Health and Home (Essex) Limited

Ravensmere Rest Home

Inspection report

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20 April 2021

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Ravensmere Rest Home is a residential care home providing personal care to 14 at the time of the inspection. The service can support up to 24 people living with dementia and mental health conditions.

People's experience of using this service and what we found
We requested a range of information from the provider, but this was not received. Three incidents within the service which had resulted in harm had not been adequately managed or escalated in line with safeguarding and duty of candour processes. We shared this with the safeguarding team. The provider had failed to submit notifications of these incidents to CQC, which they are required to do.

People continued to be at risk of harm as the registered manager and provider had not assessed and mitigated risks to people. This included risks in the environment of the service as well as risks associated with people's health and care needs. A risk was identified in relation to fire safety records. We requested a visit by the Fire and Rescue Service.

There were enough staff available to meet people's needs. However, we were not assured all staff had been recruited safely.

Medicines were not consistently managed safely. We were not reassured people had received their medicines as prescribed.

The providers monitoring and assurance systems and processes had not identified the issues found during the inspection and lessons had not been learned from previous inspections.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update: The last rating for this service was requires improvement (published 06 December 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to staffing, safeguarding concerns, infection control and the management of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We found the provider needs to make improvements. Please see the safe and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ravensmere on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.
We identified three breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014: regulations 12 (safe care and treatment), 13(safeguarding service users from abuse and improper treatment), 17 (good governance). Action we told the provider to take (refer to end of full report).

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well led findings below.

Ravensmere Rest Home

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection on day one was carried out by two inspectors. One the second day two inspectors and an inspection manager visited the providers head office.

Service and service type
Ravensmere is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had two managers 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
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke with five members of staff, and spoke to the registered manager to request documentation.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at staff supervision and a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. Unfortunately, some of the information we requested could not be found by the provider. We sent a list of outstanding information we required and unfortunately this has not been received.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

At our last inspection in August 2019 the provider failed to follow safeguarding procedures. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At this inspection, not enough improvement had been made and the provider was still in breach of regulation 13.

• The provider did not have adequate systems in place to safeguard people from the risk of abuse.
• People were at risk because we found three concerns which had not been reported to the appropriate authority for investigation. We escalated the concerns to the safeguarding team.
• We could not be assured that all staff had undertaken safeguarding training as the provider failed to provide us with training records for all staff at Ravensmere Rest Home. Following the inspection the provider sent us evidence that staff had signed a letter acknowledging they had received safeguarding training.
• One member of staff whose first language was not English was unable to answer any of our questions in relation to recognising and reporting safeguarding concerns.
• The provider was using a contractor to provide cleaning services and during the inspection we noted that this contractor was working unsupervised. Following the inspection, we asked the provider to send us evidence to show the contractor had received an enhanced Disclosure and Barring Service check (DBS). A DBS helps to prevent unsuitable people from working with vulnerable groups, including children. This was not received. Following the inspection the provider clarified that we had been given an incorrect name during the inspection for the contract cleaner and sent us the DBS for the contract cleaner working on the day of inspection..

The provider failed to ensure that people were protected from abuse and improper treatment. This was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Assessing risk, safety monitoring and management

At our last inspection in August 2019 the provider had failed to robustly assess and manage the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. At this inspection, not enough improvement had been made and the provider was still in breach of regulation 12.

• At the last inspection there was a lack of oversight to identify and manage risks associated with the spread and control of Legionella infection, a potentially fatal type of pneumonia, contracted by inhaling airborne water droplets containing viable Legionella bacteria. There are specific requirements regarding its management, one being the flushing of unused water outlets.
• At this inspection there were no records to demonstrate the water outlets in ten vacant bedrooms were flushed through on a regular basis to reduce the risk.
• The water temperature in one person's room exceeded the recommended temperature of 43°C placing them at risk of scalding. No action had been taken to prevent this from occurring..
• One person had a chair propping open their door which was a fire door, the senior told us they did not like their door closed and had a risk assessment in place. The following day we brought this to the attention of the registered manager who told us they would remove it and provide a safer method for this person to keep their door open. We requested confirmation that this had been done but this had not been received.
• There were tripping hazards caused by vinyl flooring in a bedroom that was cracked and lifting and the main stairway carpet was damaged on at least three stair treads. Following the inspection the provider sent us evidence these works were now completed.
• In two shared bedrooms only one person had access to a call bell. The registered manager told us they were replacing the call bell system; however, a risk assessment had not been completed to determine what arrangements were in place for people without access to a call bell.
• Care records held conflicting information and staff, therefore, did not have current and relevant information to protect people. Equipment used to reduce risk and alert staff was not in place to protect people. For example, one person's records were not clear about their risk of falling at night and equipment identified in some areas of the care plan was not in place to mitigate their risk of falling.
• Personal Emergency Evacuation Plans [PEEPs] were stored in people's care folder but were not easily accessible in the event of a fire. Following the inspection the provider updated PEEPs for people using the service and confirmed these were now included within an emergency grab bag.
• Fire drill information showed not all staff had participated in a fire drill. The senior told us that night staff had not attended any fire drills. This meant they may not be familiar with the actions to take in the event of a fire.

