Health and Home (Essex) Limited

Ravensmere Rest Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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 nine 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
We found two incidents which resulted in harm had not been escalated to safeguarding for investigation. The provider had failed to submit notification to the CQC in relation to these incidents in line with regulation and duty of candour.

The provider was introducing new audit tools to be used at the service covering the environment and people's care. We found these tools had not identified the issues we highlighted on inspection.

Improvements had been made to the management of medicines and people received their medicines safely. Care plans were in the process of being reviewed to reflect peoples care needs.

The provider had addressed issues within the environment to make these safe for people living there.

We observed there were enough staff on duty to meet people's needs.

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 inadequate (published 11 June 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do. At this inspection some improvements had been made but the provider was still in breach of regulations. This service has now been rated requires improvement or below for the last five inspections.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

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 improved to requires improvement. 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 Rest Home 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 two continued breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014: regulations 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 requires improvement 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?

Requires Improvement

The service was not always 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 was carried out by two 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 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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we

inspected the service and made the judgements in this report.

During the inspection
We spoke with two people who used the service about their experience of the care provided. We spoke with two members of staff, the registered manager, deputy and deputy director.

We reviewed a range of records. This included five people's care records and multiple medication records. We reviewed information held on fire safety, audits that were made available and minutes of staff meetings.

Requires Improvement

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 now improved to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection in August 2019 and April 2021 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.

Systems and processes to safeguard people from the risk of abuse

- The provider did not have adequate systems in place to safeguard people from the risk of abuse. The provider was not always fully engaged with local safeguarding systems.
- Safeguarding policies and procedures were not fully embedded, and staff did not always respond quickly enough to concerns.
- People continued to be at risk. We found two further concerns which had not been escalated to the appropriate authorities for investigation and there was no investigation completed by the service. This meant we could not be assured that people were being supported safely.
- We highlighted these concerns to the provider and assistant director. The assistant director said they would raise these safeguarding concerns retrospectively for investigation. However, they did not raise these in a timely manner which led to the CQC raising the safeguards with the local authority.

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.

At our last inspection in August 2019 and April 2021 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, enough improvement had been made and there was no longer a breach of regulation 12.

Assessing risk, safety monitoring and management

- We found improvements had been made to the environment.
- Water temperature was consistently being tested and shown to be at the recommended temperature or below to prevent scalding.
- Flooring had been replaced and stair carpet fixed to prevent tripping hazards.
- We found fire doors were no longer propped open preventing them from closing in an event of a fire.

● A new call system had been fitted so that all people using the service had access to call staff should they need assistance. On testing the system staff responded quickly to the location of the call bell.
● Personal emergency evacuation plans (PEEPS) were now more accessible in a folder. PEEPS are used to explain the support people may need in an event such as a fire or evacuation from the service. We found one PEEP contained the wrong room number for the person and another the room number was unclear. This placed people at risk of not being located during an evacuation. We highlighted this to the assistant director who corrected the PEEP.
● Care records were in the process of being updated by the assistant director. However, we found that care records did not reflect current risk. For example, one person who had developed a wound on their foot, their risk assessments had not been updated. Another person who had a fall had not had their falls assessment updated to reflect the risk.
● Fire drills were now being recorded and we saw this included practice with night staff.
● Management for the risk of Legionella infection could not be evidenced. Staff told us they did flush empty rooms and water systems weekly, but this was not recorded. Legionella infection is 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.

We recommend the provider consider current guidance on the management of Legionella infection and the flushing through of unused water outlets.

Using medicines safely
● People received their medicines safely.
● Medicine records were in good order. There were suitable systems in place for the storage, ordering, administering and monitoring of medicines.
● We reviewed a selection of medication administration charts, which contained all the information staff need to support people safely with their medication.

Staffing and recruitment
● We observed there was enough staff present to meet people's needs.
● The deputy director told us they occasionally used agency staff to support with one to one activity for people. However, we did not observe people being supported with social or well-being activities.
● The provider told us they were in the process of recruiting staff from overseas and were awaiting clearance from the home office.
● We did not review recruitment paperwork at this inspection.

Preventing and controlling infection
● Following our last inspection, the provider had made some improvements to infection control.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong

● We did not see evidence of how learning from accidents, incidents and safeguardings were shared with staff. Not all safeguardings had been reported and investigated so that lessons could be learned to keep people safe.

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.

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

- The provider remains in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. This is the fifth consecutive inspection where the provider has remained in breach of this regulation.
- The provider informed us that since the last inspection they were making changes to the management team and had appointed an assistant director to support improvements across their services. The assistant director had been in post for a few weeks and was working with the deputy manager at the service they said to make simultaneous improvements.
- Whilst the provider had made some improvement since the last inspection, we remained concerned about the management and governance systems in place that had failed to effectively assess and improve the service.
- The provider had developed an audit tool, to cover audits on the environment, housekeeping, fire equipment and infection control. This audit failed to adequately record outcomes for actions completed.
- The assistant director had begun auditing and reviewing care plans however the audit tool failed to review people's mental capacity documentation, and since our last inspection only two care plan's been audited.
- We found audits had not identified issues we raised, one persons PEEP had the wrong room number recorded. Care plan audits had not identified capacity assessments in the form of best interest decisions were missing. We also found care plans had not been updated to reflect a wound a person was receiving treatment for and a risk assessment for a person who had recently fallen had not been updated.
- Two safeguarding concerns had not been reported to the local authority to investigate to ensure people were being supported safely and this had not been identified by the quality assurance systems the provider had in place.
- Internal investigations on accidents and incidents had not been completed to share learning with staff.

● Notifications in relation to accidents had not been raised to the CQC in line with regulations.
● We could not be assured that the governance processes in place were robust enough to identify issues and address them due to the concerns we found. We raised these concerns with the provider and assistant director.
● The provider told us they were reviewing staff training and starting new records to record when staff had undertaken training however the provider still did not have in place an accurate system in place at the time of inspection.

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. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The assistant director had started to review the care plans of people living at the service. They told us they intended to make care plans more person centred.
● We did not find any evidence that care plans had been discussed with people or their relatives. The assistant director told us they would record this when they had spoken to them and discussed care.
● The provider had developed a new supervision tool and told us staff supervision records would be completed using this.
● We observed evidence that the deputy had held two staff meetings one to discuss developing positive relationships with people and one to discuss safeguarding.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

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 Prompt referrals had not been made to the local authority safeguarding team. Safeguardings had not been investigated and lessons had not been learned to keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audits were insufficient to identify required improvements. Notifications had not been sent to the CQC in relation to safeguarding people.