Health and Home (Essex) Limited

Ravensmere Rest Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**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 13 people 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
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The provider failed to engage appropriately with people, their representatives or their funding authorities when making decisions about change of accommodation. There was no record of the planning required to identify if any risks associated with these moves had been identified or mitigated to ensure people were safe.

There have been significant concerns about the quality and safety of the service, which had not been identified or addressed by the registered provider. Accidents and incidents were not effectively reported, recorded and responded to. This placed people at increased risk of harm.

People's needs were not robustly assessed on admission and people's care and support needs were not managed safely or regularly reviewed. Care plans and risk assessments did not always reflect people's needs, risks or provide up-to-date information to guide staff on how to safely support them. This placed people at significant risk of harm. Staff training information was not always kept up to date, we have made a recommendation about training.

We were not assured the provider always followed current guidance on the testing of people being admitted to the service for COVID-19. Some improvements were needed to the environment; we have made a recommendation about supportive environments for people living with dementia.

The service was not well-led. There were continued significant concerns about the quality and safety of the service. The provider had failed to take sufficient and timely action to address safety issues and to make improvements.

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 15 September 2021).

The provider completed an action plan after the last inspection; however, the action plan was not completed within the agreed timescales and did not include specific timescales in relation to when they

would improve.

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

Why we inspected
This inspection was prompted in part due to concerns received about people moving to Ravensmere Rest Home from the providers other care homes without establishing that appropriate consultation with people, their representatives or people's funding authorities was undertaken. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well led sections of this full report. 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 service is therefore rated inadequate. This service has been rated requires improvement or inadequate overall for the last five consecutive inspections.

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

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 have identified breaches in relation to management of risk, safeguarding processes, consent and governance arrangements at this inspection.

Please see the action we have told the provider to take at the end of this 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
The overall rating for this service is Inadequate and the service remains in 'special measures' as one of the key questions remains inadequate.

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 to check for significant improvements.

If the provider has not made enough improvement and there is 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well led. Details are in our well findings below.	**Inadequate**

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 was undertaken by three inspectors

Service and service type
Ravensmere Rest Home 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 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
This inspection was unannounced.

What we did before the 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 four people who used the service and eight relatives or their representatives about their experience of the care provided. We spoke with five members of care staff including the registered manager and the assistant to the director.

We reviewed a range of records. This included 13 people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. 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. We requested information by email as not all information was made available during our visits. Unfortunately, this information was not received so a further letter was sent to the provider. Some information was then received from the provider.

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 requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our previous inspection's in August 2019, April 2021 and August 2021 the provider failed to follow effective 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.

Systems and processes to safeguard people from the risk of abuse: Learning lessons when things go wrong
• People were still at risk of harm due to ineffective safeguarding procedures.
• At the two previous inspections we identified that some accidents and incidents had not been referred to safeguarding authorities appropriately. At this inspection we found a further incident that had not being referred. The incident we identified was an unwitnessed accident where the person had sustained an injury that needed treatment by a health professional. This was subsequently referred by CQC and the provider to the local authority safeguarding team after bringing it to their attention.
• Concerns had also been raised to CQC by the local authority that the provider was delaying them access to investigate safeguarding concerns.
• A safeguarding concern was raised by one person's funding authority as they had not been informed the person had been moved to another of the providers homes.
• Despite three previous breaches of this regulation for not reporting accidents or incidents that met the criteria for referral to the local safeguarding team, the provider continued to fail to assess all incidents and accidents robustly. This did not reassure us that the provider was learning lessons when things went wrong.

