Ravenswing Homes Limited

Ravenswing Manor Residential Care Home

Inspection report

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Ratings

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

Overall summary

This was an unannounced inspection which took place on 8 and 15 April 2015. We had previously inspected this service in May 2014 when we found it was meeting all of the regulations we reviewed.

Ravenswing Manor Residential Care Home is registered to provide accommodation for up to 24 older people who require support with personal care needs. At the time of our inspection there were 19 people using the service.

There was a registered manager in place at Ravenswing Manor. 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.

Summary of findings

We identified eight breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Although people told us they generally felt safe in Ravenswing Manor we found systems for identifying and reporting safeguarding concerns needed to be improved in order to ensure people who used the service were protected from abuse.

People who used the service told us staffing levels needed to be improved. We found the arrangements for staffing at night failed to ensure people were provided with safe and effective care. Recruitment systems were not sufficiently robust to protect people who used the service from the risk of unsuitable staff. Staff had also not received the necessary induction, training, supervision or appraisal to help ensure they were supported to deliver effective care.

We received positive feedback about the attitude and approach of staff from people who used the service and their relatives. People who used the service told us staff respected their dignity and privacy and supported them to maintain their independence as much as possible. Our observations during the inspection showed that staff were mostly caring and reassuring in their interactions with people in Ravenswing Manor.

Systems for the safe administration of medicine needed to be improved to ensure people always received their medicines as prescribed.

Although staff had not received specific training in the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards (DoLS) they were able to tell us how they supported people to make their own decisions. People who used the service told us staff mainly respected their choices and they were not subject to any restrictions in Ravenswing Manor. The registered manager told us they were aware of the action they should take to ensure any restrictions assessed as necessary for individuals who used the service were legally authorised.

We found care records were not always fully completed. This meant there was a risk people might not receive the care they required. People who used the service told us they had limited opportunities to comment on the care they received or the quality of care provided in Ravenswing Manor. We noted no resident meetings had taken place since the service opened in 2013 although the registered manager told us they spoke regularly with all the people who used the service and their relatives.

People who used the service told us there was a lack of activities provided for them. Although on the first day of the inspection we saw staff supported a small group of people who used the service to reminisce about past events using family photographs, there was no evidence that a regular programme of activities was in place in Ravenswing Manor.

We found the system for identifying, recording, investigating and responding to complaints needed to be improved. Quality assurance systems were also not effective in identifying where improvements needed to be made to the service.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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?

Inadequate

The service was not safe.

Although most people had no concerns about their safety in Ravenswing Manor we found the recruitment systems in place did not adequately protect people from the risk of unsuitable staff.

Staffing levels at night were insufficient to ensure people always received safe and appropriate care.

People were not adequately protected by the systems in place to manage medicines.

Is the service effective?

Requires improvement

The service was not effectively meeting people's needs.

Recording systems were not sufficiently accurate and up to date to ensure people always received the care they required.

People who used the service told us staff mainly respected their choices and they were not subject to any restrictions in Ravenswing Manor.

Induction, training, supervision and appraisal systems were insufficient to ensure staff had the necessary skills to be able to deliver effective care.

Is the service caring?

Good

The service was caring.

People who used the service told us staff respected their dignity and privacy and supported them to be as independent as possible.

We noted mostly positive interactions between staff and people who used the service.

Positive feedback had been provided about the caring nature of Ravenswing Manor in satisfaction surveys completed by visitors to the service.

Is the service responsive?

Requires improvement

The service was not always responsive to people's needs.

People who used the service had limited opportunities to make decisions about the care and support they received.

There was a lack of evidence that complaints received at the service had been recorded and investigated.

Insufficient activities were provided in Ravenswing Manor to help ensure the health and well-being of people was maintained.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

The service had a manager who was registered with the Care Quality Commission (CQC). However, quality assurance processes were not sufficiently robust to identify where improvements needed to be made to the service. This had led to the breaches of regulations identified during the inspection.

Staff told us they enjoyed working in Ravenswing Manor and felt well supported by the registered manager.

Ravenswing Manor Residential Care Home

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 8 and 15 April and was unannounced.

