Old Raven Limited

Old Raven House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was unannounced and took place on the 31 July and 2 August 2017.

Old Raven House (to be referred to as the home throughout this report) is a home which provides residential care for up to 36 people who have a range of needs, including diabetes, people living with sensory conditions such as hearing and slight loss as well as people living with dementia. At the time of the inspection 36 people were using the service.

The home comprises of a period property with a purpose built extension with front and rear gardens which offers seating areas for people, relatives, visitors and staff to enjoy. The garden also contains hutches for two rabbits and two guinea pigs which are used in animal therapy sessions.

On the ground floor the home has living accommodation with communal areas including lounges, dining rooms, a conservatory and a sun lounge which faces to the front of the house. On the ground floor there is a kitchenette area where people, relatives, staff and visitors can make hot and cold drinks. The ground floor also has a hairdressing business and salon which is also available for use by members of the public. The first floor is accessible by one main staircase which has an operational stair lift. The first floor comprises of living accommodation. Communal bathrooms and accessible toilets are available on both floors.

The home has a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. However, the policies and systems in place did not always support this practice. It had not always been clearly documented that where people lacked the capacity to make specific decisions for themselves that actions taken on their behalf were always in their best interests. Immediate action was taken following the inspection to ensure these decisions were documented fully. Staff sought people's consent before delivering their care and support.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards which apply to care homes. The registered manager showed an understanding of what constituted a deprivation of a person's liberty by the correct submission of relevant applications to ensure people were not deprived of their liberty without legal authority.

People using the service told us they felt safe. Staff understood and followed guidance to enable them to recognise and address any safeguarding concerns about people. People's safety was promoted because risks that may cause them harm had been identified and guidance provided to staff to help them manage these appropriately for people.

People were supported by sufficient numbers of staff to meet their needs. The provider was able to adapt their staffing levels appropriately when required in order to meet changes in people's needs.

Recruitment procedures were fully completed to ensure people were protected from the employment of unsuitable staff.

People received their medicines safely; senior staff were responsible for managing medicines and had received the appropriate training to enable them to complete their role safely. Medicines were stored, administered, disposed of and documented appropriately.

Contingency plans were in place to ensure the safe delivery of people's care in the event of adverse situations such as a fire or flood which may result in the loss of their living accommodation. These were accessible to staff and emergency personnel such as the fire service, if required to ensure people received continuity of care in the event of an on-going adverse situation which meant the home was uninhabitable.

People were supported by staff who received appropriate training enabling them to meet people's individual needs. Staff received regular supervision to ensure they were supported in their role.

People were supported to eat and drink safely whilst maintaining their dignity and independence. We saw that people were able to choose their meals and were offered alternative meal choices where required. People's food and drink preferences were documented in their care plans and were understood by staff. People were supported to eat and drink enough to maintain a balanced diet.

People's health needs were met as the staff and registered manager promptly engaged with other healthcare agencies and professionals to ensure people's identified health care needs were met and to maintain people's safety and welfare.

People told us that care was delivered by kind and caring staff who sought to meet their needs and ensure they were happy. We saw that people had friendly and relaxed relationships with staff who would stop and speak with them as they moved around the home.

Care plans and risk assessments contained detailed information to assist staff to provide care in a manner that respected each person's individual requirements and promoted their dignity. People were encouraged and supported by staff to make choices about their care including how they spent their day in the home.

People's care plans and risk assessments were reviewed monthly or sooner when required to ensure they remained accurate to enable staff to effectively meet people's needs.

People knew how to complain and told us they would do so if required. Procedures were in place for the registered manager to monitor, investigate and respond to complaints in an effective way.

The provider's values were communicated to staff. Staff understood these and relatives told us these standards were evidenced in the way care was delivered.

The registered manager and staff promoted a culture which focused on being open, honest and inclusive, empowering people to share their care experiences. The registered manager provided strong positive leadership and fulfilled the requirements which would be associated with their role as a registered manager.

The registered manager had informed the CQC of notifiable incidents which occurred at the service allowing

the CQC to monitor that appropriate action was taken to keep people safe. Quality assurance processes were in place to ensure that people, staff and relatives could provide feedback on the quality of the service provided. People were assisted by staff who were encouraged to raise concerns with the registered manager.

The quality of the service provided was reviewed regularly by means of effective quality control audits. These were completed to identify areas where the quality of the service provided could be improved. We could see action had been taken to address where any shortfalls in the service provision had been identified.

