Community Homes of Intensive Care and Education Limited

Ravenna Lodge

Inspection report

East Anton Farm Road
Andover
SP11 6RD

Tel: 02030190607
Website: www.choicecaregroup.com

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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

About the service: Ravenna Lodge is a residential care home that was providing personal and nursing care to 7 people aged under 65 at the time of the inspection.

People's experience of using this service:
People were safe living at the service, risks had been assessed and they were cared for by well trained staff members.

Medicines were safely managed, staff were trained and completed a competency assessment before administering medicines.

The premises were clean and well maintained, the building was one year old and had been designed specifically for the client group and was fully accessible.

Staff completed an in-depth induction and training package when they commenced working for the provider. They were supported by regular supervisions and a management team who would support the team as needed.

People had clear and comprehensive assessments and care plans. Consents were sought and capacity assessed in each area covered by the care plan.

Staff were caring and showed empathy to people living in the service. They supported them in day to day tasks, in the community and at point of crisis when they most needed person-centred support.

People had key workers who would meet with them every month to discuss their care and support.

People were supported to be independent as far as they were able and staff respected their right to privacy.

The registered manager motivated their team to provide high quality, person centred support to people.

The provider sought feedback on standards and had arranged an independent health and safety audit and inspections were completed internally.

The provider had forged positive relationships with health and social care professionals to aid in a multi-disciplinary approach to people's care.

Ravenna Lodge met the characteristic of good in all areas. More information is in the full report.
Rating at last inspection: This was the first inspection of this new service which was registered on 5 March 2018.

Why we inspected: This was a planned inspection based on our inspection schedule.

Follow up: We will continue to monitor the service and reinspect according to our reinspection schedule.

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 was safe Details are in our Safe findings below.	**Good**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was well-led Details are in our Well-Led findings below.	**Good**

Ravenna Lodge

Detailed findings

Background to this inspection

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

Inspection team:
The service was inspected by one adult social care inspector over two days.

Service and service type:
Ravenna Lodge is a care home. People in care homes receive both accommodation and personal care. CQC regulate both the care provided and the premises and both were looked at during this inspection.
The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection was unannounced, we gave no notice of the inspection.

What we did:
Before we inspected Ravenna Lodge we reviewed the information we already held about the service. We looked at notifications. Notifications are sent to us by the service to tell us about significant events.
We reviewed the Provider Information Return. The provider completes this at least once every year to tell us what the service is doing well and about any plans to improve.
During our inspection we spoke with three people who lived in the service, two support workers, a day care officer, the registered manager and the assistant regional director.
We reviewed records maintained by the service including records of accidents, incidents and complaints, audits and quality assurance reports and health and safety monitoring. We looked at two peoples care records, four staff recruitment and supervision files and policies and procedures.
We sought feedback from 13 health and social care professionals and received a response from 7 of the professionals approached.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Good: People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse
• There were safeguarding systems in place to ensure that all suspected abuse was alerted and investigated. Staff were familiar with these and received annual safeguarding training and when we inspected there was a 100% completion rate of this training.

• The provider issued a card showing their values to staff members when they commenced working in the service. On the reverse of the card were details of how to whistle-blow. There were email addresses and contact numbers for staff to use to report incidents of poor practice.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• Care records contained a suitable range of risk assessments which included guidance on how the risks should be mitigated.

• Risks assessments concerning the premises and activities were completed and people had Personal Emergency Evacuation Plans, PEEP's, in place to detail the support they would need to safely leave the premises in an emergency.
• Regular checks were completed of the premises including emergency lighting, fire alarms and water safety. New maintenance concerns were raised on an online system and dealt with by an in-house team.

• Accidents and incidents were recorded and there were flow charts which detailed the actions to take in the event of different types of incident including medical incidents, head injuries, behavioural concerns and environmental incidents.

• Each person's incident and accident record was totalled and reviewed monthly to look for trends and possible causes which could be used to minimise future occurrences.

• When there were behavioural incidents, staff in the service and an in-house behavioural team would review the possible causes, behaviours and actions taken by staff to manage the situation. New guidelines would be issued, when required, to ensure that the most effective behaviour management techniques were in use. This was a continual process of learning and evaluation which was having gradual success in supporting people to manage their own behaviours.

Staffing and recruitment

• Staff were safely recruited. We saw staff recruitment files which held evidence of necessary pre-employment checks including references, full employment histories and a Disclosure and Barring Service check (DBS). The DBS check enables employers to make safe recruitment decisions and prevents unsuitable people from working with vulnerable groups.

• There had been a high turnover of staff since the service opened however the registered manager advised us that this had settled in the last few months.

• Staff told us there were usually enough staff deployed to meet people's needs. The people living at Ravenna Lodge did not require a great deal of personal care support and some spent extended periods of time in bed. During quieter times in the service, staff could complete household tasks, update records and complete health and safety checks.

• Should additional support be required to respond to an incident, for example, the registered manager was happy to support the staff team. .

Using medicines safely
• Medicines were safely managed. The provider had recently ordered medicines through 'Pilltime', an NHS provider of prescription medicines. Medicines are packaged into transparent pouches which are labelled with each medicine contained, when they should be taken and by whom. The new system had so far proved to be accurate.

