Mitchell's Care Homes Limited

Rainscombe House

Inspection report

Rainscombe Farm
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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Rainscombe House provides care and accommodation for up to 3 people with a learning disability and autistic people. People had a range of communication, care needs and abilities. At the time of our inspection there were 3 people living at the service.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

We were unable to communicate with people directly due to their needs, instead we spent time observing interactions between staff and people to gain an understanding of the care people received.

Right Support:
We found not enough improvements had been made, staff continued to fail to focus on people's strengths and promote what they could do. People were still not being supported with opportunities and experiences so they had a fulfilling and meaningful life. The provider had failed to improve enough to ensure that they met the principles of Right support, right care, right culture. People had limited access to individualised, person-centred activities which were important to them.

People were not always supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff understood people's needs, but further work was needed to ensure people were always supported in a dignified and respectful way.

Staff enabled people to access health and social care support and they ensured people received the medicines they had been prescribed.

Right Care:
Staff were not always following professional guidance in relation to people, leaving people at risk of harm. People did not always receive kind and compassionate care as staff did not always protect or respect people's privacy and dignity.

People's care records were not always comprehensive or written in a way that was person-centred. Although some people used a form of sign language to communicate we did not observe staff using this to converse

with them. There was a lack of evidence of people being involved in their care planning or decision making.

Improvements had been made to people's living environment; however further work was needed to ensure people lived in a homely setting.

Although there were sufficient staff to look after people, we found occasions when the staff on duty did not have the appropriate skills for people's needs. Staff were not sufficiently trained or supervised to ensure they were suitably qualified to provide a good quality of care.

Right Culture:
The provider had failed to take action to robustly address the concerns found at our last inspection. The care people received was not person-centred.

Safe recruitment processes were in place and the home was clean, however, not enough improvement had been made The provider did not have suitable processes and systems in place to ensure people, relatives and staff were involved in the running of the service.

Positive comments were received about the service from relatives and staff worked with external agencies to help improve people's care.

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

Rating at last inspection and update
The last rating for this service was inadequate (report published 2 June 2023).

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found some improvements had been made but the provider remained in breach of some regulations.

At our last inspection we recommended that the registered provider reviewed their staffing rotas to include a fully trained and competency-assessed staff member on shift able to administer medicines safely. We found the registered provider had not fully acted on this recommendation.

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

We have found evidence the provider needs to make improvements. Please see the safe, effective, caring, responsive 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.

The overall rating for the service has remained Inadequate based on the findings of this inspection.

Enforcement and Recommendations
We have identified breaches in relation to unsafe care, staffing, medicines, and the lack of trained and appropriately supervised staff. We also identified breaches in relation to staff not respecting people's dignity, a lack of meaningful activities and person-centred care, as well as a lack of robust management oversight.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least Good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information, we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service remains 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.

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

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 always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Rainscombe House

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 Health and Social Care Act 2008.

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 3 inspectors.

Service and service type
Rainscombe House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Rainscombe house is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. There was a manager in post who intended to submit an application to register.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 29 November 2023 and ended on 15 December 2023. We visited the location's service as well as the office for the service on 29 November 2023 and 4 December 2023. The office is based at Rainscombe Bungalow which is next door to the house and also one of the provider's care homes.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information the provider had sent us following our last inspection. This helped us to judge whether the improvements they had promised to make had happened.

We also reviewed the information we had received about the service since our last inspection. For example, notifications of incidents, accidents or safeguarding concerns.

We used all this information to plan our inspection.

During the inspection
We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the care documentation for 3 people and looked at medicines information for people living at the service. We observed care interactions between staff and people. We spoke with 6 staff, which included the provider (who was also the nominated individual), area manager, the new manager, deputy manager and 2 care staff. We look at other documentation related to the running of the service, such as recruitment information, training and supervision for staff, audits and health and safety information.

The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Following our inspection we spoke with or received feedback from 2 care professionals, 1 person's legal representative and 2 relatives.

We also requested additional documentation from the provider to assist us with analysing the quality of the service. This included evidence of actions taken since our last inspection, auditing carried out by external providers, training information and evidence of activities with people.

Inadequate

Is the service safe?

Our findings

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

At our last focused inspection we rated this key question Inadequate. At this inspection the rating has remained Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff were not following relevant guidance related to people's risks. We found similar concerns at this inspection.