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 safeguarded from the risk of abuse. Staff were trained in safeguarding, understood how to protect people from abuse and knew how to report any concerns.

Risks to people had been identified. Recorded guidance was provided for staff and reviewed monthly to ensure people's needs were managed safely

People were supported by sufficient numbers of staff to meet their needs in a timely fashion. There was a robust recruitment process in place to ensure staff had undergone thorough and relevant pre-employment checks prior to commencing their role.

Medicines were administered safely by senior staff who received training appropriate to their role to ensure medicines were stored, administered, documented and disposed of safely.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered manager had not ensured that consent had been obtained for shared rooms and where care was provided in a person's best interests that this had always been documented appropriately involving all relevant parties in those discussions.

People were supported by staff who were not always able to discuss the principles of the MCA however, demonstrated a detailed awareness of how to enable and support people to make choices in their daily lives.

People were supported by staff who completed a nationally recognised induction process to ensure they had the skills and knowledge required to meet people's needs in an effective way.

People were encouraged to participate fully in mealtimes to ensure they ate and drank sufficient to maintain their health and wellbeing.

Is the service caring?

Good

Staff were kind and caring in their approach with people, supporting them in a kind and sensitive manner.

Staff had a well-developed understanding of people and had developed companionable and friendly relationships with them.

Where possible people were encouraged to assist in creating their own personal care plans to ensure their individual needs and preferences were known and provided by staff.

People received care which was respectful of their right to privacy and maintained their dignity at all times.

Is the service responsive?

Good

The service was responsive.

People's needs had been appropriately assessed. Staff reviewed and updated people's care plans and risk assessments on a regular basis with additional reviews held when people's needs changed.

People were encouraged to make choices about their care which included their participation in home activities and how they wished to spend their time at the service.

There were processes in place to enable people to raise any issues or concerns they had about the service. Any issues, when raised, had been responded to in an appropriate and timely manner in accordance with the provider's complaint policy.

Is the service well-led?

Good

The service was well led.

The registered manager promoted a culture which placed the emphasis on all staff being open, positive and inclusive with people receiving care.

The registered manager provided strong leadership and fulfilled the requirements of being a registered manager by informing the Care Quality Commission about important and significant events.

Staff felt supported by the registered manager. They told us they were able to raise concerns and felt the registered manager provided strong leadership.

The registered manager regularly monitored the quality of the service provided so that continual improvements could be made.	

Old Raven 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 function. This inspection checked whether the provider was 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 the 31 July 2017 and 2 August 2017 and was unannounced. The inspection was conducted by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service; on this occasion they had experience of family members who had received care. The Expert by Experience spoke with people using the service and their relatives.

Before this inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. We also asked the provider to complete a Provider Information Return (PIR) before the inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 10 people, four relatives, one visiting health care professional, two senior care assistants, four members of staff, the deputy manager and the home's registered manager. We looked at 10 care plans, five staff recruitment files, staff training records and people's medication administration records. We also looked at staff rotas for the period 3 July 2017 to 31 July 2017, quality assurance audits, the provider's policies and procedures, complaints and compliments and staff and relative meeting minutes. Not all the people living at the home could share their experiences during the inspection we spent time observing staff interactions with people including during activities and lunch time sittings.

Following the inspection we spoke with the activities coordinator, the chef and a healthcare professional who works with the home.

The home was previously inspected 24 and 26 March 2016 when no concerns were identified.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living at the home, one person told us, "Oh definitely, 100%", another person said, "Oh yes. I look around and see all the girls (staff) and feel safe". This was a view shared by relatives, one relative told us, "You want them (family members) to be somewhere where they're safe and happy as they can be in their own world". A healthcare professional told us, 'I find staff to have a good understanding of assessment of risk, health and safety…staff are very vigilant about the whereabouts of residents.'

People were protected from the risk of suffering abuse as staff were able to demonstrate their awareness of what actions and behaviours would constitute abuse and provided examples of the types of abuse people could experience. Staff were also able to describe the physical and emotional symptoms people suffering from abuse could exhibit if they were unable to verbally express their concerns. Staff were knowledgeable about their responsibilities when reporting safeguarding concerns and felt confident to report any concerns. This included to the registered manager, the provider and external agencies such as the local authority and the Care Quality Commission if required.

