Ashdown Care Homes Ltd

Ravenscroft

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 10 August 2018 and was unannounced. This meant the staff and provider did not know we would be visiting.

Ravenscroft 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.

Ravenscroft provides accommodation for a maximum of seven people who have a learning impairment or associated condition. At the time of inspection seven people were living at the service accommodated in two adjoining bungalows.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities who use the service can live as ordinary a life as any citizen.

At our last inspection in April 2016 we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Some people were unable to tell us about the service because of their complex needs. People appeared content and relaxed with the staff who supported them. Other people told us they were satisfied with the service provided by staff. Staff knew the people they were supporting well and there were enough staff on duty to provide individual care to people.

Detailed records accurately reflected the care provided by staff. People's privacy and dignity were maintained. Staff understood the needs of people and care plans and associated documentation were clear and person-centred. Risk assessments were in place and they accurately identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. People received their medicines safely. We have made a recommendation about medicines management. People received a varied diet.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. Staff received other appropriate training and they were supervised and supported. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

People were encouraged and supported to go out and engage with the local community and maintain relationships that were important to them. They 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.

People and staff spoke well of the registered manager, they said the management team were approachable. There were effective systems to enable people to raise complaints, and to assess and monitor the quality of the service. The provider undertook a range of audits to check on the quality of care provided.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service remains good.	**Good**

Ravenscroft

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 10 August 2018 and was unannounced.

It was carried out by one adult social care inspector.

Before the inspection, we had received a completed Provider Information Return (PIR). We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We also contacted commissioners from the Local Authorities who contracted people's care.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during a mealtime.

During the inspection we spoke with five people who lived at Ravenscroft, the deputy manager, one senior support worker and two support workers. We reviewed a range of records about people's care and how the service was managed. We looked at care records for three people, recruitment records for three staff, two peoples' medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service, maintenance contracts and quality assurance audits the registered manager had completed.

Good

Is the service safe?

Our findings

Systems were in place to ensure people were protected and kept safe. Some people who lived at the home did not express their views verbally about the service. They appeared calm and relaxed as they were supported by staff. One person told us, "I am safe here. It is the best place I have ever been." Another person said, "I do feel safe, staff are around to help me."

Staff were able to explain the services available in relation to the safeguarding of adults. They told us they had completed training and would know how to take the appropriate action to protect the individual and other people who could be at risk.

There were sufficient staff to support people at the time of inspection. The deputy manager told us six staff were on duty to support seven people during the day and two waking members of staff were on duty overnight. They told us staffing levels were flexible and they were monitored to ensure they were sufficient to meet people's identified needs.

Risk assessments were in place that were regularly reviewed and evaluated to keep people safe. These included environmental risks and any risks due to the health and support needs of the person such as for bathing and distressed behaviour. The risk assessments were also part of the person's support plan and there was a clear link between these plans and risk assessments.

Staff had received positive behaviour support training to support the management of distressed behaviours. They also used positive support behavioural guidance specific to each person which advised distraction techniques and other measures to calm and help re-assure the person and detailed records were in place to support this.

The home was well-maintained and there were appropriate emergency evacuation procedures in place, regular fire drills had been completed and all fire extinguishers had been regularly serviced. There was a good standard of hygiene. Staff received training in infection control and protective equipment was available for use as required.

Medicines were given as prescribed. People received their medicines when they needed them. Staff had completed medicines training and the deputy manager told us competency checks were carried out. Records showed that where people lacked mental capacity to be involved in their own decision making, the correct process had not always been used for the use of covert medicines (covert medicine refers to medicine which is hidden in food or drink). We saw 'best interest' decision making did not adhere to the National Institute for Health and Care Excellence (NICE) guidelines. Documentation did not show a best interest decision had been made with the relevant people to agree whether administering medicines without the person knowing (covertly) is in their best interests.

We recommend the registered manager considers the National Institute for Health and Clinical Excellence guidelines on managing medicines in care homes.

