences had in the main, been documented. Staff we spoke with were familiar with these.

Throughout the day of our visit we observed staff sitting with people in the lounge and anticipating or responding to their needs. They were very vigilant and recognised the signs if a person required support or reassurance.

We saw one person becoming restless, and staff realised this was a sign that the person wanted to go outside into the garden. A member of staff accompanied them and when seen later this person was completely calm and relaxed. Similarly, staff recognised when another person wanted a cigarette and facilitated this.

People told us they were able to talk to the registered manager if they were unhappy, "I would speak to the manager if something was really bad, but don't expect to because they let me do what I like." Another person said, "I don't have problems or worries because they treat me well. I stay in my room because I don't like the noise out there (the lounge)." Relatives said they would be confident to raise any concerns, "I would contact the manager by e-mail if I was worried."

People had access to a range of activities which included, pampering, pet therapy, memory lane and gardening club. However, on the day of our visit the afternoon activity, gardening club, was cancelled but no explanation was given. Activity provision was audited monthly and records kept of who had participated. People were supported to go out if they wished, for example people had been to the seafront and had coffee, out to the garden centre and on shopping trips. Not all people were able nor wished to engage in activities, and this was respected.

People received kind and compassionate end of life care. We saw positive feedback from one person's relative. Staff told us they ensured people's needs were met so that they could be calm, comfortable and pain-free. One member of staff said, "Its important they don't feel isolated or alone, they need to know we are there for them. We involve people as much as we can." Staff described also being available to support people's family and friends. However, care plans did not contain sufficient information about people's wishes. For example, one person wished a Catholic funeral, however there was no information to record if they would like a priest to visit.

Is the service well-led?

Our findings

Relatives were positive about leadership in the service. One relative told us, "There is a very gentle atmosphere at the home, it is friendly and clean; it is well run and well managed; [Name], the manager, is mostly in [their] office but can be seen walking around at times; it is easy to see [them] if you want, you just have to ask, [they are] willing to listen and is friendly and professional." The clinical lead and the nurse on duty were aware of improvement plans since the last inspection. The clinical lead said, "It's much better. Care plans have improved, although we know it's a work in progress and staff have access to more training. We've worked hard to get staff to understand people's needs."

Staff said morale was improved and "a lot better." They spoke highly of the registered manager, with comments including, "[Registered manager] is visible, [they] walk around a lot and do spot checks." The clinical lead said, "Families are more involved now. We welcome their input and suggestions and get them involved in care plan reviews."

Staff spoke highly of the registered manager. Comments included, "[Registered manager] is very good. Any problems, [they] always speak kindly to us. [They're] really good at their job" and "[Registered manager] and I have a good relationship. We work very closely together."

There was a comprehensive governance framework in place. The registered manager undertook audits of systems and processes in the service and developed action plans where shortfalls were identified. Where an action plan had been developed it had been dated and signed off when completed.

The majority of audit systems and processes at the service were good. We identified improvements since the last inspection. Where we found shortfalls was mainly in capacity recording and care planning. Whilst care plans had improved they continued to need further work.

The provider sought the views of staff, people living at the service and their relatives through surveys. We saw the most recent survey responses which had not yet been collated; they were overwhelmingly positive. Other feedback stated, "Thanks for looking after [Name] so brilliantly. You are exceptional people and I am continually impressed by your kindness."

There were care staff and nurse meetings where issues could be raised. We saw one set of minutes where staff had been reminded of how to support people in the heat, following comments by a professional visitor.