Risks to people's health and wellbeing were identified and guidance provided to mitigate the risk of harm to them. All people's care plans included their assessed areas of risk; for example, people's moving and handling needs, their identified falls risk and any individualised risks identified such as the risk of them leaving the home without staff's knowledge. Risk assessments included information about action to be taken by staff to minimise the possibility of harm occurring to people. For example, some people using the service could be reluctant to receive personal care and expressed this through both verbal and physical resistance. Information was provided in people's care plans for staff with regards to how to support people safely with these behaviours, in order to ensure their health and wellbeing needs were met. Risks to people's care were identified, documented and staff knew and demonstrated when supporting people how they ensured people's safety.

There were robust contingency plans in place in the event of an untoward event such as fire, flood, and power loss. The provider's Emergency Contingency plan contained detailed and relevant information to ensure people would continue to receive the care they required in an emergency situation. This also included arranging alternative accommodation arrangements if required. This plan was up to date and accessible to all emergency service personnel such as fire and police if required.

Robust recruitment procedures ensured people were assisted by staff with appropriate experience and who were of suitable character. Staff had undergone detailed recruitment checks as part of their application and these were documented. These records included evidence that pre-employment checks had been made which included obtaining written references with regards to applicants previous work experiences and personal character. Recruitment checks also included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care services. People were kept safe as they were supported by staff who had been assessed as suitable for the role.

Relatives and staff we spoke with felt there were sufficient numbers of staff deployed in order to meet people's needs. One member of staff told us, "Yes, I don't feel rushed and I think we give good care". Another member of staff told us, "It (staffing) is not a problem. We are a good team and we will cover for each other. If we are short because someone is sick, one of us will come in". Staff told us if someone was unable to work due to last minute reported sickness they would work as a team in order to ensure all people's needs were met. Staff also said the registered manager would assist if required in order to support the existing staff team to meet people's needs; by for example, assisting people at mealtimes and managing people's medicines, which we saw during the inspection.

The registered manager identified the minimum staffing levels required to provide safe care which consisted of five members of staff plus a team leader throughout the day and two members of staff plus a team leader working during the night. The home also used additional 'twilight' staff to support people during busy periods such as supper and bed times. There was no reduction in staffing levels at weekends and staff were supported by housekeeping, activity, maintenance and kitchen staff on duty allowing care staff to focus on supporting people. Records and observations during the inspection showed sufficient numbers of staff were deployed to meet people's needs safely. Staffing levels were reviewed by the registered manager and adapted to meet an increase in the level of people's needs when required.

People living at the home received their medicines safely. Senior staff received training in relation to medicines management. The home used an electronic system of medicines management, staff used an electronic 'tablet device' for medicines administration and recording. People's electronic medicines administration records (eMARs) were correctly completed to identify people had received their medicines as prescribed. Senior staff were required to undertake three monthly competency assessments to ensure people's medicines were managed and administered safely. Senior staff ensured the administration and management of medicines followed guidance provided by the Royal Pharmaceutical Society.

We noted that medicines given on an 'as needed' basis (known as PRN) were managed in a safe and effective way. PRN protocols were in place for each person taking medicines in this way; they outlined how, when and why they should be taken and included maximum doses over a 24 hour period.
All medicines were delivered and disposed of by an external provider. We noted the management of this was safe and effective, in line with the provider's policy. Medicines were labelled with directions for use and contained both the expiry date and the date of opening, to ensure they were used within a safe time period. Topical creams which are applied to the skin, dressings and lotions were labelled with the name of the person who used them. Their use was signed for on topical eMAR charts when they had been administered and they were safely stored. Other medications were safely stored in locked cupboards. There were no medicines requiring refrigeration at the time of our inspection however, the provider did have access to suitable equipment to ensure it could be stored appropriately if required.

Some prescription medicines are controlled under the Misuse of Drugs Act 1971, these are called controlled drugs and they have additional safety precautions and requirements. At the time of the inspection the home were not storing any controlled drugs, however, if required appropriate systems were in place to ensure these would be stored, documented and audited appropriately.

Requires Improvement

Is the service effective?

Our findings

Most people spoke positively of the food they received, one person told us, "It's quite good", another person said, "Lovely, I'm happy with that". Relatives confirmed food was of a good quality, one relative told us, "I'm impressed with the food looking at it and there's a lot of it". Relatives told us staff had the skills and experience to care for their family members, one relative told us, "(staff) deal with residents according to their needs…they definitely know how to handle him (family member) when to be strong with him and kind as well". A healthcare professional told us, 'I have always found staff to be knowledgeable about their residents and have the required knowledge to underpin safe and effective care…the home has experienced team leaders who have more extended knowledge...team leaders contact health care professionals for advice or referral in a timely and appropriate way.'