On the first day of the inspection the inspection team consisted of two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of services for older people. On the second day of the inspection the service was inspected by two adult social care inspectors.

We had not requested the service complete a provider information return (PIR); this is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. However, before our inspection we reviewed the information we held about the service including notifications the provider had sent to us. We contacted the local authority safeguarding team, the local Healthwatch organisation and the local authority commissioning team to obtain their views about the service.

On the first day of the inspection we spoke with 12 people who used the service and three visiting relatives. We also spoke with the registered manager, a senior carer, a member of care staff and the chef .In addition we spoke with a health care professional who visited the service during the inspection. On the second day of the inspection we spoke with the registered manager and a member of care staff. We also spoke with one person who used the service and their relative. Following the inspection we telephoned a district nurse who regularly visited Ravenswing Manor to find out their opinion of the service.

We carried out observations in the public areas of the service. We looked at the care records for five people who used the service and the records relating to the administration of medicines for all the people who used the service. We also looked at the records relating to the administration of prescribed creams for five people who used the service.

In addition we looked at a range of records relating to how the service was managed; these included twelve staff personnel files, training records, quality assurance systems and policies and procedures.

Inadequate

Is the service safe?

Our findings

Most of the people who used the service told us they felt safe in Ravenswing Manor. Comments people made to us included, "Yes I would say I feel safe here and the staff are all very good" and "I do feel safe and everyone is kind to me." Relatives we spoke with told us they had no concerns about the safety of their family member in Ravenswing Manor. However one person who used the service told us they had been frightened by the behaviour of another person who lived in Ravenswing Manor. We discussed this with the registered manager and staff. They told us the person had felt threatened by the behaviour of another person which they were now closely monitoring.

We looked at the recruitment procedures in place in the service and found these were not sufficiently robust to protect people from the risks of unsuitable staff. We looked at the personnel files for all of the staff employed to work in the service and found a lack of evidence that the registered manager had established that candidates were of good character and suitable to work with vulnerable adults. We found that there was only one reference on file for two members of staff; for one person this reference had been provided by a neighbour rather than an employer although the person had previously worked in services for vulnerable adults. We also saw that negative information about the person's performance was contained on the file. The registered manager told us this had been followed up with the person's previous employer but there was no evidence on file to support this.

We noted the registered manager at Ravenswing Manor had acted as the main referee for two staff based on their knowledge of these staff from previous employment at another service where they had been the manager; however, no efforts had been made to seek additional references for these two staff from other care homes in which they had also been employed. The registered manager told us they did have difficulties in obtaining references from previous employers but they were unable to show us evidence of actions they had taken to follow up on any reference requests.

The lack of robust recruitment procedures was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On each day of the inspection there were three members of care staff on duty. We noted staff responded promptly to requests for assistance from people who used the service. However, people told us they did not think there were always enough staff on duty. One person told us, "I would say I feel safe and confident in the staff but I do think we could do with a few more of them." Another person commented, "I do think there is nothing wrong with this place that a few more staff couldn't fix."

We discussed the staff rota with the registered manager. They told us there were always three staff on duty during the day but at night time there was only one waking night staff with another member of staff asleep on the premises to provide additional support if needed. The registered manager told us this member of staff was not usually disturbed and they were therefore satisfied that the staffing levels were sufficient at night.

When we discussed the care needs of people who used the service with the registered manager we were informed that three people required the assistance of two carers to meet their personal care needs, with one person requiring two carers to support them to reposition both during the day and at night. We asked how this care could be provided during the night given there was only one member of staff awake to deliver the care people needed. We advised the registered manager we had been told by a member of care staff that the person who required repositioning at regular intervals was cared for by only one member of staff using a slide sheet. This practice is unsafe and could result in injury to either the person using the service or the member of staff. The registered manager told us they had no knowledge of this practice being used at night.

The lack of sufficient staff to meet people's needs in a safe and appropriate manner was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. When we returned on the second day of the inspection the registered manager informed us the rota would be amended to ensure two staff were awake on duty at night.