The provider failed to ensure that people were protected from abuse. 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; Preventing and controlling infection
• Risks to people's safety were not reviewed or updated effectively.
• Risk assessments for two people's mobility did not reflect the current equipment or method needed to move them safely. For example, it was recorded that one person was able to walk a few steps, but this person was no longer able to do this, and a full hoist was being used to help them transfer safely. One person had a recent review, however the information from this review had not been used to update their care plan.
• We were only able to speak in detail with two staff at Ravensmere. Both these staff members were aware of current risks for these two people.
• One person's risk assessment for falls recorded that they were at no or low risk of falls. This person was found to have had two unwitnessed falls and another accident resulting in an injury. This information had

not been used to review or update the person's risk assessment.
• The providers fire risk assessment had not been reviewed since 2019 and personal emergency evacuation plans (PEEPS) did not always reflect peoples' current mobility needs. The provider told us following the inspection, "Staff know people inside and out." However, in the event of a fire emergency if people's information was not current, this could place people, staff and fire personnel at risk of harm and compromise their safety. Following the inspection the provider sent updated PEEPS documents and an updated fire risk assessment.
• The provider had recently moved six people from other homes within their organisation to Ravensmere Rest Home.
• We were not provided with any information to evidence people had been moved safely from one home to another and adequate risk assessments had not been completed. For example there was a lack of information regarding people's fitness to travel, appropriate transport and who had been consulted as part of the process.
• We were not provided with evidence to reflect COVID-19 testing had been completed in accordance with the latest government guidance for people admitted from other care homes.
• There were no designated 'donning and doffing' area or facility in the laundry room which is considered best practice. A staff member told us they would go to the nearest bathroom to dispose of personal protective equipment (PPE). This meant this increased the risk of cross infection if staff were moving from one area to another with soiled PPE. The two staff we spoke with did not recognise the term donning and doffing, and one of these staff members could not confirm they had received training in this area.
• Storage baskets were also stored on the floor of the laundry room and personal protective equipment (PPE) was found disposed of in the normal waste bin.
• Systems in place to prevent visitors from catching and spreading infections were not always followed. Inspectors were not asked to provide evidence we had completed a COVID-19 test prior to entering the service. However, relatives we spoke with told us they were asked to complete a COVID-19 test.
• The provider had stopped people's relatives from visiting even though no people using the service had tested positive for COVID-19.
• The provider sent us training information for five staff at Ravensmere Rest Home and only one of the five had up to date infection control training. On 14 December 2021 the provider sent us a training plan that recorded staff had all completed infection control training in November 2021.

We found no evidence people had been harmed, however systems were either not in place or robust enough to demonstrate risks to people were managed safely. This placed people at risk of harm. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• At the last two inspections there was a lack of oversight to identify and manage risks associated with the spread and control of infection, such as legionella which placed people at risk of harm. Legionnaires' disease is a potentially fatal type of pneumonia, contracted by inhaling airborne water droplets containing viable Legionella bacteria. The service was now recording that vacant water outlets were flushed through on a regular basis.

Staffing and recruitment
• We were provided with recruitment files for newly recruited staff. These staff had been recruited from overseas by the provider. The staff files looked at did not contain a current disclosure and barring check (DBS) or up to date references. Disclosure and Barring checks assist employers in making safer recruitment decisions.
• The provider told us these staff members had not started or were still under supervision from existing staff.
• Our observations during the day, indicated there was enough staff on duty to meet people's identified

needs.
• The two staff we spoke with told us there were enough staff available. One staff member told us, "If we need help, we can call someone else, I think [staffing] it is okay."

Using medicines safely
• Medicines were managed safely. Records indicated people had received their medicine as required.
• A senior staff member completed regular audits of the medicines to check they were being safely administered.
• On the first day of inspection the temperature in the medicine room exceeded the recommended temperature for storing medicines safely. The senior took steps to reduce the temperature and told us they would monitor this. On the second visit to Ravensmere Rest Home we found the temperature was within recommended temperature guidance.

Inadequate

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.

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 people's care, support and outcomes.