When people had been assessed as not having the capacity to make key decisions about their care, the provider had not always documented actions taken in people's best interests. 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 checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager understood the appropriate legislation which was evidenced through the appropriately submitted DoLS applications and authorisations. However, for some people applications made to deprive them of their liberty had not always been discussed with relevant persons and the appropriate action documented fully as being in their best interests, to ensure legal requirements were met. Best interests decisions are made in conjunction with people close to the person the decision is being made on behalf of, to ensure their needs are met fairly and any action taken is for the benefit of the person.

Staff were not always able to clearly identify the principles of the MCA however, people told us and staff demonstrated that they complied effectively with the MCA by offering people choices with their day to day care. One member of staff told us, "Most people have dementia but they can still make decisions for themselves. We always try to give residents as much independence as possible". Staff spoken with understood why DoLS were required.

For people who were no longer able to make decisions regarding their care the registered manager had not ensured that the appropriate processes had always been followed to make decisions in people's best interests. A number of people living in the home shared double rooms. However, the provider had not always protected people's rights to privacy and ensured they had consented to sharing a room with another person. We saw there were six shared rooms with two people living in each. However, people's consent had

not been obtained and where this could not be provided, appropriate MCA or best interests' records had not been completed. This meant that people were at risk of sharing rooms where it had not been appropriately assessed as being in their best interests or the appropriate consent sought before this action was taken.

We brought this to the attention of the registered manager who took immediate action following the inspection to ensure people's consent had been sought or the appropriate MCA and best interest decision discussions held with relevant parties and the results documented accordingly. More time was needed to ensure this practice became embedded in working practices.

For other people we saw the principles of the MCA were followed clearly. Some people living at the home received their medicines covertly, that is without their knowledge or consent. Documentation relating to the needs for this method of administration were accurately and fully completed. The appropriate MCA assessments had been completed with best interest meetings held with relevant persons. This ensured the care provided was fully documented as being in a persons' best interest.

People were assisted by staff who received a thorough and effective induction into their role at Old Raven. This induction included a period of shadowing experienced staff to ensure that they were competent and confident before supporting people. New staff were required to complete an induction which was based on the Care Certificate. This is a nationally recognised structured induction programme which ensures staff are sufficiently supported, skilled and assessed as competent to conduct their role and meet the needs of the people they support. The provider had adapted the Care Certificate so the learning was focused on meeting the needs of those living in the home.

The provider had identified training which they felt was essential for staff to complete to enable them to provide care and training; refreshers were completed by staff when required. Staff spoke positively of the training provided, one told us, "It's good, I'm happy with what we do, we get together and we have little groups which is nice and we also have people from outside who come in and if we're not sure (registered manager) will get training, we'll only have to ask there's plenty going on all the time". Another member of staff said, "Yes, the training has been useful, certainly when (deputy manager) gave training for dementia….that opened up my mind and that's one bit of training I've really taken on board and ran with". As a mandatory package staff had undergone training in areas which included: infection control, health and safety, moving and handling people, fire awareness, safeguarding adults, first aid and food hygiene.

Staff were also supported to complete training in the following areas, nutrition awareness, end of life care, the MCA, the care of people with dementia, diabetes awareness, food allergy awareness and record keeping.

People were assisted by staff who received support in their role. There were documented processes in place to supervise and appraise all staff to ensure they were meeting the requirements of their role. Supervisions and appraisals are processes which offer support, assurance and learning to help staff develop their skills and abilities.

Supervision and appraisal records were detailed and individualised. During these processes issues of importance to both the supervisor and member of staff were discussed. Staff told us they were able to speak to the registered manager at any time and felt supported as a result. All staff told us their supervisions were a useful process in allowing them to share their views and any concerns they had. Processes were in place so that staff received the most relevant, current knowledge and support to enable them to conduct their role effectively.

We saw people enjoyed the meals which were provided and were supported by staff who were patient and attentive to their needs. Staff were flexible in their approach when supporting people to ensure they were offered every opportunity to enjoy their meals. Lunch was not rushed and there was a relaxed atmosphere in the dining rooms. When people required additional support to eat and drink the home ran a 'Lunch club,' whereby people were encouraged to eat their meals in the quiet conservatory area. Where there were fewer distractions which allowed people to focus on what they were eating. Staff supported people in the lunch club to ensure they were eating and drinking sufficient to maintain their nutritional and hydration needs. This was also seen as a social occasion as staff ate their meals at the same time offering an unobtrusive and relaxed environment.

