Extrafriend Limited

Ravenswood

Inspection report

47 Bristol Road Lower
Weston Super Mare
Somerset
BS23 2PX
Tel: 01934 412091
Website:

Date of inspection visit: 04 & 05 December 2014
Date of publication: 13/04/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Overall summary

This inspection was unannounced and took place on the 4 and 5 December 2014. The previous inspection took place in May 2013 and all regulations were met. Ravenswood is registered to provide nursing care for up to 36 people with a dementia illness or mental health needs.

The manager was registered with the Care Quality Commission to manage the home in November 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe at the home and there were enough staff to meet their needs.

Safe systems of medicine management were in place. We saw that people were supported with medication and the staff ensured that people received and took their medicines as prescribed.

Summary of findings

People told us the staff knew how to meet their needs. Members of staff attended training relevant to their roles. The staff were not able to show a sound understanding of the principles of Mental Capacity Act 2005 (MCA). People's personal choices were not always taken into consideration. This is a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) 2010.

Deprivation of Liberty Safeguards (DoLS) applications were in progress for the people living at the home because they were subject to continuous supervision and lacked the option to leave the home without staff supervision.

People told us the staff were caring and their rights were respected by the staff. However, staff used inappropriate terminology when they referred to people who needed support. This showed that staff did not consider people as individuals because their qualities, abilities interest's and preferences were not taken into account.

People told us the food was good and their dietary needs were catered for. People at risk of poor nutrition or at risk of choking were served with enriched or textured meals.

Care plans were detailed and told the staff how to deliver appropriate care to meet people's needs. People knew they had a care plan and they could read it. Staff did not routinely read the care plans. They were informed of people's needs during handovers. Staff comments about what routines were followed showed there was little flexibility if people to ask for something different.

People told us they had a GP, which they saw as required. People were referred to other health professionals for advice regarding audiology, or eye appointments for example. This showed that people had support to meet their health needs.

The views of people and their relatives about the service were gathered using surveys. Their feedback was to be used to improve the care and treatment provided. There was an effective quality assurance system in place to assess the quality of service provision. Outcomes from audits were used to develop staff learning.

Staff were knowledgeable about the culture of the service. Several staff told us "We aim to provide a compassionate service for people.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

People told us they felt safe and gave examples to show what made them feel safe. Members of staff attended safeguarding adults training. Staff knew the signs of abuse and felt confident to report any suspicions or allegations of abuse.

Recruitment procedures ensured the staff employed were suitable to work with vulnerable adults but application forms did not ask staff to disclose their criminal background. This meant the recruitment procedure did not fully verify staff's character against the Disclosure and Barring Services (DBS) check

People told us "staff were always around" The rotas in place confirmed the staffing levels were maintained to meet the needs of people.

People were protected from unsafe medicine systems. We saw that people were supported with medication and the members of staff ensured that people received and took their medicines as prescribed.

Is the service effective?

Requires Improvement

Staff attended Mental Capacity Act 2005 (MCA) training but they were not able to show a good understanding of enabling people to make decisions.

We saw people were not able to leave the property because exits had key pads and the codes were not known by them. People told us they were always accompanied by staff in the community. Deprivation of Liberty Safeguards (DoLS) applications were in progress for the people living at the home due to this continuous supervision and lacked the option to leave the home without staff supervision.

People told us the staff knew how to care for them. New staff received an induction when they started work at the home. Staff were supported by appropriate training, supervision and appraisals.

People told us the food was good. They were provided with a choice of meals at each mealtime. People's preferences and specialist diets were catered for.

Is the service caring?

Requires Improvement

Staff used inappropriate terminology when they were referring to people who needed support." This did not promote respect or show a person centred approach.

People told us the staff were good. We observed staff were calm and spoke to people by name. People were not rushed for example, to eat their meals and we saw staff speak to people and ensured they understood the tasks they were undertaking.

Summary of findings

Is the service responsive?

Requires Improvement 

People were helped to express their identity and to recognise their surroundings by the use memory boxes and sensory signs. People knew they had a care plan and were able to read it, if they wanted to. However, not all staff read the care plans and there was little flexibility because of the set routines followed by the staff.

People were helped pursue their hobbies and interests. Group and individual activities were organised and took place daily. Activities organisers and staff participated in activities and entertainments.

People told us they knew who to approach with complaints and felt confident their concerns would be taken seriously and acted upon

Is the service well-led?

Good 

The service was well led. The views of people and their relatives about the running of the home were gathered using surveys. Feedback from people was included the variety of activities and menu choices available. Relative's feedback about the service was good.