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 when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
• Although people's capacity to make decisions was recorded, people were not supported to have maximum choice and control of their lives. No information was recorded to demonstrate people using the service or those acting on their behalf, had been consulted or consented to the transfer from another of the provider's service's to Ravensmere Rest Home.
• The provider was asked for information to confirm people or their representatives had been involved. The provider wrote to us confirming they had involved people, their relatives or representatives.
• Of the six people who moved from other services belonging to the provider, one person, a relative and two representatives told us they had not been consulted or given a choice in relation to these moves. One person told us, "I did not have a choice, I was just moved here. I will be here 'forever', as I do not have the money to move."
• A relative told us, "We were given notice they were moving the next day. So were the staff at Barling Lodge, we were just told that residents were moving to Ravensmere. I was not asked to give consent, just told. I was told it was to revamp Barling Lodge and was not told if the move was permanent or temporary."
• Two other people's representatives told us they were not informed that people were moving and only found out when they contacted the previous home to make an appointment to visit.
• One of the representatives told us they had confirmed their appointment to visit with the provider the previous day and still had not been informed the person they were visiting had moved. They turned up for their pre-arranged appointment at the previous home to find it empty.
• One relative did confirm they were consulted, however, they were not informed if the move was temporary

or permanent.
• Where people had been moved from other care homes and had a DoLS authorisation or application in place, these had not been updated to reflect whether new applications had been sent in relation to the change of accommodation. The provider sent us an overview following the inspection confirming all applications had been applied for. However, this overview did not include the dates of applications applied for.
• Following the inspection, the provider sent us consent forms signed by either people or their relatives in relation to the moves. These were all dated after the inspection.
• The consent forms signed by some people did not always reflect the information in their care plan. For example, the care plan of one person recorded that they required support with more significant decisions such as moving home. This person had signed to say they had consented to the move, we found no evidence that the person was supported with this decision.
• Another person had signed to say they consented to the move. However, a previous mental capacity assessment had been completed in 2019 to record they did not have capacity to consent to a change in accommodation. We could not find any information to establish if this person's capacity to consent to the recent move had been carried out.
• Five people who were moved from other homes had either an authorised deprivation of their liberty or an application to authorise the deprivation of their liberty sent by the provider. This demonstrated that the provider was aware that at least five people may have required an assessment or best interest meeting to establish if they had capacity to consent to a change in accommodation.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• There was no information in the care plans of the six people moved from the other services to evidence if their care and support reflected current evidence-based guidance, standards and best practice in their new environment. All the care plans for the six people were from their previous home.
• No assessments had been carried out prior to admission to the new care home.

Care was not always delivered with peoples consent and in their best interests. This is a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• Minimal information was available during the inspection to assure us staff had the skills and knowledge required to meet people's needs. The provider told us, "I have started a new system." This new system consisted of a tick sheet and did not provide the information required to demonstrate the provider had a system in place to ensure staff were appropriately trained.
• We requested this information on two occasions following the inspection. The provider sent us information for five staff working at Ravensmere Rest Home. This did not assure us their mandatory training was up to date. One member of staff on duty on the day of inspection was not included in the information sent to us.
• One person who had moved from another home had a mental health condition. The training information sent to us for staff at Ravensmere Rest Home recorded only two staff had completed training for mental health, one staff member had completed this in 2018 and the other staff member in 2016. Following the inspection an updated training plan was sent to us by the provider to confirm staff had updated their training.

We recommend that the provider seeks national guidance to assure staff are adequately trained, this is up to date and in line with practice.

Supporting people to eat and drink enough to maintain a balanced diet
• The menu board recorded the choices available for breakfast but there was no recording for lunch or

dinner.
• The Chef told us that lunch was chicken, boiled potatoes, vegetables and gravy. We asked if there was another choice but was told that everyone likes chicken. The Chef said, "If they want something else, they can ask."
• Lunch was plated and served to people and did not give us the assurance that people always received a choice.

Adapting service, design, decoration to meet people's needs
• There was some signage for bathrooms and toilets, however, more work was needed to create a more enabling environment for people living with dementia. There was a lack of visual clues or items of interest around the service that could support wayfinding such as pictures, or objects of interest.
• Some people's bedrooms were quite bare and contained minimal personal items.

