Ravenscroft Rest Home Limited

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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

The inspection visit took place on 19 and 24 October 2018. The first day was unannounced.

Ravenscroft Rest Home Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Ravenscroft Rest Home Limited is registered to provide accommodation and personal care for up to 34 older adults who require support with their personal care needs. At the time of the inspection, there were 32 people accommodated in the home.

The service was managed by 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.

At the last inspection in April 2016 the service was rated 'Good'. At this inspection in October 2018 we found the evidence continued to support the rating of good. However, we found some shortfalls in relation to staff training. Eight of the staff had not completed training in up to nine areas that the provider had deemed necessary for their role. The registered manager addressed these shortfalls immediately after our inspection. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

People who lived at the home and their relatives told us they felt safe and were happy with staffing levels. They told us staff provided them with support when they needed it.

People told us the staff who supported them were caring and respected their right to privacy and dignity. They told us staff encouraged them to be as independent as they could be, and we saw evidence of this during the inspection.

The registered manager had systems in place to record safeguarding concerns, accidents and incidents and take appropriate action when required. Improvements were required to ensure incidents were analysed to identify patterns and lessons learned. Recruitment checks were carried out to ensure suitable people were employed to work at the service.

The majority of staff employed at the home had received induction, training and support and their knowledge demonstrated a commitment to providing high standards of care. However, this was not consistent throughout the staff team. We found some staff had not received training that the provider had deemed essential for the role. The registered manager and the owner took immediate action to address this. However, we would expect this to have been identified and rectified without our intervention. We made a

recommendation about staff training.

The service put people's views at the forefront of the service and designed the service around their needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Improvements were required to the process for seeking consent for equipment such as bedrails.
Risk assessments had been developed to minimise the potential risk of harm to people who used the home. These had been kept under review and were relevant to the care and support people required. Care plans were in place detailing how people wished to be supported.

Staff responsible for assisting people with their medicines had received training to ensure they had the competency and skills required. We noted some improvements were required to the documentation for medicines prescribed as 'as required medicines'. The registered manager took immediate action to rectify this.

We found people had been assisted to have access to healthcare professionals and their healthcare needs were met and reviewed regularly. Feedback from health professionals was positive.

People had been supported with various activities of their choice. There was a strong emphasis on maintaining people's independence and ensuring people remained active members of their local community.

People who used the service and their relatives knew how to raise a concern or to make a complaint. The complaints procedure was available, and people said they were encouraged to raise concerns. Staff had received compliments from people's relatives.

People living at the service and staff were happy with how the service was being managed. They found the registered manager and owner approachable and supportive.

The registered manager and staff had worked collaboratively to maintain standards in the home. The governance systems had continued to be reviewed since our last inspection. A variety of audits and checks were completed regularly by the registered manager and the owner. These included regular internal audits of the service, surveys and staff and peoples' meetings to seek the views of people about the quality of care being provided. We found that the majority of the audits completed were effective in identifying areas of improvements. Although we found shortfalls in staff training, it was evident that there was a commitment from the staff, the provider and the registered manager to maintain high standards of care and to continue improving the home.

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 remains Good.

Is the service effective?

Requires Improvement

This service was not consistently effective.

Staff had received induction, supervision and appraisals. However, there were shortfalls in staff training in various areas that the provider deemed necessary for the role.

People's consent was considered before they received care. Consent and mental capacity was considered.

The environment was adapted to meet the needs of people living at the home.

People's health needs were met, and specialist professionals were involved appropriately.

Is the service caring?

Good

This service remains Good.

Is the service responsive?

Good

This service remains Good.

Is the service well-led?

Good

The service remains Good.

Ravenscroft Rest Home Limited

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 site visits took place on 19 and 24 October 2018. The first day was unannounced.

The inspection team consisted of one adult social care inspector, who is the lead inspector for the service and an expert by experience, who had experience of caring for older adults and those living with dementia.

Before our inspection visit we reviewed the information we held on the service. This included notifications we had received from the provider about incidents that affect the health, safety and welfare of people who used the service. We also reviewed the Provider Information Return (PIR) we received prior to our inspection. 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. This provided us with information and numerical data about the operation of the service.

We spoke to eight people who used the service and three relatives. We also spoke to six staff members. In addition, we spoke to the owner, chef, the administrator, and the registered manager.

We looked at care records of four people, training records, three recruitment records of staff members and records relating to the management of the service. Before the inspection we also contacted the safeguarding and contracts monitoring departments at the local authority.