Staff told us the aim of the home was to deliver compassionate care to people. The manager said the culture was being developed to provide more responsive and sensitive care.

Audits were used to assess the quality and safety of the service. This included care planning, infection control and the management of medicines. Outcomes from the audits were used to develop staff learning.

Ravenswood

Detailed findings

Background to this inspection

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

This inspection took place on 4 and 5 December 2014 and was unannounced. It was carried out by an inspector and an expert by experience who had knowledge of dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we spoke to and looked at information from Commissioners of the service and previous inspection reports and notifications. Services tell us about important events relating to the care they provide using a notification.

During the inspection we spoke with people, their relatives and other visitors including social workers and commissioners. We interviewed staff, observed the interactions between people and staff; we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed records including the care records of six people, policies and procedures, schedules and monitoring charts, audits of systems, reports of accidents and incidents and medicine administration records.

Good

Is the service safe?

Our findings

People told us they felt safe. They said the feeling of safety was achieved by having staff to provide their care and a secure environment. One person said "I feel safe because the staff will sort whatever problem I have."

Staff attended safeguarding adults training. We spoke with three members of staff and they demonstrated a good knowledge of how to keep people safe and how to protect people from abuse, including how to report any concerns. One member of staff described the signs of abuse and the actions they were expected to take to protect people from possible harm. A member of staff told us they had reported allegations of abuse to their line manager. We saw the safeguarding procedure on display which told people and visitors how to recognise and report abuse.

Staff told us there were people who at times used aggression to express their frustrations. One person told us "occasionally people will get angry with each other and the staff will manage the situation." The staff told us there were people who at times became angry towards each other. They told us information in care plans on how to manage difficult behaviours ensured staff were able to respond to these situations in a consistent manner. People were protected from potential harm because the staff were able to recognise triggers and diffuse aggressive situations.

Staff told us how risks were managed. Risk assessments were undertaken to determine the risk associated with developing pressure ulcers, malnutrition or falling One member of staff told us the clinical lead assessed the dependency needs of people and developed risk assessments on how to lower the level of risk.

Systems were in place to ensure the premises were safe and the staff knew the procedure to follow in the event of an emergency. Personal emergency evacuation plans were in place which determined each person's ability and the support they needed to leave the building in the event of an emergency. Staff received fire training and attended fire drills to ensure they knew the evacuation procedure in the event of a fire. Checks of the premises for example bedrooms, heating systems and water temperatures were conducted by a designated member of staff.

One person told us "most of the time there is enough staff." Another person said "staff are always around." The staff we asked told us staffing levels were "ok". The manager told us the way staffing levels were calculated to meet the needs of the people at the home. We were told there was a registered nurse and care assistants on duty at all times and a senior member of staff during the day but not at night. Rotas confirmed the staffing levels were arranged to meet people's needs, for example there were more staff on duty during peak periods.

One member of staff told us about the recruitment procedure followed. Checks of their criminal background were conducted and references from previous employers were sought. The personnel files confirmed the procedure described by the staff.

Medicines were stored in a locked cupboard, within the locked staff office. The nurse in charge was responsible for medicines administration.

We observed part of a medicines round and a monitored dosage system was used. All of the tablets and liquids were dispensed by the pharmacy into "pods" for each person. Each person had their own set of pods for the week. The pods showed a photograph of the person and full prescribing instructions of each medicine. This reduced the risk of error. The nurse in charge ensured each person took their medicines..

Medicines were disposed of safely when they were no longer needed.

People's medicines were reviewed with the GP to ensure they were still required. On the day of our inspection, one person was having a medication review based on the recent changes in their behaviour. This was clearly documented in care records. The staff member accompanying the person was able to tell us the reasons for the review.

There were some people whose medicines were administered covertly (hidden in food or drink). Best interest meetings to administer medicines covertly were documented in people's records where this applied. The nurse in charge was knowledgeable about why someone may need to take their medicines covertly and was aware of the processes to follow to ensure it was undertaken correctly.

Requires Improvement

Is the service effective?

Our findings

People told us they made daily living decisions such as their clothes, food and time to rise and retire. Members of staff told us people were given choices. They told us people made decisions from the choices shown to them. One member of staff told us people were asked to make choices about their meals and activities and some people were supported by their families to make difficult decisions.