When staff supported people to eat they were patient and gentle in their approach and gave people time to eat and drink what was provided. People had drinks readily available to them and biscuits were regularly offered to support people who may not always be willing to eat a main meal. Snacks such as sandwiches, fruits, cake, toast and a selection of hot drinks were available to people day and night in the event they wished to have something additional to eat.

The chef working at the home evidenced they clearly knew the people they supported and obtained their feedback regularly to ensure they enjoyed the food provided. They were able to discuss people's specific dietary needs such as those who required a diabetic, fortified or soft diet. The chef evidenced they knew people's preferences and had designed a menu to meet people's needs. Adaptive cutlery and plates were available to people to enable them to maintain their independence whilst eating.

People were supported to maintain good health and could access health care services when needed. Processes were in place to ensure the early detection of illness or ill-health for people. Some people living at the home required regular weighing as they were at risk of losing weight due to poor nutritional input. Professional health care advice was sought and followed by staff which was evidenced during the interactions with the staff. For example, for people experiencing weight loss staff appropriately sought professional support and guidance from other professionals such as the people's GP when these situations arose. This was sought to identify whether or not there was any additional action the home could take to meet people's needs. There was evidence of referral to and collaborative working with healthcare professionals, families, people and staff.

Good

Is the service caring?

Our findings

People and relatives confirmed that support was delivered by caring staff. One person we spoke with told us, "I can't moan about the attention you get from the carers, it's excellent. They (staff) do their best to do what you want, they are terrific". Another person said, "I look at the girls and they have to look after us miserable lot, but they are great, they're (staff) all nice, and that makes a difference". This view was shared by relatives we spoke with, one relative told us, "They're (staff) professional, kind and courteous…the staff are always happy and smiley and always very helpful". Another relative told us, "They're (staff) extremely caring…they're interested in the residents and they care about him in the way they talk about him and are attentive to their needs". A healthcare professional told us, 'I visit Old Raven regularly and observe staff interacting with residents, staff know their residents well and are extremely kind and caring. I have observed residents being supported to do as much as they can for themselves.'

Caring, supportive and friendly relationships had been developed by staff with people, this was observed by relatives we spoke with, one relative told us, "He's (family member) been made to feel so at home and he's made relationships with staff which is wonderful because they smile when they come up to him…and there is this spark between them, it's lovely to see, I can't fault them (staff) they've been absolutely amazing". These relationships were supported by care plans which had been written in a person centred way. Person centred is a way of ensuring that care is focused on the needs and wishes of the individual. Care plans were written in a way which showed affection for the people they were discussing. They contained personal information to assist staff to know about them as individuals, describing both their care and support needs along with the positive personality traits they wanted staff to acknowledge. These allowed staff to have a greater understanding of people's needs and the care they required.

Staff were knowledgeable about people's personal histories and preferences and were able to tell us about people's families and hobbies. Staff in the home took time to engage and listen to people as they moved around the home.

People who were distressed or upset were supported by staff who could recognise and respond appropriately to their needs. For people unable to verbally communicate guidance was provided for staff on how to recognise and respond when people were attempting to communicate. This guidance was known by staff who were able to evidence they knew how to interact with people unable to verbally interact to ensure their wellbeing needs were met.

Staff knew how to comfort people who were in distress and offered reassurance when required. During the inspection we saw staff took quick action when a person was showing signs of distress as they were about to receive personal care. Staff were quick to offer verbal reassurance and ensure people were comforted following the guidance provided in their care plans. Staff were aware, and took positive action to promote people's mental wellbeing minimising the risk of them suffering emotional distress.

Where appropriate, physical contact was used as a way of offering reassurance and comfort to people. We saw that people were comfortable and actively sought this physical contact with staff. We saw friendly

conversations were held whilst staff and people held hands and cuddled whilst they talked. The registered manager acknowledged that some people may not always wish to receive this kind of physical interaction and documented the instances where this may not always be appropriate. Through discussions staff evidenced they acknowledged when it would be appropriate to hold a person's hand and offer a hug as a means of reassurance and when this would not be a wanted course of action.

People were supported to express their views and where possible involved in making decisions about their care and support. Staff were able to explain how they supported people to express their views and to make decisions about their day to day care. This included enabling people to have choices about what they would like to wear or how they would like to spend their day. Care plans were agreed with the person's relative or nominated person such as those with a Power of Attorney (POA). A person who has been provided with POA is there to make decisions for people when they are unable to do so for themselves.