Good

Is the service safe?

Our findings

People told us they felt safe living at Ravenscroft Rest Home Limited because they trusted the staff that supported them. All people we spoke with were confident they could tell someone if they felt unsafe about anything or anyone in the home. Comments from people who lived at the home included, "I've never felt unsafe and I never even think about it. If there was something I'd tell the staff, but I've never had to," "I could talk to anybody (staff) if I was worried about anything" and "I would have been frightened on my own at home. I am well looked-after here." Similarly comments from relatives were positive. People, relatives and staff had good working relationships which enabled them to communicate honestly and without fear of repercussions and this was evident in our discussions with people. One relative said, "My [relative] has had one fall here, but they fell a lot at home. The staff got there very quickly I believe and [my relative] was fine. Since then, there's been no problem. We are happy that staff keep an eye on them."

Risks to people were assessed and their safety was monitored and managed so they were supported to stay safe and their freedom respected. The provider's risk management policies and procedures showed the ethos of the service was to support people to have as much freedom of choice in their lives as possible. Staff we spoke with demonstrated a positive risk-taking approach which was underpinned by a desire to ensure people's freedom was not limited due to risks around them. People were regularly going in the village to use the library and into town for shopping. We noted that the registered manager had introduced a system to support people who were able to go in the community to ensure they could easily be supported in the event of the people getting lost or going missing.

The registered manager had procedures in place to minimise the potential risk of abuse, neglect , discrimination or unsafe care. In addition, staff had been recruited safely. Safeguarding training had continued to be updated for some of the staff however, this needed to be improved. A safeguarding champion had been identified; they attended external safeguarding workshops and meetings and shared best practice with other staff. Safeguarding concerns had been reported to the local safeguarding authority. Lessons learned had been shared with staff.

We found that records had been kept in relation to accidents that had taken place at the service and appropriate action had been taken to manage people's risks, including referrals to their GPs and the local falls team. Sensor mats were also in place to alert staff if people who were at a high risk of falls tried to move independently. However, improvements were required to ensure that accident incident records were analysed to identify any trends and patterns and ensure lessons could be learned to prevent future occurrences. This would assist the registered manager to monitor to monitor whether appropriate action had been taken, such as reporting significant incidents to CQC and the local safeguarding team. People with medical devices such as catheters, were reviewed and monitored regularly to ensure the equipment was working as intended. There were regular audits on records related to risk management. This helped to ensure that people's risks were managed appropriately.

We looked at how medicines were recorded and administered. In majority of the cases staff had ensured that people's medicines were managed safely. Risk assessments had been undertaken to ensure people

received the right support with their medicines. Each person had received an annual review of their medicines. We looked at medication administration records for five people. Records showed medicines had been signed for. The registered manager had internal audits in place to monitor medicines procedures. However, there were no records kept, explaining how to give "when required" medicines also known as PRN protocols. These are important to support people who have communication difficulties and unable to ask for their medicines. We spoke to the registered manager and they took immediate action to rectify this soon after the inspection.

Medicines had been stored securely. The room was secure, clean and tidy. Room temperatures were monitored to ensure medicines were stored at the right temperature. This helped to ensure that the effectiveness of medicines was not compromised.

The service monitored and regularly assessed staffing levels to ensure sufficient staff were available to provide the support people needed. During our inspection visit staffing levels were observed to be sufficient to meet the needs of people who lived at the home. Comments from people demonstrated that the provider had ensured that people had the right number of staff to support them. We found that the staffing levels set by the service had been met on all occasions. In addition, we observed the registered manager was actively supporting staff delivering care during the busy times in the home.

Policies and practices at Ravenscroft Rest Home Limited ensured people were protected by the prevention and control of infection. For example, staff had received induction and training on infection control and prevention. This helped to ensure people would be protected from risks of infections. Equipment had been serviced and maintained as required. For example, records confirmed gas appliances and electrical equipment complied with statutory requirements and were safe for use. Regular inspections and tests had been undertaken, these included a review of the weekly fire safety checks and their own checks on the fire alarm system. This meant that inspections were taking place to ensure that people were not put at risk from fire.

Requires Improvement

Is the service effective?

Our findings

People's assessed needs, preferences and choices were not always met by staff with the appropriate qualifications, skills, knowledge and experience. The majority of the staff had received training and induction including national vocational qualifications in health and social care. The induction process included a period of shadowing where new staff worked alongside experienced staff before they started working independently. However, records of training we reviewed showed that eight of the staff had not completed training in up to nine areas of training and care delivery that the provider had deemed necessary for the roles staff were employed to perform. The shortfalls in training meant that care staff had not received or updated their training to ensure their practice and knowledge was up to date.

