ARP Charitable Services

Ravenswood Road

Quality Report

21 Ravenswood Road
London
E17 9LY
Tel: 020 8521 4486
Website: www.foundation66.org.uk

Date of inspection visit: 18 August 2015
Date of publication: 12/10/2015

This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations.

Overall summary

We found:

- The management of medicines was not safe. The supply of medicines was not consistent. People using the service were not always given medicines as prescribed. Medicine records were not complete and were sometimes amended. Medicine errors were not always reported as incidents.
- Staff did not understand safeguarding issues. They did not know how to make a safeguarding referral.
- The assessment of people using the service did not identify all of their needs. There was no record that peoples' views or preferences had been sought.
- Most people using the service did not have a care plan.
- There were limited records concerning the care, treatment and progress of residents.
- There was no permanent manager for the service. The registered manager was not in day to day control or management of the service.
- The service was in a period of transition. New systems were being introduced. There had been significant staff changes.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- The management of medicines was not safe. The supply of medicines was not consistent. People using the service were not always given medicines as prescribed. Medicine records were not complete and were sometimes amended. Medicine errors were not always reported as incidents.
- Staff did not understand safeguarding issues. They did not know how to make a safeguarding referral.

Are services effective?

- The assessment of people using the service did not identify all of their needs. There was no record that peoples' views or preferences had been sought.
- Most people using the service did not have a care plan.
- There were limited records concerning the care, treatment and progress of residents.

Are services well-led?

- There was no permanent manager for the service. The registered manager was not in day to day control or management of the service.
- The service was in a period of transition. New systems were being introduced. There had been significant staff changes.

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Substance misuse services		As this was a focussed inspection no rating was given to the service. We found: • The management of medicines was not safe. The supply of medicines was not consistent. People using the service were not always given medicines as prescribed. Medicine records were not complete and were sometimes amended. Medicine errors were not always reported as incidents. • Staff did not understand safeguarding issues. They did not know how to make a safeguarding referral. • The assessment of people using the service did not identify all of their needs. There was no record that peoples' views or preferences had been sought. • Most people using the service did not have a care plan. • There were limited records concerning the care, treatment and progress of residents. • There was no permanent manager for the service. The registered manager was not in day to day control or management of the service. • The service was in a period of transition. New systems were being introduced. There had been significant staff changes.

Ravenswood Road

Detailed findings

Services we looked at
Substance misuse services

Detailed findings

Contents

Background to Ravenswood Road

Ravenswood Road provides accommodation and a therapeutic programme for adults recovering from their use of alcohol. They also provide a service to people with a dual diagnosis of a mental health problem and issues related to alcohol use. The service provides a service for up to ten people.

The service is registered to provide:

- Accommodation for persons who require treatment for substance misuse

Our inspection team

Team Leader: Steve George, Care Quality Commission

The team that inspected Ravenswood Road consisted of two inspectors.

How we carried out this inspection

We inspected this service to find out whether improvements had been made in the area of medicines management, since our last inspection in February 2014. As this was a focussed inspection no rating was given to the service.

To see whether improvements had been made in the area of medicines management, since the inspection in February 2014, we focussed on aspects of three key questions:

Is it safe?

Is it effective?

Is it well led?

Before the inspection visit we reviewed information we held about the service.

During the inspection visit the inspection team:

- Visited the service
- Spoke with the manager currently providing oversight of the service
- Spoke with three members of staff
- Looked at the medicine records of four people, and some medicine records of a person who had recently left the service
- Looked at the care records of five people using the service
- Looked at a range of policies, procedures and documents related to the running of the service

Are services safe?

Our findings

Assessing and managing risk to patients and staff

- The manager who was overseeing the service understood the circumstances when a safeguarding referral should be made. They understood the process for making a referral. With regard to medicine errors, they said a referral to the relevant safeguarding team would not normally be made. This would depend upon the frequency of the errors. The providers' policy detailed under or overuse, or withholding of medicines, as a potential safeguarding issue. Two members of staff did not understand the term 'safeguarding'. They did not know the safeguarding referral process. One member of staff listed circumstances they considered were safeguarding issues. Most of these circumstances were not safeguarding issues. They were unaware of the process for referring people to the local safeguarding team.
- The management of medicines at the service was unsafe. On some occasions there was a very limited, or no, supply of certain medicines for people using the service. When this occurred, these medicines were subsequently obtained, although there was a delay. When medicines were required this was meant to be recorded in the medication message book. This did not always happen. Some messages concerning peoples' medicine were recorded in the service message book. This meant that the system in place for ensuring people using the service had a stock of medicine was not effective. People using the service were not always administered their medicines as prescribed. On some occasions, they had their medicines less frequently than was prescribed. On other occasions, people had not received their prescribed medicine for some days. There was no record that the person had refused the medicine during this time. In one week, a person who had recently left the service was recorded as having received a medicine regularly. However, the name and preparation of the medicine was not recorded.
- The stock balance for medicines was not always recorded accurately. Some medicines with misuse potential were unaccounted for. Some medicine records were subsequently amended, but had no initials, signature or date. This meant it was not possible to identify who, or when, they were amended. One person using the service was administered medicines for their weekend leave from the service. The medicines were administered into non-pharmacy packaging. The medicine name, dose and frequency were written on the package by staff. This increased the risk of a medicine error.