Staff personnel files showed that a robust recruitment system was in place. This helped to ensure only suitable people were employed to care for people who required some support.

Good

Is the service effective?

Our findings

People were cared for by skilled, knowledgeable and suitably supported staff. Staff told us, and records confirmed, they attended training relevant to their role, people's needs and safety. All staff were expected to attend key training topics at clearly defined intervals. Training records showed staff training was up-to-date. Topics included health and safety and care related topics to give staff an understanding of people's needs. One staff member told us, "There are opportunities for progression within the company." Another staff member said, "There is plenty of training."

Staff made positive comments about their team working approach and the support they received. One staff member told us, "We're a good staff team, we work well together." Staff told us they were supported by the management team. Regular supervision sessions took place with each staff member. One staff member told us, "We have supervision every eight weeks." All staff members also had an annual appraisal of their performance with the registered manager.

People's needs were assessed before they started to use the service. This ensured that staff could meet their needs and the service had the necessary equipment for their safety and comfort. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who lack the mental capacity to do so for themselves. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The deputy manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. We found as a result, that four people were currently subject to such restrictions.

The service worked within the principles of the MCA and trained staff to understand the implications for their practice. Consent was obtained from people in relation to different aspects of their care, with clear records confirming how the person had demonstrated their understanding. Mental capacity assessments had been carried out leading to most decisions being made in people's best interests. A recommendation has been made about best interests decision making and the use of covert medicines.

People were supported to access community health services to have their healthcare needs met. Their care records showed they had input from different health professionals. For example, the GP, district nurse and speech and language therapist.

People enjoyed a varied diet. They were offered regular drinks and snacks throughout the day in addition to the main meals. People's care records included nutrition care plans, information about their food likes and

dislikes and identified requirements such as the need for a modified diet. Some people had specialist needs regarding how they received their nutrition and staff received guidance and support to ensure these needs were met.

Good

Is the service caring?

Our findings

People appeared comfortable and relaxed with staff. There was a calm and pleasant atmosphere in the home. Staff interacted well with people. One person told us, "Staff are very kind." Another person said, "Staff do listen to what I say."

Positive, caring relationships had been developed with people. Staff interacted with people in a kind, pleasant and friendly manner. We observed staff were patient in their interactions with people and took time to listen and observe people's verbal and non-verbal communication. Staff asked people's permission before carrying out any tasks and explained what they were doing as they supported them. Support plans were written in a person-centred way, outlining for the staff how to provide individually tailored care and support. The language used within people's care records was informative and respectful.

People were encouraged to make choices about their day-to-day lives and staff used pictures, signs and symbols to help people make choices and express their views. Support plans provided information to inform staff how a person communicated. For example, one recorded, "I am still listening but may not be looking." Information was available for people that explained signs of discomfort when a person may not be able to say if they were in pain.

Staff were given training in equality and diversity and person-centred approaches to help them recognise the importance of treating people as unique individuals with different and diverse needs. They were aware of and respected the cultural beliefs and traditions of people.

People's care records were up-to-date and personal to the individual. They contained information about people's likes, dislikes and preferred routines. Examples in their records included, "[Name] enjoys music", "[Name] enjoys a bath each night as it relaxes them" and "I am learning to make jelly and custard and trifles."

People were encouraged to make choices about their day to day lives. They told us they decided, for example, when to get up and go to bed, what to eat, what to wear and what they might like to do. One person told us, "I can get up and go to bed when I want. I usually go to bed about 10pm." Records also provided prompts for staff to ensure people were kept involved. For example, one care plan stated, "[Name] chooses their clothes and they are hung up on their wardrobe ready for the next day." People were supported to be as involved as possible in choosing menus and grocery shopping. People were asked at their regular house meetings if there were any dishes they would like to add to the menu.

Staff informally advocated on behalf of people they supported where necessary, bringing to the attention of the registered manager or senior staff any issues or concerns. Advocates can represent the views of people who are not able to express their wishes, or have no family involvement. The deputy manager told us a formal advocacy service was available and was used for some people.

