Extrafriend Limited

Ravenswood

Inspection report

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22 March 2018

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Ratings

Overall rating for this service	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

We carried out a comprehensive inspection of Ravenswood on 31 July and 1 August 2017. Following this inspection, we served a Warning Notice for a breach of regulation 17 of the Health and Social Care Act 2008. This was because the provider did not have fully effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service. This was because people who used the service were not protected from the proper and safe management of medicines and their rights were not consistently upheld in line with the Mental Capacity Act 2005.

We undertook a focused inspection on 22 March 2018 to check the provider was meeting the legal requirements in regards to one of the regulations they had breached, and check they had complied with the Warning Notice. This focused inspection looked at the breach of regulation 17. This report only covers our findings in relation to this area. You can read the report from our last comprehensive by selecting the, 'All reports' link for 'Ravenswood' on our website at www.cqc.org.uk

Ravenswood provides accommodation and personal care for up to 36 older people, some of whom are living with dementia. At the time of our inspection, the service was providing accommodation and personal care to 28 people.

There was a registered manager in post. 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.

At this inspection, we found the provider had taken action to comply with the warning notice.

At our previous inspection, the provider did not have fully effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service. At this inspection we found that their auditing processes had improved.

At our previous inspection, we found that the provider did not consistently provide safe care and treatment. At this inspection, we found improvements had been made this area of their work. Medicines were managed safely and where risks had been identified, care plans consistently detailed the steps staff should take in order to keep people safe.

At our previous inspection, people's rights were not consistently upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. At this inspection improvements had been made. We found consent to care was now sought in line with legislation.

At the previous inspection, people's care plans were not person centred or sufficiently detailed and electronic versions of the care plans were not as detailed as the written ones. At this inspection, care plans we saw were person centred and provided clear and detailed guidance for staff on how to meet people's needs. Electronic plans were also in place and now provided the same level of detail.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

Good

At this latest inspection we found action had been taken to improve how well led the service was. As we undertook this inspection to check whether the provider met legal requirements, this report only covers our findings in relation to these requirements.

The provider had fully effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service.

This means the rating of this key question has improved.

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.

Following our inspection on 31 July and 1 August 2017, we served a Warning Notice for a breach of Regulation 17 of the Health and Social Care Act 2008.

We undertook a focused inspection of Ravenswood on 22 March 2018. During this inspection we checked that the improvements required by the provider after our last inspection had been made. This was in relation to having effective systems and processes, which identified and assessed risks to the health, safety and welfare of people who use the service.

The inspection was unannounced and undertaken by one inspector. We inspected the service against one of the five questions we ask about services: is the service well led. This is because the breach found at the last inspection for which the Warning Notice was served was in relation to this question.

During our focused inspection we spoke with the registered manager and one staff member. We reviewed seven people's records in regards to the management of their medicines, their rights in line with the Mental Capacity Act (MCA) 2005 and whether they were sufficiently detailed and person centred.

Good

Is the service well-led?

Our findings

At the last inspection of this service on 31 July and 1 August 2016 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This was because the provider did not have fully effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service. This was because people who used the service were not protected from the proper and safe management of medicines and their rights were not consistently upheld in line with the Mental Capacity Act 2005.

At this latest inspection, we found some actions had been taken to improve shortfalls found during the last inspection. As we undertook this inspection to check the provider met legal requirements, this report only covers our findings in relation to these requirements. This means the rating of this key question has improved. The provider had developed their own action plan for the service following our last inspection. This covered areas which required improvement and identified the person responsible for ensuring actions were taken. The provider had worked through their plan and had addressed all actions.

To ensure continuous improvement the registered manager and nominated individual conducted a number of audits such as; health and safety; infection control; care plans; training; and medicines. This has resulted in improvements in the quality of service. The shortfalls identified at our previous inspection had been addressed.

The registered manager confirmed they had implemented mental capacity assessments and best interest decisions for people following the last inspection. We reviewed seven people's care plans and found all seven people had mental capacity assessments and best interest decisions in place. For example, best interest decisions had been made relating to medication, personal care, modifying diets and photos. Records confirmed how the service had communicated with the person and their representatives about the outcome of the decision making process. This meant the service had undertaken best interest decisions and records reflected that relatives had been involved in these best interest decisions.

We found that protocols were in place in all records we reviewed for people's medicines people took as needed. These protocols described when a person may require the medicine and how this may be demonstrated and communicated to staff. Records were kept when required medicines had been administered. This enabled the service to monitor and review the effectiveness of these medicines and for any emerging patterns or trends.

All the records we reviewed contained a description of how people preferred to take their medicine. For example one record said, '[Name of person] likes to know what tablets they are.'

The provider's policy in regards to medicines had been reviewed, updated and reflected what was happening within the service.