Reporting incidents and learning when things go wrong

- Staff did not record medicine errors consistently using the providers' incident reporting system. On 11 occasions, when medicine errors had occurred or were discovered, no incident report had been completed. The providers' medication and detoxification policy was not followed.

Are services effective?

Our findings

Assessment of needs and planning of care

- Every person using the service had an assessment when they arrived at the service. The assessments were comprehensive, incorporating emotional, physical and social circumstances. At the end of the assessment document was a summary of the person's needs. The list of potential areas of need included accommodation, psychological/emotional needs and physical health. In two care records this summary was blank. Both people had needs in these areas. The summary of needs for one of them was listed as 'remain free from alcohol'. There was no record that peoples' views or preferences had been sought.
- Most people did not have care plans. One person had a weekly care plan, but this provided minimal detail. This meant peoples' needs, and action to address those needs, was not recorded. One person had tooth pain and required a dentist. Another person had emotional needs following the ending of a relationship. A third person required assistance with social skills and daily living skills. There was no plan of care for them to address their needs. A community health professional requested that staff monitor a person's sleep pattern. There was no care plan for this, and sleep monitoring stopped after two nights. People using the service had an 'intervention plan'. This was mainly a list of psychological approaches to substance misuse. The intervention plan consisted of ticking the boxes of which intervention applied to the person. This was not personalised and did not demonstrate the person had been involved with the plan. The intervention plans were recorded on the providers' electronic system. Only one member of staff had been trained to use this system. This meant they were not easily accessible to all staff.
- One person using the service had daily entries in their care records recording their needs and progress. This continued for the first two weeks they were admitted to the service and then ended. Other people had one or two notes of one to one sessions with staff in their care records. Very limited information concerning people using the service was intermittently recorded in the service message book. The shift handover document was used to record information about people. This consisted of one to three lines describing what each person had done during that shift. This meant there was not a complete record of the care, treatment and decisions taken regarding people's treatment. The views and preferences of people using the service were not consistently recorded.

Are services well-led?

Our findings

Good governance

- The service did not have a permanent manager actively managing the service. A manager had not been in place for over eight weeks. The registered manager was the manager of three services but did not manage Ravenswood Road on a daily basis. A different manager was providing oversight of the service. This manager was also opening a new service at a different location. This meant there was little management oversight of the service. A manager for the service had been recruited. The provider told us the new manager would apply for registration with CQC.
- There was limited documentation concerning people using the service. Most people did not have a care plan. Documentation concerning people's needs and progress was minimal. There was no evidence that people had been involved in planning their care or treatment. There was no evidence that documentation was checked by managers or senior staff.
- A medicines audit two months prior to the inspection had identified at least 17 medicine errors. The date, and who undertook the audit, was not recorded. An action plan had been produced. The action plan did not address all of the issues identified. The staff member responsible for ensuring actions were completed was not recorded. The date by which actions should be completed was not recorded.
- The service was in a period of transition. Following organisational changes new systems were being introduced. There had been significant staff changes in the previous months.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure that the supply and management of medicines is safe.
- The provider must ensure that staff have an understanding of circumstances requiring a safeguarding referral. Staff must know how to make such a referral.
- The provider must ensure that each assessment of a person using the service records all of their needs, their views and preferences. Each person must have a care plan reflecting all of their needs and their preferences.
- The provider must ensure that there are accurate, detailed, and complete records for each person using the service.

Action the hospital SHOULD take to improve

- The provider should ensure that there is appropriate management of the service during a period of transition.
- The provider should ensure that there are appropriate and effective systems to monitor and improve the quality of care. Actions arising from these should not be delayed.
- The provider should ensure that a registered manager is in day to day control of the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of people did not meet their needs. Assessments were not carried out collaboratively with people, to assess their needs and preferences for care and treatment. Care was not designed with a view to achieving peoples' preferences and ensuring their needs were met. Not all peoples' needs were recorded during assessment. Most people using the service did not have care plans. This was a breach of regulation 9(1)(b)(c)(3)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People using the service were not protected from abuse or improper treatment. Systems and processes in place to prevent abuse were not effective. This was a breach of regulation 13(1)(2)

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

There was no effective system to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

This was a breach of regulation 17(1)(2)(c)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment There were insufficient quantities of medicines to ensure the safety of people using the service and to meet their needs. The management of medicines was not safe. This was a breach of regulation 12(1)(2)(f)(g)