Members of staff told us they had attended Mental Capacity Act 2005 training. However, these staff were not able show a good understanding of the act. Members of staff were not able to explain the reasons for assessing people's capacity to make decisions. One person told us they were not able to lock their door to stop other people entering their bedroom. Some people had to ask the staff for their cigarettes and lighters. Where people's cigarettes were restricted, care plans were in place but Mental Capacity Act assessments were not undertaken. Although best interest decisions were made by the staff, people's capacity to understand the consequences of them making inappropriate decisions were not conducted. This is a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) 2010

Some doors were locked to restrict people's access to the lower floors where there were bedrooms and bathroom. It was acknowledged these restrictions were to reduce the risk of falls and prevent people from accessing these areas without the supervision of the staff. This meant parts of the property looked institutional (behaviours and attitudes that have existed for long periods and viewed as acceptable practice) We recommend the service seek guidance on devises and systems which enables people to be independent in a safe environment.

People told us they were always accompanied by the staff in the community. One person said "I can't go out alone. Staff take me to the bank in town." We observed a security code was needed to leave the property but the code was not on display and the people we asked were not aware of the code. The manager told us Deprivation of Liberty Safeguards (DoLS) applications were in progress for the people living at the home because they were subject to continuous supervision and lacked the option to leave the home without staff supervision. DoL's provide a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

People told us the staff knew how to care for them. One person said "the staff know I am nervous and they help me settle. "Another person said "it's very nice here, the staff know me."

New staff received an induction to prepare them for their role. A new member of staff told us part of their induction included shadowing more experienced staff. A team leader told us their role included the induction of new staff. They said the induction centred on activities of daily living including a safe environment, eating and drinking and communication. They said it took three to six months to complete.

Staff told us the training provided ensured they were able to meet the needs of people. The training matrix showed that staff had attended training in infection control, moving and handling, safeguarding adults, food hygiene, Health and Safety and Mental Capacity Act. However, not all staff had attended infection control, food hygiene and first aid. The manager told us training was to improve and explained training packages were purchased for dementia and mental health. They said the provider was developing links with the local college for staff training and that training from the local pharmacist was also planned.

Staff told us their performance was monitored and they were encouraged to develop their skills. They told us appraisals were annual and individual supervision was with the manager or clinical lead. The appraisal and supervision matrix showed all staff had appraisals and regular supervision.

People told us the food served was good. One person told us alternatives to the menu choices were always available. This person said snacks were served with drinks. Another person told us they preferred a vegetarian diet and this was catered for. The cook told us the menus devised were based on people's food preferences. We were told about the types of diets people needed to be healthy for example, enriched, diabetic and textured diets. On the menu each day for lunch was a choice of two meals and vegetarian option and a selection of desserts.

Malnutrition Universal Screening Tools (MUST) assessments were undertaken to determine the potential

Requires Improvement

Is the service effective?

of people developing malnutrition. Care plans were devised for people with low weights which included the actions to help the person maintain their weight. One person told us they were weighed two weekly. We saw people were weighed according to information detailed in their care plan. Staff told us about people's needs and were clearly knowledgeable about them. One member of staff told us "some people might require special drinks to supplement their diet, so we make sure to write down whenever they have one, how much they drink ". This showed us that staff knew the importance of monitoring people's dietary input.

People told us they had a GP, which they saw as required. One person told us they saw a psychiatrist and were accompanied by staff on these appointments. We saw evidence in people's care plans that referrals were made to other health professionals for advice regarding audiology, or eye appointments for example. This showed that people had support to meet their health needs.

Requires Improvement

Is the service caring?

Our findings

People told us the staff were good. One person said "the staff are lovely, they are all very kind. They understand me." Another person said "it's very nice here." A third person told us "the staff are very caring; they help me when I get anxious and reassure me" and "they really are marvellous staff". One staff member told us "I know the people here so I understand their care needs". We were told handovers took place when shift changes occurred. This ensured staff were aware of people's current needs. Another member of staff said "I really feel that people are well cared for here, the team is great".

We saw people were alert and engaged with the activities that were taking place. We observed staff speaking with people in a caring and patient way. Staff were calm and spoke to people by name. A member of staff told us "we speak to people and communicate with them in a way they understand. I know people's communication needs here from years of experience of caring for them".

Surveys were used to capture the views of people about the running of the home. People made comments about the variety of activities and about the meals. We saw examples of menu surveys that had been carried out. People were asked if they enjoyed the food and if they wanted any changes to the menu. The manager told us about the action taken to address the feedback people had given. This included ensuring there were choices available at every mealtime.

People told us the staff respected them. One person said "yes I feel respected" and another person said "the staff don't just walk in [bedrooms] they knock first". One member of staff told us "dignity is about maintaining a person's privacy, keeping their room door closed when doing personal care, keeping them covered up, telling people what you're doing; it's all part of our job". However, staff's terminology was not respectful. For example, the staff referred to people who needed support as "walkers" or "feeders". This showed that staff did not respect people as individuals in a person centred way. We spoke with the manager and with directors about the use of terminology. They said training was to be provided to staff.