Staff we spoke with told us they had received training in the safeguarding of vulnerable adults and were aware of the action to take to protect people who used the service. However, when we looked at the care records for one person we noted there had been an incident where another person who used the service had made an allegation that they had been physically abused by the

person whose records we reviewed. When we discussed this with care staff and the registered manager there was a lack of understanding that such incidents should be reported to the local authority in order to ensure they were independently investigated. On the second day of the inspection the registered manager provided evidence that the required referral had been made.

We spoke with a person who used the service regarding their experience of the care provided to them. During our conversation the person alleged they had experienced poor care from a member of night staff. When we discussed this allegation with the registered manager they were reluctant to accept the possibility that the person might have experienced poor care and again were unaware of the need that any such allegations or comments by people regarding potential abuse or poor care should be taken seriously and referred to the local authority safeguarding team. However, the registered manager assured us the referral would be made as a matter of urgency.

The lack of appropriate reporting of safeguarding concerns meant people who used the service might not be adequately protected. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the systems for the administration of medicines in the service. People who used the service were generally satisfied with the arrangements in place to ensure they received their medicines as prescribed. However one person told us they thought staff were sometimes too slow in obtaining new medicines proscribed by their GP. Another person told us they were dissatisfied that they had been told they were unable to access pain relief medicines after 10pm. They told us, “You can’t even have painkillers. I have asked before and been told we [staff] can’t give any tablets out.” They told us this meant they were often in significant pain overnight.

We discussed access to pain relief at night time with the registered manager as this was an issue which had been raised with CQC previously by a relative and we had received reassurances from the registered manager that all night staff would be provided with training in the administration of medicines. The registered manager told us there had been difficulties in recruiting and retaining night staff and acknowledged that as a result there were night shifts when no staff were trained to administer medicines. They told us there was an on call system in place where a member of senior staff was available to respond to any requests for medicines by people who used the service at night. However, they acknowledged this meant there could be a delay to people receiving the medicines prescribed for them.

During the first day of the inspection we noted a medicine prescribed for a person who used the service was in the registered manager’s office. We asked why this was and whether the person was still prescribed the medicine. The registered manager was unable to given any explanation as to why the medicine was not stored securely; they confirmed the person was still prescribed the medicine concerned and had been taking it regularly. On the second day of the inspection we noted the medicine had been removed. It is important that all medicines are stored securely or disposed of appropriately when no longer required.

We looked at the medication administration record (MAR) charts for all the people who used the service and found these to be fully completed. However, we noted where additional entries had been made to the pre-printed MAR charts by staff, these had not been countersigned to ensure they were accurate. We also noted not all the administration information had been included on the MAR chart. This meant there was a risk people might not receive their medicines as prescribed.

We reviewed the cream administration records for five people who used the service. We saw none of these records were fully completed. This meant we could not be certain that people had received their creams as prescribed.

The lack of appropriate systems in place for the safe administration of medicines was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw arrangements were in place to ensure equipment used in Ravenswing Manor was regularly checked and serviced; this included equipment relating to fire safety. A personal evacuation plan (PEEP) had been completed for each person who used the service; this documented the support people would need in the event of an emergency at the service.

A business continuity plan was in place to provide information for staff about the action they should take in

Inadequate

Is the service safe?

the event of an emergency. However this needed to be updated to ensure all relevant information was available for staff including what alternative location should be used in the event of an emergency.

Requires improvement

Is the service effective?

Our findings

People who used the service told us they considered staff knew them well and were aware of the care they required. Relatives we spoke with told us they were confident that staff had the skills and abilities to be able to deliver effective care.

Staff we spoke with told us they considered they had the training they required for their role. One staff member told us the induction they received had been limited and they were expected to work on shift, although not independently, before they had received any training at the service. However, they told us they had felt confident in their role as they had previously worked in a different service with vulnerable adults.

We asked the registered manager to provide us information about the training staff had received since starting work at the service. The registered manager told us they had not yet completed a training matrix although they had been asked to provide one to the local authority commissioning team by the end of March 2015. They told us they were in the process of arranging training via the local authority and from a private provider but they did not have a list of training which they expected all staff to have completed.