Good

Is the service responsive?

Our findings

People received care and support that was personalised and responsive to their individual needs and interests. They had the opportunity to go out every day and they were supported to go on day trips. They were involved in a range of vocational and leisure activities. These included sessions at a local gardening group. People had opportunities to go out each evening and at weekends to social or sports activities such as bowling, discos, hydrotherapy, walking, shopping, visiting the pub, cinema, arts and crafts and meals out. People's choices about whether to engage in these activities were respected. One person told us, "I have lots of medals from bowling." And, "I am going to town to buy my friend a birthday present."

People told us they were supported to keep in touch with their relatives and in some cases helped to visit and spend time with family members. One person commented, "I visit my Dad." Care records also documented people of importance in a person's life. For example, one record stated, "I do not like it when I cannot see my sister."

Records showed pre-admission information had been provided by relatives of people who were to use the service and other professionals. Support plans were developed from assessments that outlined how people's needs were to be met. For example, for nutrition, personal care, behaviour support, mobility and communication needs. The plans provided instructions to staff to help people learn the skills and become more independent in aspects of daily living whatever their need. They provided a description of the steps staff should take to meet the person's needs. For example, one support plan for personal hygiene stated, "[Name] can give themselves a dry shave with supervision from staff." A nutrition care plan recorded, "[Name]'s chair must be pulled right up the table with two trays on top of each other for the plate, to reduce the distance of putting food into mouth."

Staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a more personalised service. Staff completed a daily diary for each person and recorded their daily routine and progress to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. This was necessary to make sure staff had information that was accurate so people could be supported in the way they wanted and needed.

Records documented the end-of-life wishes of people and their relatives, about their wishes as they approached death. This was to include people's spiritual requirements and funeral arrangements and who they wanted to be involved in their care. Some people's care plans detailed the 'Do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for them. This was discussed with relevant people to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

The provider had a complaints procedure which was available to people, relatives and stakeholders. A copy of the complaints procedure was available that was written in a way to help people understand if they did not read. A record of complaints was maintained. People told us they could talk to staff if they were worried and raise any concerns.

Good

Is the service well-led?

Our findings

A registered manager was in place who had registered with the predecessor organisation. 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.

The registered manager understood their role and responsibilities to ensure notifiable incidents such as safeguarding and serious injuries were reported to the appropriate authorities and independent investigations were carried out. We saw that incidents had been investigated and resolved internally and information had been shared with other agencies, for example, safeguarding.

The deputy manager assisted us with the inspection, as the registered manger was on annual leave. Records we requested were produced promptly and we accessed the care records we required. They were open to working with us in a co-operative and transparent way.

The staff team were longstanding, experienced, knowledgeable and familiar with the needs of the people they supported. They told us they were well supported by the provider's management team. They had regular contact with head office, ensuring there was on-going communication about the running of the service. Regular meetings were held where the management were appraised of and discussed the operation and development of the service.

Staff told us and meeting minutes showed staff meetings took place. Meetings kept staff updated with any changes in the service and allowed them to discuss any issues. Staff told us meeting minutes were made available for staff who were unable to attend meetings.

Monthly meetings were held with people to discuss the running of their household. Meeting minutes showed topics discussed included activities, outings, menus and complaints.

Regular audits were completed internally to monitor service provision and to ensure the safety of people who lived in the home. The audits consisted of a wide range of weekly, monthly, quarterly and annual checks. They included the environment, health and safety, accidents and incidents, complaints, personnel documentation and care documentation. Regular monthly analysis of incidents and accidents took place. The deputy manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of re- occurrence.

Three monthly visits were carried out by a representative from head office who observed and spent time with people and the staff regarding the standards in the home. All audits were available and we saw the information was filtered to ensure any identified deficits were actioned.

The deputy manager told us the registered provider monitored the quality of service provision through

information collected from comments, compliments, complaints and survey questionnaires that were sent out annually to people who used the service and relatives.