Requires Improvement

Is the service responsive?

Our findings

Memory boxes on doors helped people express their identity and recognise their surroundings. Each person had a personalised door sign to their room that had been hand painted and was based on their personal life. For example, one person had worked as a fireman and had a picture of a fire engine with their name as the number plate. Another person who was blind had their name written in raised letters so that they could feel which room was theirs.

People knew they had a care plan. One person said "I have a care plan; I think it's reviewed and yes I can read it." Care plans we saw all contained details of the person's personal choices; for example, what they liked to eat, what time they preferred to get up and go to bed. We saw that changes in people's behaviour were documented and staff had responded appropriately. For example, staff had identified one person's behaviour was raising some concerns and a hospital review appointment had been made. A member of staff accompanied the person to this appointment during our inspection.

Care plans were detailed but were not routinely read by all staff. For example, one care plan showed that one person with communication difficulties used pictures to communicate with staff. Copies of these pictures were in the care plan. The staff were able to tell us how they communicated with the person but they did not make any reference to the care plan or the pictures. Members of staff told us care plans were developed by the clinical lead or qualified nurses. These staff told us they did not routinely read the care plans. It was stated communication books and handovers kept them informed about people's current needs. A comment made by a member of staff indicated people's care was not always responsive. We were told "everyone here is in a routine and everything we do is to a routine. I know exactly what needs to be done and when". This meant there was little room for flexibility or for people to ask for something different.

Activities were organised daily. The activities coordinator described the types of activities provided. They said some people preferred individual attention while others preferred group activities. Group activities included quizzes, poetry and singing while individual activities involved helping people to write letters and reading newspapers. Training was provided to ensure the activities organised were meaningful for people living with dementia. This included using smells and objects to evoke memories. We observed activities were taking place throughout the day and we saw people and support staff as well as activities organisers participated in entertainment and in activities.

People told us they knew who to approach with concerns. One person told us "yes I can complain. Yes I trust XX to deal with it [complain]". Another person said "problems go to the staff if not go to the manager." We saw the complaint procedure on display which told people and visitors the procedure for making complaints. Members of staff told us complaints were passed to the manager for investigation. There were three recorded complaints which the manager had investigated in line with the homes policy and were resolved satisfactorily.

Good

Is the service well-led?

Our findings

The views of people about the running of the home were gathered using surveys. The registered manager told us relatives, staff and activities coordinator helped people to complete the surveys. People's feedback centred on the variety of activities and choices of meals. Although the feedback from relatives about the running of the home was good, the registered manager told us only a small number of surveys were returned. The quality assurance system was to be developed further to seek the views of the staff and of social and health care professionals who visited the home.

People told us they knew the registered manager. One person said they were able to discuss their care and concerns with the manager. Staff told us there were good working relationships among the staff. They praised the manager for the changes which had improved people's care. A member of staff told us the manager cared about the people living in the home and worked alongside them when needed. Another member of staff told us "good team, everybody gets on" and another said "the manager is fair" we are told "the door is always open". A third member of staff said the manager "will listen and works with me to get things right".

The registered manager told us a "hands on" and supportive approach to management was used. They said "if I am needed on the floor that is where I will be". It was explained the culture of the home was in transition. This included a shift from a detached management style to a more involved style and by developing staff skills to provide responsive and sensitive care. Members of staff said the aim was to deliver compassionate care to people.

Audits were used to assess the quality and safety of the service. There were health and safety, care plan, infection control and medicine audits. The manager told us sample checks were conducted and outcomes from the audits were used to develop staff learning. We saw there was a response from the manager or clinical lead where shortfalls had been identified. Records showed how staff had been informed and received further information in order to prevent a recurrence.

Maintenance checks and tests were undertaken to ensure the premises were safe. For example checks of fire fighting equipment, portable electrical appliances and heating systems were conducted.

Incidents and accidents were analysed monthly to identify patterns and trends. The analysis included an assessment of person's level of understanding, history and cause of the accident or incident. The analysis helped the manager to review the care people received and reduce any reoccurrences of the incident or accident.

The quality of the service was monitored by directors of the organisation. Visits from the directors were monthly and included reviewing audits, monitoring reports such as occupancy levels, staffing, assessing trends and patterns from accidents and incidents and touring the property. For example, improvements needed to the property.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People who use services were not enabled to make decisions because their capacity was not assessed.