From the records we reviewed we noted none of the staff had received training in infection control. We saw one member of staff who had started work at the service in February 2015 had not completed any training since their employment commenced; the registered manager told us this was because the person was also employed in another service working with older adults and had received training in this role although there was no evidence of this training on the person's staff file. There was also no record of staff having completed safeguarding training on seven of the personnel files we reviewed.

When we looked at the personnel files for staff we noted the records showed the chef had not completed food hygiene training since 2006. We checked this with the member of staff concerned and they confirmed this record was correct. Since they had not completed any recent training we asked them about their knowledge of the food allergen labelling rules which came into effect in December 2014 to assist people with food allergies to make it easier to identify ingredients they need to avoid. The chef told us they were unaware of this change in legislation and had not introduced any allergen labelling to the food prepared in the service.

Staff files we looked at showed only one person had received regular supervision since they started work at the service. Eight staff files contained no evidence of supervision or appraisal. The registered manager told us they would speak regularly with staff regarding their training needs but that these discussions were not recorded.

The lack of effective systems in place to ensure staff received appropriate induction, training, supervision and appraisal was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We therefore asked the registered manager how they ensured people were not subject to unnecessary restrictions and, where such restrictions were necessary, what action they took to ensure people's rights were protected. The registered manager told us they were aware of a change to the law regarding when people might be considered as deprived of their liberty in a residential care setting.

The registered manager told us they had made an application to the local authority when a person had been admitted to the service who had been subject to a DOLs authorisation in their previous care setting; they had not as yet completed any assessments to determine if other people who used the service might be considered to be deprived of their liberty in Ravenswing Manor.

Staff told us they had not received any specific training in the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards. However, they told us they would always support people to make their own decisions and choices.

We asked people who used the service if they felt able to make choices about the care they received and whether staff respected their decisions. Most people told us staff asked for their agreement before providing care but one person said that this was not always the case. One person commented, "Mostly the staff ask before beginning any

Requires improvement

Is the service effective?

care activity but not always and I am not sure whether or not I have seen my own care plan. It is the same with making personal choices, mostly I can and mostly I do not feel restricted in any way."

None of the people we spoke with raised any concerns about the food provided in Ravenswing Manor although one person told us the food could sometimes vary. On the first day of the inspection one member of the inspection team ate lunch with people who used the service. We noted the lunchtime atmosphere was relaxed and staff provided appropriate support to people who required assistance to eat. We found the quality and presentation of the food to be good.

We asked the registered manager about systems in place to monitor the nutritional needs of people who used the service. They told us people were weighed regularly and a referral was always made to a person's GP should any concerns be raised. The registered manager told us they were regularly monitoring the amount of fluid one person was drinking because of their medical condition. They told us a fluid monitoring chart was in place to record how much the person had had to drink each day. However when we looked at the person's records we noted this chart had not been regularly completed. There was no chart in place for the week commencing 19 January 2015 and there were no records completed for the period 20 February 2015 to 14 March 2015. The registered manager was unable to explain why these records had not been completed.

We spoke with two members of staff regarding the needs of the person who required monitoring in respect of their fluid intake. One member of staff was fully aware of the need for monitoring and the reasons why this was in place. However the second staff member told us there was no one in Ravenswing Manor who required monitoring regarding their fluid intake. This meant there was a risk the person might not receive effective care.

We looked at the records in relation to the person who required regular repositioning in order to maintain their skin integrity. On the first day of the inspection we had been told by the registered manager that the repositioning chart had only been in place since 7 April 2015 on the advice of a district nurse. However when we looked at the person's care records we noted the care plan written on 20 March 2015 had stated that the person required turning on a two hourly basis throughout the day and night and that this should be documented on a repositioning chart. The lack of a repositioning chart from 20 March 2015 to 7 April 2015 meant there was no evidence that the person had received the care they required to meet their needs. However when we telephoned the district nurse responsible for visiting the person in relation to their skin integrity we were told they had no concerns about the care the person received in Ravenswing Manor.

From our review of the care records for the person who required regular repositioning we were not confident that the repositioning chart had been completed by the staff on duty on 7 and 8 April 2015. This was because the signatures on this chart did not correspond with those of the staff who were on duty and had completed the daily notes for the person during the relevant time period. We raised this with the registered manager and senior carer on duty during the inspection; they could not give any explanation for this discrepancy.