Records we reviewed and our conversation with the registered manager and the owner also demonstrated that they were aware of the training shortfalls. We also noted that the shortfalls had been highlighted by visiting professionals. We noted that some of the staff were newly employed. We spoke to the registered manager and the owner regarding the shortfall, they immediately took action to address the shortfalls. After our inspection they sent us an update showing that all staff had completed their training as required by the provider's policies. In addition, the owner informed us that they had reviewed the training needs of staff and had recently recruited a new role for a worker who will be responsible for supporting staff with their competences and learning needs, which would assist in ensuring staff maintained their training needs. However, we would have expected the provider to have ensured staff were up to date with their training without our intervention.

We recommend the provider and the registered manager to review their training practices and systems for monitoring and providing staff training and update their practices accordingly.

Staff had received supervision and appraisals regularly and in line with the organisation's policy. Records we reviewed showed various topics had been discussed during the supervisions including safeguarding, infection control and medicines management among other topics. The registered manager undertook competence observations in various areas including medicines management.

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).

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. A significant number of DoLS authorisation requests had been submitted to the local authority. However, none of the requests had been authorised. The registered manager was regularly checking progress of the applications.

We saw evidence that people's consent in various areas been sought in all care files we looked at. We observed staff seeking consent. People signed their own care records including risk assessments to show they agreed with the proposed care plans. One person told us, "I think I've signed six documents in my care plan in the last few weeks. There's such a lot of paperwork about everything they do here." There was an up to date policy in relation to seeking consent and mental capacity. The registered manager had completed mental capacity assessments where people needed to make specific decisions. We discussed the need to ensure consent records were completed for use of equipment such as bedrails and for records of best interest decisions to be recorded where people lacked capacity to consent.

People who lived at the home and their relatives told us they felt their needs were effectively met. Comments included, "The carers always sort of ask if you want some help. They never force you into anything; they're just very helpful", "I have help with getting up and going to bed, and to some degree mealtimes as well. They will ask if they can help you but mostly it's you asking them." And, "Staff help me to dress as I can't do it myself. They're very respectful and polite."

We observed that people's needs, and choices were considered during the delivery of care. For example, we saw people being asked what they wanted to eat and where they wanted to sit. People told us they could get up anytime they wanted and chose to spend time in their bedrooms if they wanted to.

Staff knew how to protect people against discrimination, including in relation to protected characteristics. There was a policy on how protect people against discrimination and harassment as well as a policy on equality and diversity. These policies were important in demonstrating how the registered provider implemented or applied human rights principles (fairness, respect, equality, dignity and autonomy) at the service. Information on how to report concerns was readily available in prominent places within the home.

Staff completed a range of assessments to check people's abilities and review their support levels. For instance, assessments were done before people started living at the home, they checked individual's needs in relation to mobility, mental and physical health and medicines. Specific requirements for each individual had been identified. For example, they identified those people who required assistance with moving, soft diet, people who were at risk of falling and people who were at risk due to their vulnerability. Assessments and all associated documentation were personalised to each individual who stayed at the home. Care plans and risk assessments had been reviewed and dated. This ensured a person-centred approach to care reviews.

People's individual needs were met by the adaptation, design and decoration of premises. We saw people who lived at the home had access to a garden that was enclosed and safe for people to use. In addition, there were two lounges for people to spend some time in and a quiet sitting area for people to sit with their visitors if they needed privacy. We observed that people moved around the building freely. We saw some people had brought their own personal items that helped personalise their bedrooms and made it homely for them. Each bedroom had a notice board for people to display information and reminders that were important to them.

People were supported to eat and drink enough to maintain a balanced diet. We observed staff supported people to eat their meals. The atmosphere was calm and caring and people were able to eat their meals at their own pace. All people appeared to have enjoyed their meal and had eaten very well. There were choices of drinks available for people to help themselves if they were able to. Staff encouraged individuals with their meals and checked they had enough to eat. They gave people an alternative if they did not like the meals on offer. There was a system for supporting people to share their views on meals and the menu. We saw the registered manager asked people to share their views and comments on their dietary preferences on a

monthly basis. This was shared with the chef to ensure they were aware of any changes in people's preferences. The chef told us "I meet new clients as soon as possible and talk to them and their family about their dietary needs and preferences. It's all recorded in the files in the kitchen." There was a sensitive approach to supporting people who had special dietary requirement such as vegans.