• Staff completed online training, face to face training and a competence check before being permitted to administer medicines to people.

• To reduce medicines errors, two staff checked and signed for all medicines administered.
• We checked medicines to ensure they were accurately accounted for and all were as expected.

Preventing and controlling infection
• The service was clean and smelt fresh. The service opened one year ago and was still very new looking, décor was intact and fixtures and fittings in good condition.

• People were encouraged to maintain the cleanliness of their own rooms, apartments and studios.

• Monthly infection control audits were completed and there had been no outbreaks or infection in the last 12 months.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Ensuring consent to care and treatment in line with law and guidance
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 with appropriate legal authority. In care homes this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• The registered manager understood when a DoLS application as required and had applied for emergency authorisations when necessary.

• Staff were trained in the MCA and understood that most of the time, people they worked with, had capacity to make decisions. They were also aware that during periods of crisis, people's capacity may change and decisions may need to be considered in their best interests.

• There was evidence that mental capacity was considered as part of the broader care planning approach. This helped to protect people's rights and choices?

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• The provider had a team of assessors who met with people and supplied detailed assessments to the registered manager. The registered manager, if they believed the service could meet the persons needs would review their information and meet with the person to evaluate their suitability for the placement.

• Staff supported people with their needs in line with current good practice guidance. Regular reviews ensured care plans and positive behaviour guidelines were updated in line with people's changing support needs. .

• There was a handover meeting each day and a 'must read' file held relevant information that must be seen by staff. Staff did not hesitate to ask the registered manager or shift leader for advice if they were uncertain

about anything.

Staff support: induction, training, skills and experience
• Staff completed a 10-week induction process when commencing in their post at Ravenna Lodge. This included face to face training, online training, supervision, shadowing experienced staff and completing the Care Certificate. The Care Certificate is an agreed set of 15 standards that staff working in a caring environment adhere to.

• Staff participated in mandatory training which included courses on, person centred care, moving and handling, safeguarding, first aid, data protection and medicines. In total there were 18 courses included in mandatory training which were a mix of practical and online training sessions.

• Staff were trained in positive behaviour support and in strategies for crisis intervention and prevention (SCIP). One of the management team was a SCIP trainer and could provide support and training as needed.

• Staff received regular supervision. When they commenced in post, supervision was weekly and this gradually reduced throughout their probation as they built in confidence and competence to a minimum of four meetings per year. Staff told us that supervisions were useful. One staff member said, "Yes, it helps me to get things off my chest or if I am rattled about something it helps to talk about it…. We set goals to achieve before my next supervision".

• The service had been open for one year and the registered manager had started to complete appraisals with relevant staff members.

Supporting people to eat and drink enough to maintain a balanced diet
• People chose their own meals and both the apartments and the studios both had basic cooking facilities so that people could, with support, make their own meals. One person had chosen to make their own breakfast and lunch, and was provided with a budget to shop for these meals and support to make them.

• The service could provide support to people who had specialist nutritional needs. One person had regular fortified food supplements as they were not keen on eating meals and another person who had diabetes was supported to maintain stable blood glucose levels, in part through a balanced diet.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• The provider was able to effectively respond to issues of behavioural management and support people with mental health crises. A member of the in-house Positive Behaviour Support Team would attend the service at least every two weeks and could respond to problems within a couple of days. They would review existing plans and advise and plan for the future with people.

• The provider had also forged positive working relationships with GP surgeries, district and community nurses who supported them with insulin administration, community mental health teams, local safeguarding teams and commissioners. This ensured that appropriate health care was available to people in a timely way.

• The provider supported people to access both mainstream and specialised services. One person attended a specialist dental service and another a substance abuse support group. The GP provided home visits to people who found going to the surgery a problem.

Adapting service, design, decoration to meet people's needs

• The service was purpose built and first opened in March 2018. The design was fully accessible for people, wheelchair users and those who had poor mobility. There was no passenger lift therefore only people who could manage stairs could be accommodated on the first floor.

• Extensive gardens were available and again accessible to everyone living in the service.

• For safety reasons, there was a key coded entry system and some areas such as the kitchen had key coded locks. People had the codes to access the kitchen unless there were agreed reasons for their access to be limited. People had the code to exit the building unless they had a DoLS authorisation which meant they had to be accompanied in the community.

• People could personalise their rooms however furniture was supplied and specially designed to minimise risks of harm or self-harm. For example, all furniture had been securely fixed to walls and instead of hanging rails in the wardrobes, there were grooves to hook hangers onto as a rail could be hazardous. Curtains were also either fixed to windows using magnets or clips, both of which would release if any weight were to be put on them.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• Some people in the home identified with protected characteristics as defined in the Equality Act 2010. The provider responded extremely well in meeting their needs in a person-centred way.

• One person who had a complex condition was supported by the registered manager in making menu choices. The registered manager provided numerous written options so that they could make choices.