The lack of complete and contemporaneous records in relation to the care provided to people who used the service was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service told us staff would always contact their GP if they felt unwell. The registered manager told us an optician visited the service on an annual basis. We saw that records were maintained of contact staff had with health professionals and of any advice given. Both professionals we spoke with told us they were confident staff would always follow any instructions they gave.

Good

Is the service caring?

Our findings

People we spoke with during the inspection provided positive feedback about the attitude and approach of staff. People who used the service told us staff respected their privacy and dignity and supported them to be as independent as possible. Comments people made to us included, “The staff are very kind and understanding and they mostly treat me with respect. They do listen to me and mostly act on it and they do respect my privacy and dignity” and “I love it here; the staff are so good and they work very hard…. I feel they are kind to me, treat me with respect and are careful about my privacy and dignity. They are happy to listen to me and to act on it wherever possible. They encourage all of us to remain as independent as possible.”

Staff we spoke with told us they would always take the time to listen to people who used the service in order to ensure they received the care they wanted. One staff member told us, “I treat residents like I would want my relatives to be cared for.”

During the inspection we noted positive interactions between staff and people who used the service. Staff spoke to people in a kind and respectful manner and were careful to provide reassurance to people when assisting them to transfer within the service. However we noted one person who used the service regularly called out to ask staff for help. We were told this person was blind and always acted in this manner but we saw some staff did not always respond to provide them with the necessary reassurance. However we also saw examples of staff responding to the person in warm and caring manner.

During the inspection we noted visitors were welcomed in to the service. People who used the service were able to meet with their visitors in the communal areas or in their own room if they preferred.

We noted positive feedback regarding staff in the service’s satisfaction surveys which had been completed by visitors. Comments we saw included, “I have found the home to be a very friendly and caring place. I have always felt welcomed and believe [my relative] is well looked after” and “I feel [my relative] is cared for as well as I would wish to care for her.”

Requires improvement

Is the service responsive?

Our findings

We looked at the care records for four people who used the service including one person who had been admitted for a period of respite care. We saw an assessment had been completed on all the files we reviewed; this should help ensure the service was able to meet people's needs.

We noted care plans were in place on three of the files we reviewed. However these contained limited information about people's wishes and preferences in relation to their care. There were no care plans in place in relation to the person who had been admitted for respite care. Although this person spoke positively to us about the care they were receiving in Ravenswing Manor, the lack of care plans meant there was a risk staff would not be aware of how they should respond to the person's needs.

Although the registered manager told us people were asked their opinion of the care they received, care records we reviewed did not provide any evidence that people had been involved in reviewing their care plans. People we spoke with told us they were not sure that they had seen their care plans or had any opportunity to discuss how their care was provided with staff. The registered manager told us they would consider how they could improve engagement with people who used the service in care plan reviews.

Most of the people we spoke with told us there was a general lack of activities in Ravenswing Manor, although one person told us they had made Easter bonnets and sometimes did exercises. People who used the service also told us there had not been any resident meetings organised where they could influence the way the service was delivered. Comments people made to us included, "There are no outings and little in the way of activities", "I don't do any activities as I'm not really up to it and I have not attended any residents meetings, if there were any. I have no problems expressing my views to the management and the staff or with keeping my links with family or friends" and "On balance they are very good here but I am not sure I have seen a care plan or much by way of activities and meetings."

On the first day of the inspection we observed a small group of people who used the service discuss old family photographs with staff. The registered manager told us this was an activity which took place regularly in the service but they were unable to provide any evidence of a weekly plan of activities. Involvement in activities is important to help promote the health and well-being of people. On the second day of the inspection the registered manager told us they had made arrangements for a group of people from Ravenswing Manor to attend a social event at the local church. We noted staff encouraged people to put their names down to attend.

The registered manager confirmed that they had not arranged any resident meetings since the service opened in 2013. However they told us they regularly spoke with people on an individual basis and the owner had involved people in making decisions about the wall covering for a recently decorated lounge. The lack of regular structured opportunities for people to provide feedback on the service they received and to comment on service developments meant there was a risk people's views would not be listened to or acted upon.