Comments about the food were positive. One person who lived at the home said, "Everything I've had to eat is okay. There's more than enough" and, "I think the food's very good. I was in a meeting and we were asked what the food was like and I said, 'as good as 'Harrods'." A menu was on display in the home and in each person's bedroom. The care records we reviewed had a section that noted people's dietary requirements such as vegetarian diet, vegan or the need for a soft diet. Staff recorded in care records each person's food and fluid likes and dislikes. This was good practice to provide preferred meals to increase their nutritional intake. Where necessary, people were weighed regularly. Staff assessed people against the risks of malnutrition and made referrals to dieticians and speech and language therapists (SALT) where appropriate.

People were supported to live healthier lives, have access to healthcare services and receive ongoing healthcare support. Care records we looked at contained information about other healthcare services that people had access to. Staff had documented when individuals were supported to attend appointments or received visits from for example, GPs and district nurses. Documentation was updated to reflect the outcomes of professional health visits and appointments. We observed a district nurse visiting during the inspection. They informed us the staff were proactive in involving specialist professionals and that they would seek advice if ever they were unsure about people's conditions. This meant that people could be assured they would have access to specialist professionals if they needed them.

Good

Is the service caring?

Our findings

The home had a positive and caring culture which people, relatives and staff supported and promoted. People told us they were well supported and well cared for. Comments from people included, "The staff are all very good to me; I have a chat with them occasionally" and "The staff leave me to my own devices really, because they know they can. I am pretty independent." Another person told us, "Support is given to you quite nicely really, they're polite and treat you properly, on the whole. Nothing undignified, let's put it that way."

All the relatives we spoke with told us they trusted the staff and the service in general with the care of their relatives. They commented that their family members were thriving under the care of the staff.
A visiting professional told us, "We always observe staff approaching people in a caring manner when we visit." Another professional added, "There is always a caring and sensitive approach and they seek support for people in a timely manner."

There was a person-centred culture within the home and staff understood that people were at the heart of the service. This was because the registered manager and staff promoted a caring culture based on a range of clear policies and procedures they had in place. Staff had a good understanding of protecting and respecting people's human rights. Some of them had received training which included guidance in equality and diversity. The staff described the importance of promoting each individual's uniqueness. There was a sensitive and caring approach, underpinned by awareness of the Equality Act 2010. The Equality Act 2010 legally protects people from discrimination in the work place and in wider society.

Through our discussions with people and their relatives, we noted that arrangements had been made to meet their personal wants and diverse needs. From the information contained in their care records; we saw people were fully enabled to develop and maintain their personal relationships with their circle of support, including family members, friends and health care professionals. For example, where possible, families took their relatives out into town and on day trips.

Staff and the registered manager were motivated and reflected pride in their work. They talked about people in a way which demonstrated they were fully committed to supporting people in any way they could, in order for them to achieve as much independence as possible. Staff sought to provide the best standards of care for each individual. One member of staff said, "We support them as if they are family and most of them are from the local village, so we know them well."

Staff explained how they promoted independence, by enabling people to do things for themselves. One staff member said, "People sit outside in the front garden, two people go into town regularly and another person goes in the village whenever they want to shop and use the library." Care records outlined the goals and outcomes that people wanted to achieve and what support they needed.

There was evidence of how the provider had engaged with people during the design and delivery of care. In addition, staff made sure they gave information to people, their families and other carers about external

bodies, community organisations and advocacy services that could provide independent support and advice. This included organisations that could answer questions about their care, treatment and support, and, where necessary, advocate for them.

Good

Is the service responsive?

Our findings

People received personalised care that was specific to meet their needs and they were involved in the planning, goal setting and reviewing of their care. Comments included, "We go to chapel every Sunday; we walk there usually. If it's raining, we put our raincoats on. We tell staff if we're going out with visitors, and we sign the book, so they know we've gone out", "I think [activities provision] is very good; we have some good fun. I'm involved in setting up the quiz; the activities coordinator asks me to sort out the questions."

People's care records demonstrated that the home had ensured that people's care plans fully reflected their physical, mental, emotional and social needs. They had been developed where possible with each person, their family and professionals involved with them, identifying what support they required. Relatives told us they had been consulted about their family member's care where required. They told us they sat down with the registered manager regularly to discuss what had gone well and what could be improved.