Using medicines safely
• We were not assured that people always received their medicine consistently. We identified several gaps in people's medicine administration records on the last day of the previous cycle. A weekly medicine audit covering that time period had not picked up these gaps and identify whether they were recording errors or people had not received their prescribed medicine.
• The provider could not demonstrate staff were appropriately trained and competent to support people with their medicines safely. Following the inspection, the provider forwarded staffs competency assessments to the Care Quality Commission. However, the assessments provided no information relating to what had been specifically assessed or if they had been assessed by a person who was competent to carry them out.
• Medicines were stored safely in line with requirements in locked trolleys.

Preventing and controlling infection
• Concerns were raised at the last inspections about infection control and the poor condition of some areas of the environment. We found continued shortfalls at this inspection.
• We inspected the bedrooms and found that beds had been made, however on checking, many of the beds were made with stained or soiled linen. We showed the senior who agreed to change the bed linen. This had been identified at our previous inspection.
• The provider had made some improvements to the laundry facilities however, we found that heavily soiled mop heads had just been left on the floor of the laundry.

• We could not be assured that all staff had undertaken infection control training as the provider failed to provide us with all the training records for Ravensmere. Following the inspection the provider sent us evidence that two staff had completed infection control training.
• Staff were wearing the required levels of personal protective equipment (PPE) and told us they had a plentiful supply.
• We were assured that the provider was preventing visitors from catching and spreading infections and meeting shielding and social distancing rules.
• We were assured that the provider was using personal protective equipment (PPE) effectively and safely.
• We were assured that the provider was accessing testing for people using the service and staff.

The provider failed to ensure that people received care and treatment in a safe way and protect them from the risk of harm. This is a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection in August 2019 we found the provider's recruitment processes were not robust and placed people at risk of harm. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19. However, some improvements were still required.

• The registered manager could not locate one staff member's file. They could only produce a copy of the staff member Disclosure and Barring (DBS) check dated 16 September 2020. We requested this file be sent to us by the 21 April 2021 and this was not received until the 30 April 2021 and did not contain a start date for the staff member which meant we were unable to establish if the recruitment checks and documents were in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, when appointing staff. Following the inspection the provider sent us the staff members contract which provided a start date so we were able to assess that the documents were in line with schedule 3 of the health and social care act.

Learning lessons when things go wrong
• The provider was unable to provide any records of analysis from accidents or incidents or provide a rationale for their absence.
• The provider was unable to provide any records to identify if incidents or accidents had been shared with staff as learning opportunities.

Inadequate

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care: Working in partnership with others

At our last inspection in August 2019 there was a lack of governance and oversight. This resulted in a breach of Regulation 17 of the Health and Social care act 2008 (Regulated Activities) Regulation 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

• There were no robust systems in place to monitor the quality of the service. The providers governance and quality assurance arrangements were not reliable or effective to make the required improvements. The lack of effective oversight and governance of the service has resulted in a fourth consecutive breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• Most of the provider's audits we looked at had not been completed since July 2020 and were not effective enough to pick up the concerns and risks throughout the service. For example, the last recorded IPC audit from the provider was completed 21 July 2020. The audit primarily comprised of a check list and provided limited evidence of IPC areas reviewed and no reference to COVID 19 and compliance.
• Consideration to the impact of the pandemic and COVID-19, had not been considered and integrated into people's care plans.
• Safeguarding concerns were not being reported to the Local Authority and investigations completed to safeguard service users. During the visit to the providers office we asked the provider if they had referred the concerns to the safeguarding authority and they told us they did not have this information.
• We identified concerns with the provider in relation to their openness and transparency. The provider told us if information was not available at Ravensmere, this was held at the organisation's head office. However, the provider was not able to confirm on 19 and 20 April 2021 if all documents requested existed or where these were located. We requested information to be provided by 21 April 2021, but no further information was submitted until after the inspection.
• There was little evidence to demonstrate how staff were actively supported to question practice or raise issues. Staff received regular supervision, but these consisted of discussions relating to individual topics. There was no evidence to show that the staff member's welfare, training needs, monitoring of their

performance was actively discussed and recorded.
• Insufficient information was provided to demonstrate staff received effective training in safety systems, processes and practices.
• We asked the provider about their oversight in relation to incidents and they were unable to provide any records or provide a rationale for the absence of these records.
• The lack of detailed internal investigations following accidents or incidents and the lack of understanding around reportable incidents indicated the provider was not fully aware of their responsibilities under the duty of candour.
• There were two managers registered for the service, one who was also the provider. They told us that the other registered manager was no longer actively involved with Ravensmere. The provider told us that the senior on duty would deputise for them in their absence. The provider was also registered as the manager at three other services. This did not give us assurance that there was adequate managerial oversight at the service on a day to day basis.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;
• No information was provided to evidence how people using the service, relatives and staff were engaged and involved in developing the service.
• We observed positive interactions with people and staff however the length of the interactions was minimal and mainly focused on staff responding to people's care needs. One person told us, "I do not want to spend the rest of my life doing nothing. I am hoping when lockdown finishes, I can get out and about." Another person said, "I do get bored as there is nothing to do."

The provider failed to ensure that their systems and processes operated effectively to improve the quality and safety of the service they provided to people. All of the above evidence was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

• People we spoke with were positive about the staff working at the service. One person told us, "Staff are okay, they do their best and are all nice."
• Staff were complimentary about the registered manager and they told us they felt supported. One staff member told us, "Yes I am happy here. I can talk to the managers."