People were treated with respect and had their privacy maintained at all times. Care plans and associated risk assessments were kept securely in a staff area on the ground floor to protect confidentiality. During the inspection staff were responsive, respectful, kind and sensitive to people's individuals needs whilst promoting their independence and dignity. This was confirmed by people we spoke with, one person told us, ""They (staff) knock before they come in (my room) and ask how I am". Staff were able to provide examples of how they respected people's dignity and treated people with compassion. This included making sure people were suitably clothed and had their modesty protected when they were assisted with their personal care. People were provided with personal care with the doors shut and curtains drawn to protect their privacy.

The home had undertaken a number of 'Dignity Days' to promote discussion amongst staff and to agree actions they would take in order to continue to promote people's dignity whilst delivering their care. All staff came together and discussed in small groups how care could be delivered in a kind, respectful and caring way which also promoted people's right to dignity.

The home had a Dignity Champion and Dignity Ambassadors who would promote best practices. The registered manager told us, "It's one of the most important things that people are still offered dignity, that's the last thing you can offer people right up to the end of their lives". Staff told us these working days had an impact on the way they spoke with people and ensured their dignity was maintained at all times. One member of staff told us that it changed the way they spoke about people and instead of talking about assisting people as a task, such as "Put X to bed", staff would say, "We're going to assist X". The training had empowered all staff to question the language used by other members of staff and ensured people's privacy was also respected further. Another member of staff told us they would no longer ask someone in any of the public areas if they needed to go to the toilet, they would ask if that person would accompany them to their room then ask them out of the hearing of others. This type of respectful language we saw used throughout the inspection.

People had their spiritual needs met. A Roman Catholic and an Anglican Church priest regularly visited the home to carry out services for people who wished to attend or receive communion. Should persons of alternative faiths move to the home the registered manager told us they would ensure people were able to continue practicing the belief and spiritual system of their choice.

Good

Is the service responsive?

Our findings

Where possible people were engaged in creating their care plan. People not able or unwilling to engage in creating their care plans had relatives who contributed to the assessment and the planning of the care provided. Relatives were informed when changes in planned care were due to occur, one relative said "Staff will phone me (if there are changes to care)…they always keep me up to date". Another relative told us, "They (staff) always ring. (Family member) had a couple of falls, they rang me and updated me". The provider sought to provide a range of activities for people to participate in. One relative told us their family member attended the activities they enjoyed, "There is always something going on". A healthcare professional told us, 'Residents are included in the planning of their care whenever they have the capacity to do so…I have often see the great rapport Old Raven staff have with resident's loved ones and the involvement and sharing of information which takes place.'

People's care needs had been assessed and documented by the registered manager before they started receiving care. These pre-admission assessments were undertaken to identify people's support needs and care plans developed outlining how these needs were to be met. People's individual needs were reviewed monthly and care plans provided the most current information for staff to follow. Care plans were also reviewed when people's individual needs changed. For example, when there had been a change in people's health needs, their care plans were updated to reflect the change of care which was required. People, staff and relatives were encouraged to be involved in reviews to ensure people received personalised care.

For people living with pressure sores we saw the home took appropriate action to respond to these appropriately. The home had a Tissue Viability lead who had received additional training to enable them to provide additional support and guidance for staff on managing people whose skin was at risk of breakdown. Pressure sores are usually caused by unrelieved pressure on a persons' skin and can be experienced more by those persons with severely restricted mobility. We noted care plans for people's skin integrity included possible contributory factors; such as: people's lack of mobility, continence issues and concern regarding people's nutrition and hydration. When staff identified people's skin was at risk advice was sought from the District Nursing Team, this was then documented and followed. It was identified during the inspection that one person's pressure area had been reviewed by the District Nursing team and care was being provided as necessary however, had not been documented fully. The registered manager was made aware and action was taken to ensure the required care was documented appropriately to evidence the correct care was being provided.

People were provided with the opportunity to participate in meaningful activities which would enable them to live fulfilled lives. Care plans detailed people's hobbies and previous interests to help staff to encourage people to participate in as broad a range of social activities as possible. Whilst not all the people we spoke with could share their experiences of the activities they participated in observations showed people positively interacted with activities staff and activities provided to them. One person told us, "I like to go into the garden and find somewhere to sit", another person said, "I join in with the music", and another person said, "We have a band, I know all the songs".

Care plans also contained activities questionnaires which detailed people's particular social interaction needs and sought their feedback on the activity types they enjoyed.