We recommend the provider reviews best practice guidance on creating a supportive environment for people living with dementia.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Care plans showed people had access to healthcare professionals including their GP, community nurses and outpatient specialists.
• Relatives told us they were confident the service would contact the GP if required. One relative told us, "They are very good with [family members] health and 100% call a GP when needed."
• The provider had not always worked with other agencies in an effective and timely way which we have detailed in the well led findings below.

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 Inadequate. At this inspection this key question has remained the same. 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.

At our last inspection 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people: 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; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Continuous learning and improving care: Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• The provider remains in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. This is the sixth consecutive inspection where the provider has remained in breach of this regulation.

• Since December 2018, we have rated this service as 'inadequate' or 'requires improvement.' The service has a history of breaching regulations and failing to sustain improvement. This showed a systematic failure in the provider's organisation and leadership of the service.
• The provider was not open or willing to support the inspection in a constructive way. They were often uncooperative and demonstrated a failure to respond to previous recommendations.
• At the previous inspection the provider did not produce the action plan in the timescales stated. We had to request for this to be sent. The action plan was not specific, measurable, attainable, relevant, or time-based. We requested an improvement and a new action plan was sent with minimal change.
• People were at risk of harm, because the service was not well-led.
• The provider who was also the registered manager had failed to demonstrate they had the knowledge, skills and competence to fulfil their role. For example, in relation to the mental capacity act, safeguarding processes, staff training, care planning and risk assessment.
• The provider was unable to demonstrate effective quality assurance processes were established and in place to ensure compliance with regulatory requirements. During the inspection we requested information, which was not available, this information was subsequently requested by email and then again by letter.
• We were provided with minimal evidence to demonstrate the provider's auditing arrangements were effective. Where audits were in place these provided limited information or were not available. For example, the service's infection prevention control (IPC) audits were not completed robustly. The audit primarily

comprised of a check list and provided limited evidence that IPC areas were reviewed and contained no reference to COVID-19 and compliance.
• In the previous three inspections the providers safeguarding arrangements were not effective and safeguarding concerns were not reported to the relevant authorities. At this inspection another concern had been identified that needed a referral. This meant the providers oversight of accidents and incidents remained poor.
• There was a failing to ensure risks associated with people's care needs were identified, reviewed and updated in a timely manner. When care plans and PEEPS needed updating or additional information was required this was not completed in a timely manner.
• The provider demonstrated a poor understanding of the Mental Capacity Act 2005 and its application.
• Openness and transparency were lacking. Systems for identifying, capturing and managing organisational risks and issues were ineffective. There was no management plan or risk plan to support people to move accommodation safely. Whilst people were not harmed, we were not assured this would not happen again in the future.
• There was poor collaboration and cooperation with external stakeholders and other services. The provider failed to engage with external organisations and professionals, such as the Local Authority and Care Quality Commission. The provider had refused access to professionals either when reviewing people's care or investigating safeguarding concerns. When appointments were made these were often cancelled.
• Lack of managerial oversight of training records meant these were not up to date. The provider told us due to different staff in the past that were responsible for keeping these up to date they had found it difficult to collate all the information and required longer to do this. They had set a deadline for staff to update all mandatory training.
• There was little evidence to demonstrate how staff were actively supported to question practice or raise issues. During this inspection only two staff had consented to be interviewed by CQC. The provider had asked staff to complete a consent form and most staff had declined to speak with us. This meant we were unable to establish if staff competencies, skills and knowledge were appropriate to meet people's needs.

We found no evidence that people had been harmed however the registered manager and provider had consistently failed to have effective oversight of the quality of care, risk and governance. This placed people at risk of harm. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The two staff we spoke with told us they felt supported. One staff member said, "Staff are happy, there is a good team, yes it's alright."
• Relatives spoken with told us they were happy with the care provided. One relative told us, "The staff from Barling Lodge also went with [person] and they know them really well. Ravensmere Rest Home seems okay, I think they treat her well. Other residents from Barling also went there so they know them as well."
• An advocate we spoke with was very positive about the service. They told us, "The turnover is low, the staff are open and helpful, and the management skill set seems fit for purpose."