All of the people we spoke with told us they would feel able to raise any complaints or concerns with the registered manager and were confident they would be listened to. This was confirmed by the relatives we spoke with. One relative told us, "I did have to make a minor complaint some time ago but it was quickly resolved."

We asked the registered manager about the system for recording and responding to complaints received by the service. They told us there had not been any complaints received but records we looked at from the most recent staff meeting referred to a complaint made by a relative regarding the attitude of staff towards their family member. When we raised this with the registered manager we were told they had not considered the comments of the family member to be a complaint, although it was clearly recorded as such in the staff meeting minutes, and had therefore not recorded it in a complaints log. The registered manager told us they had not conducted a formal investigation into the complaint although they had raised it at the staff meeting and spoken with the family of the person concerned.

The lack of appropriate systems to record and respond to complaints was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The service had a manager in place who was registered with the Care Quality Commission (CQC) as required under the conditions of their registration.

People who used the service and their relatives spoke positively about the registered manager. Comments people made to us included, "I come here as often as possible to see [my relative] and I have full confidence in the manager and her staff here" and "We are sure that our relative is very well cared for and have no doubt that this Home is well managed." However, we found the registered manager was reactive in their approach to managing Ravenswing Manor rather than actively identifying where improvements needed to be made and ensuring the necessary actions were taken to improve the quality of the service provided.

All the staff we spoke with told us they enjoyed working at Ravenswing Manor and considered the registered manager was approachable. One staff member told us, "[The registered manager's] door is always open. She tells us what we need to do to make sure everything runs smoothly." Another staff member commented, "We all support each other and the senior carers and manager are very approachable."

Records we looked at showed regular staff meetings had taken place. All the staff we spoke with told us they felt they were able to raise any issues or concerns at these meetings and that any suggestions they made to improve the service were listened to by the registered manager.

We asked the registered manager to tell us about the quality assurance systems in place in the service. They told us they had recently had a quality monitoring visit from the local authority contract monitoring team but had yet to receive a copy of the report.

We asked the registered manager about their own internal systems for monitoring and reviewing the service so that areas of improvement were identified and addressed. We were told there were a number of health and safety audits which had been delegated to specific staff members to complete. When we looked at these audits we found they were lacking in detail and did not provide evidence of robust checks to ensure health and safety requirements were met, including the prevention and control of infection in the service. The registered manager also told us they were not completing any audits in relation to the administration of medicines in the service or any formal care plan audits, although they told us they would regularly check that care plans had been completed. However, our findings from the inspection showed their review of care records had not been robust enough to identify the shortfalls we had noted.

The registered manager told us they were not routinely asking people who used the service or their family members to complete satisfaction surveys although there were copies of the survey in the reception area of the service for people to fill in if they so wished. The lack of a regular survey meant the registered manager did not have the opportunity to formally review the opinions of people about the service provided in Ravenswing Manor and take any required action to improve the quality of the service.

The lack of effective systems to monitor the quality of the service in Ravenswing Manor was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were aware from our contact with the local authority commissioning team that the provider had been asked to make a number of improvements to the fabric of the building and to provide amenities for people who used the service, including a smoking shelter. During the inspection the registered manager was unable to tell us the timescale for any planned refurbishment. Following the inspection the provider sent us some information about plans to improve the building and the external environment of the service.

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	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had failed to deploy sufficient numbers of staff to meet people's care needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks associated with the unsafe management of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not maintained complete and contemporaneous records in relation to the care and support people needed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider did not have an effective system for identifying, recording, handling and responding to complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

The provider did not have an effective system to regularly assess and monitor the quality of service that people received.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider did not have effective recruitment and selection processes in place.

The enforcement action we took:
A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have effective systems in place to protect people who used the service from abuse.

The enforcement action we took:
A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not have suitable arrangements in place to ensure that people employed for the purposes of carrying on the regulated activity are supported by receiving appropriate induction, training and supervision and appraisal.

The enforcement action we took:
A warning notice was issued.