The home had two activities coordinators which enabled people to participate in two activities a day. The main activities coordinator promoted the use of homely activities such as baking, dusting, tidying and preparing the tables for meals. These types of activities can help a person living with dementia feel connected to their life before receiving care and can maximise their choice and control. Some activities such as those involving reminiscence can help people seek an emotional connection with others.

A typical week activities rota was viewed and included activities such as: memory groups, colouring and relaxation, music therapy, hand massage, poetry groups along with activities outside the home such as animal therapy, garden games and guinea pig handling. The home also supported people to visit the local community to complete shopping tasks when wanted. External trips were also available for people to enjoy which included canal boat trips, trips to the beach, strawberry picking, tea dances and visits to a local beauty area.

External agencies were also encouraged to visit the home to encourage people to experience new and different situations; this included having visiting animal groups, bands and singing groups. Staff at the home were keen to support people to participate in activities they may not usually be able to enjoy. This included providing opportunities for people who suffered from travel sickness, this limited the range of travel they would be able to manage before becoming ill. Staff would therefore find alternative opportunities which were closer to the home to enable people to experience fulfilling and interesting activities.

People were encouraged to give their views and raise any concerns or complaints. People and relatives were confident they could speak to staff or the registered manager to address any concerns. The provider's policy was available in the home's dining room and was readily accessible to people, visitors and relatives. The policy offered advice and guidance to people, relatives and visitors to the home regarding how they would be able to raise a complaint, the timescales for any response to such a complaint and how to raise complaints with the local authority and the Care Quality Commission.

The provider's complaints policy also included information on how to raise concerns with the Local Government Ombudsmen if the complainant remained dissatisfied with the outcome of their complaint.

The staff members we spoke with were clear about their responsibilities in the management of complaints or concerns. They were aware of the provider's complaints policy and procedures and where to find them.

Complaints were documented and stored in the registered manager's office so were kept securely, however, were accessible to review to identify trends or repeated incidents involving people or staff. Five formal complaints had been received since the last inspection. We could see the complaints had been investigated by the registered manager with steps taken to address the causes of the complaints. These had been responded to by the registered manager in line with the provider's policy.

Good

Is the service well-led?

Our findings

Relatives knew who the registered manager was and spoke positively of their ability to manage and support them and people living at the home, one relative told us of the registered manager, "(They're) excellent… you don't feel you're dealing with anything on your own, there's always somebody there that you know who will give you a straight answer". Another relative told us, "I think she (registered manager) is wonderful… she's a strong but quiet person…everybody is relaxed and happy and if you ask them something they'll answer it". People and relatives told us they were happy with the quality of the service provided. One relative told us, "I wouldn't choose anywhere else (for family member); I hope I never have to move him". Another relative said, "I can't fault the place". A healthcare professional told us, 'X (registered manager) is an outstanding manager…she is constantly looking for ways to improve care and the develop the service and her staff…she has recently been instrumental in getting some North Hampshire care home link nurse/carer groups started…we now have eight homes participating…this is a really exciting initiative with the potential to share and develop best practice…The thing I like the most about Old Raven is that it feels like home, not a hotel or institution.'

The registered manager was keen to encourage an open, positive and inclusive culture between all people living at the home, staff and relatives. In order to achieve this, the registered manager sought to engage and involve people, staff and family members in regular contact, which staff and relatives confirmed. During the inspection visitors and family visiting the home had friendly conversations with staff and the registered manager which showed detailed knowledge of the people living at the home and the care they were receiving. The registered manager was available to people and staff to offer guidance and support whenever they were required. All staff we spoke with confirmed the registered manager was open to their requests for assistance, operating an 'open door' policy and was supportive in her actions. A member of staff told us about the registered manager's openness, "Yes, very much so, I don't think there would be anybody who would say different, she's amazing, she cares about us all". Another member of staff said, "Whenever you need someone to talk to she's always there, she's really supportive and kind".

The registered manager was keen to promote an atmosphere where people felt they were receiving care in a happy home from staff who treated them as if they were their own loved ones. Relatives we spoke with told us they felt the home provided a homely environment for their loved ones, one relative told us, "(Atmosphere) is always friendly…it's a friendly homely environment". Another relative said, "It has such a wonderful homely environment…the atmosphere when you come in you can see everybody knows what they're doing".