Staff completed a range of assessments to check people's abilities and review their support levels. For instance, they checked individual's needs in relation to mobility, mental and physical health and medicines. Any specific requirements for each individual had been identified, for example, people who required assistance with moving, eating and drinking needs, people who were at risk of choking and people who were at risk due to their vulnerability. For example, there were risk assessments in place for people who could access the local community independently so that measures were in place in case they went missing or were lost. Staff we spoke with demonstrated that they had taken time to familiarise themselves with people's care records. This meant that staff understood people's needs and wishes.

People were supported to maintain local connections and important relationships. There was a strong emphasis on encouraging and supporting people to maintain local community links and to have an active social life in their community. This helped to maintain continuity and reduce social exclusion for these individuals.

Technology was used to support people to receive care and support, this included the use of call bells, broadband, defibrillator, telephone facilities and Wi-Fi connectivity for those people who had gadgets that required internet connection. Assistive technology such as sensor mat alarms were also available for people who required them to maintain their safety.

None of the people we spoke with had needed to make a complaint, but they were able to tell us who they would approach if they needed to. The service had a complaints procedure in place. Records we looked at showed that one complaint made had been dealt with in line with company policy.
Comments from people included, "There's nothing to complain about but if I did have a concern, I would go to someone in charge, the manager", "I've hardly had any issues, within the capacity of the staff, that is. When I have, they've been resolved."

We checked whether the provider was following the Accessible Information Standard (AIS). The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must

make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. Records had been adapted to meet people's needs, for example some information was available in an easy read format. People's records had communication care plans that detailed people's communication needs. We discussed with the registered manager and the owner the need to establish a policy on the Accessible Information Standard to ensure consistence in their practices.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Records we reviewed demonstrated that the provider and the staff had taken into consideration people's preferences and choices for their end of life care. However, staff had not received training in this area. The completion of end of life training would increase staff's knowledge and skill as well as assuring people that they would receive consistent care from a skilled staff team.

Good

Is the service well-led?

Our findings

All the people we spoke with knew who the registered manager was. All of them told us they were approachable. Two people said, "The manager is a nice person. I would say they listen and if there are any problems will see me about them" and "Yes, I think the home is all right and I think I'm lucky to be here." Similarly comments from professionals were positive.

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

Staff we spoke with told us they felt the registered manager worked with them and supported them to provide good quality care. Comments included, "Management here are very supportive, I find [name removed, Manager] to be listening and I think they are the reason why I have worked here longer."

The registered manager and provider had auditing systems to assess quality assurance and the maintenance of people's wellbeing. We found regular audits had been completed. These included medicines, the environment, accidents and incidents and infection control. Any issues found on audits were quickly acted upon and lessons learnt to improve the care the service provided.

At the last inspection we rated the service Good and at this inspection the service had remained good. The providers to demonstrated how they provided formal oversight on the service and to ensure the registered manager was complying with regulations. However, we made a recommendation in relation to staff training and development. We found shortfalls in staff training. This meant that the quality assurance processes at the home needed further improvements to enable the manager and the provider to identify shortfalls in training and take timely action to rectify them.

Our checks confirmed that the provider was meeting the requirement to display their most recent CQC rating within the service. The registered manager had notified CQC of any deaths in the home. We discussed the need to ensure all accidents, serious incidents and safeguarding allegations were reported. This was because we found one incident that had not been reported to CQC. The registered manager took immediate action and reviewed their processes for monitoring and analysing accident and incidents. This would ensure that we could see if appropriate action had been taken to ensure people were kept safe.

Staff we talked with demonstrated they had a good understanding of their roles and responsibilities. There were clear lines of responsibility and accountability with a structured management team in place. All staff had delegated roles including provisions of personal care, and medicines administration.

Staff and people's meetings were held on a regular basis. In addition, 'relative/family' surveys were carried out regularly. This included general surveys and surveys related to catering and dietary preferences. The registered manager analysed any comments and had acted upon them. The feedback we saw

demonstrated people felt the service was of a good quality. We saw people and staff were consulted on the daily running of the service and any future plans.

The service continuously learned, improved and developed. The registered manager and the owner attended various local provider meetings to share best practice and any new developments. Some staff had been nominated as champions in various aspects including safeguarding and infection control. These staff would attend multi-disciplinary meetings with other stakeholders such as the local Clinical Commissioning Groups and adult social care services within the local authorities.

The registered manager and the staff had worked hard to sustain the standards that they had set at our last inspection. We saw there were visions, plans and a desire from the registered provider, the registered manager and the staff to continue to move the home forward and ensure people received high standard of care.