• We saw staff working with complex individuals who had a diverse range of mental health conditions. At times staff could be put under significant pressure if someone was experiencing a crisis. Despite this, the support was provided with empathy. After such an incident, a staff member told us, "I really try to make things better for them, I can't imagine how awful they must feel to act in the way they do".
Supporting people to express their views and be involved in making decisions about their care
• People had one to one time with their allocated key worker every month so their care needs could be reviewed.

• People were involved in compiling their care plans and we saw care records and plans that had been signed by people to say they had agreed with the content.

Respecting and promoting people's privacy, dignity and independence
• People living in the home were enabled to have privacy to have personal relationships and to take time away from those with whom they lived. When people had conditions which required close monitoring, this was done in a respectful way, for example remaining at a discreet distance when monitoring someone using the shower.

• One person had chosen not to have any monitoring equipment installed to alert if they were experiencing a seizure. This had been risk assessed and measures were in place to reduce the risk. The registered manager supported this as the person had capacity to choose not to use the equipment and had a right to privacy which would be compromised with the monitors in place.

• People were encouraged to maintain their independence. One person had, supported by staff, set up a cleaning schedule for their room. They had already worked towards being more independent with laundry and hoped, if they continued to develop skills of independence, to be able to move into one of the studios or apartments in the house.

• Staff knocked people's doors before entering and people had keys to their rooms so they could have

privacy when they wanted. If people entered the staff office, confidential documents were placed out of view to ensure people's privacy was maintained.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Good: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Care plans were extensive and person centred. Each plan was person-centred and had been discussed with, and consented to, by the person. Areas in the care plan included communication, mental health, behaviour, addictive behaviours, self-harm and hope and trust. Hope and trust detailed how people felt about their future, issues they may have in terms of trusting people, including support staff, and where they felt safe.

• Each person's care record had an extensive personal history including information about where they were from, their family and their life before moving to Ravenna Lodge. Staff told us this was useful as it informed them about who the person was when they first met them and gave talking points to use in conversation.

• The provider met the requirements of the Accessible Information Standard.
• The registered manager emailed one person who had a visual impairment so they could use an application to read the information to them. They provided photographic prompts to another person who did not respond to written information. Another person had a need to have everything put into a letter format which the provider ensured was done.

• There was currently no activities programme at the service, this was mainly due to people being reluctant to participate in group activities. A new programme was being developed to try to engage people in activities both individually and in groups. When we inspected, all activities were on a one to one basis, as and when possible.

• The needs of people living in the home were complex and required staff to constantly adapt their approach to situations to ensure the safety and well-being of them and others.

Improving care quality in response to complaints or concerns
• There was a complaints procedure however issues were dealt with as they arose if possible. Compliments were also received by the provider and we saw thank you cards from people who had positive experiences of the service.

End of life care and support
• People could work with staff to develop a care plan regarding the end of their lives however at this time the people living at Ravenna Lodge had chosen not to consider this area of care planning.

• The registered manager told us that if a person was at the end of their life, the service would work in

partnership with medical professionals to enable them to remain at Ravenna Lodge if that was their preference.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Good: The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility
• The registered manager motivated staff to enable people to meet their outcomes in a person-centred way. A range of desired outcomes were achieved through creative approaches and staff commitment to person-centred care. One person had been driven by a staff member to a specialist shop over 100 miles from the home to meet a specific outcome.

• Staff told us they felt supported by both the registered manager and the assistant area director. One staff member told us, "I was feeling lost one day due to things happening in my personal life. The registered manager saw this immediately and supported me. They support me with practical advice and always ask about my family". Staff told us they would not hesitate in reporting concerns to anyone in the management team.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• There was a clear management structure within the home. There was a shift leader allocated to deal with the day to day running of the service and the registered manager was supported by a deputy and an assistant manager.

• Throughout the first year of the service, the registered manager had close support from the assistant area director. This support was now reducing as the service became more established however they would still visit at least monthly and provide additional support as needed.

• The registered manager was clear about their responsibilities, they sent notifications of significant events to CQC as required and understood their responsibilities under the Duty of Candour. The Duty of Candour is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Registered persons must act in an open and honest way with people about their care.

• The registered manager completed a range of audits including health and safety, accident and incident and medicines. The provider had completed an internal inspection and an independent health and safety audit had also been completed. These had identified areas for improvements that were being acted upon.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics
• Monthly staff meetings were held, mainly discussing day to day service matters. Staff could add their own items to the agenda for discussion.

• Residents meetings were held monthly but not always well attended due to people's needs. The registered manager told us that staff were however able to speak with them individually to keep them informed about matters in and about the service.

• A quality assurance questionnaire was sent to people, relatives and professionals. Feedback was generally positive and where it wasn't, it had been followed up by the provider.

Working in partnership with others; Continuous learning and improving care
• The provider worked closely with commissioners, safeguarding, the police and healthcare providers in the area. Positive relationships had also been forged as far as possible with neighbours to the service including a local school and community centre.

• The provider had arranged a coffee morning to invite the local community into the home to meet people and become more familiar with the service to strengthen relationships.

• The provider had a range of services caring for people who had a range of disabilities and health conditions. They were constantly updating policies and procedures in line with current legislation and best practice.