The home had a Philosophy of Care which was created by staff and explained the way in which people should expect to receive care whilst living in the home. This stated the provider would ensure Old Raven was a unique, happy and safe home where care reflected people's choices. It continued that staff would take pride in creating a warm, welcoming environment were the best possible standard of care would be delivered. People would have their individuality promoted, people's independence would be encouraged and the wellbeing of residents, visitors and staff would be paramount. Staff were able to identify the home's values and we observed they demonstrated these values in the way they delivered care. One member of

staff told us, "She (registered manager) has an amazing vision about what she wants for the home and for the residents, it's their home, we're in their home". Another member of staff said, "It's just noticeable here that the love actually it seems really obvious…everybody deeply cares about everyone and it has a family feel".

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC), of important events that happen in the service. We use this information to monitor the service and ensure they responded appropriately to keep people safe. The registered manager had submitted notifications to the CQC in an appropriate and timely manner in line with CQC guidance. We asked staff if they thought the home was well led by a strong registered manager. All staff agreed that the registered manager offered strong, positive leadership and the home was well led. One member of staff said, "I think it is (well led) I've seen quite a few managers here and X is the best one, she's very caring and will always listen". Another member of staff told us, "I really like the manager and I think the home is really well managed. I think it's outstanding". A further member of staff said, "(strong manager), Yes…she's very approachable and she knows a lot…her depth of knowledge is quite amazing".

The quality of the service people experienced was monitored through regular care plan reviews, family meetings, annually completed surveys and requesting people to submit anonymous online public accessible care reviews. Relatives told us they were continually asked to provide their feedback on the quality of the service their loved one was receiving. One relative told us, "Yes (asked for feedback), they're continually asking for feedback on how they could improve things and feeding back on what they're doing". The last relatives meeting had occurred on 21 June 2017 and relatives and representatives were asked to raise ideas and suggestions for service improvement under the title of 'Capturing Family Ideas'. At this meeting it had been suggested that the home could establish a social media page for relatives to keep in touch with each other and developments at the home. A relative we spoke with told us this had been actioned and allowed them to log in and see the photos of what was happening at the home activities wise and if their loved one was participating.

The provider also sought feedback by the means of using a 'Family Response Questionnaire' which were sent to people's families to ask for their feedback on the quality of the service provided. At the last survey completed in June 2017 there had been nine responses. All of whom spoke positively of the quality of the service their loved ones received. Relatives were asked to provide a response to a number of questions. These questions included asking; if they felt there were enough staff to look after their family members well, if staff treated their family member as a special and valued individual and if the home responded appropriately to their family members personal, intellectual, artistic and spiritual values. Positive written responses included, 'I feel that staff go the extra mile to meet mum's changing needs, sometimes having to receive some anger on her part', 'The range of activities are very impressive', and 'It is obvious when visiting to see how the staff interact with residents and families and that when challenges arise there is such a willingness to overcome them to the advantage of the family member'.

There was a system in place to monitor the quality of the service people received through the use of regular registered manager audits. The registered manager conducted a number of audits on a monthly basis which included; environmental cleanliness, medication and health and safety audits. The registered manager had also started developing quality assurance audits which were based on the Care Quality Commissions inspection process. These were to review whether or not the home was safe, effective, caring, responsive and well led and made recommendations for improvement where required.

Following these audits actions plans were put in place which detailed any actions needed and prioritised timescales for any work to be completed. For example, in April 2017 it had been identified during the

environmental cleanliness audit that repair works were needed to people's rooms. Documentation showed on a number of occasions actions were taken to rectify the areas identified the following day. A health and safety audit completed in June 2017 identified there was an unstable wardrobe in a person's room which would place them at risk of injury should it fall. Immediate action was taken to ensure brackets were purchased and used to secure the wardrobe to the wall limiting the risk of harm to the person. The provider ensured through the use of regular monitoring, areas which required improvement were identified and timely action taken, to continue to improve the quality of the service people received.

People, their relatives and visitors spoke positively of the quality of the care provided. Relatives told us they had a high degree of satisfaction with the home. Written compliments had been received by the home which evidenced staff were motivated to treat people as individuals and deliver care in the way people requested and required. Some of these were viewed, one relative had written, 'To (registered manager) and the staff with grateful thanks for all you did for (family member), your efforts are much appreciated and your dedication in making her end of life so dignified and peaceful'. Another family member had written to the home, 'To all the staff at Old Raven house, thank you for the wonderful care you provided to X over the last five years. You looked after (her) with professionalism, respect, kindness and love'. People were assisted by staff who were able to recognise the traits of good quality care and ensured these were followed.