- People were at risk of potential harm as staff did not follow people's care plans. One person had had a speech and language therapy assessment in 2019. The advice of the practitioner was that this person's food should be of a wet consistency, not dry. The person's care records and our observation showed staff failed to follow this guidance as staff regularly gave this person pizza, biscuits and crisps. This meant the person was at risk of choking.
- A second person had a particular system when eating and drinking. But we did not see staff not use the 2-cup system when they gave them a drink after lunch on one occasion. This left the person at risk of choking as they had a tendency to drink too quickly.
- People may be at risk of not receiving appropriate treatment if they became unwell. One person who lived at Rainscombe House had epilepsy. Although the person did not have regular seizures on 2 occasions between September and November 2023 the night staff member had not undertaken epilepsy training and on 5 occasions the night staff member was not trained in how to use emergency epilepsy medicines.
- Risk assessments for people were not always individualised, which meant staff may not be provided with appropriate information relating to each specific person. All 3 people had been on holiday for the weekend. We read the risk assessments staff had prepared in advance of their holiday and found they were identical. None of the risk assessments recorded distinct information relating to each person as an individual, such as 1 person who had poor mobility and was at risk of falls. One person required a 2-plate, 2-cup system when eating and drinking. However, their risk assessment for eating/choking did not mention this.

The lack of consideration towards people's safety and a failure to identify, record or follow guidance in relation to risks to people was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Other risk assessments were detailed and staff understood what they needed to do in order to help keep people safe. One person's mobility had deteriorated and staff had recorded when they walked, staff needed to support them by linking their arms. We observed staff doing this each time the person got up from their chair.
- A second person had a tendency to refuse personal care and would sit on the floor of the bathroom. Guidance advised staff to leave the person and return a short while later to check they were safe and

whether they had changed their mind. We read in the daily notes of occasions when this happened and staff responded appropriately.
● Although staff did not always know people's diagnoses in detail, they knew people's needs and risks well. For example, a staff member said, "We hold his hand like this (when walking) to support him as he needs support now. He needs help to shower and mobility in general."
● Staff managed the safety of the living environment and equipment in it through checks and action to minimise risk. In addition each person had a personal evacuation plan which recorded what assistance they needed in the event of a fire.
● Additionally, the fire service had recently carried out a fire safety check of the premises and had reported no concerns.

Staffing and recruitment

At our last focused inspection we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to ensure there were sufficient staff on duty each day. At this inspection, we found improvement to staffing levels, but had concerns about staff skills and experience.

● People were not always being cared for by staff who had the skills that matched the needs of people as some staff had not undertaken appropriate training.
● We reviewed the staff rotas for 91 days covering a period from September to November 2023 and found during this period there were occasions when the staff on duty were not suitably trained. On 4 occasions, the 2 day staff had not undertaken epilepsy training, despite 1 person having epilepsy. On 4 occasions 1 of these staff members was working with another staff member who had not been trained in how to give emergency epilepsy medicines. During 1 night shift, the staff member on duty had not undertaken their first aid training.
● People did not always receive care that supported their needs as some people were not always receiving the one-to-one care they should do. It was recorded in 1 person's care plan they should have 6 hours of one-to-one care from staff each day. From observations during our 2 inspection visits, as well as a review of 3-months' worth of daily care notes, there was nothing to demonstrate this person was receiving this level of input from staff.

The lack of suitably skilled staff on duty or staff providing the level of one-to-one care people should expect was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015.

● Since our last inspection, staff had stopped working back-to-back shifts which meant they no longer worked very long hours. This meant a reduction in the risk of staff being over-tired and as such making mistakes or not providing the best care.
● We were told that 2 staff should be on duty during the day and 1 waking staff on duty each night. We reviewed the staff rotas for 91 days covering a period from September to November 2023 and found these levels had been reached.
●At our last inspection, we found recruitment processes were not robust. We checked the paperwork for the 1 staff member who had been recruited since our last visit at this inspection and had no such concerns. We found evidence of a full employment history, performance at their last job and appropriate references had been sought.

Using medicines safely

At our last inspection we gave a recommendation to the provider to include a trained and competency assessed staff on shift who could administer medicines. At this inspection, we found the provider had not acted on this recommendation.

● People may not always be cared for by staff who had undertaken medicines training or had their competency assessed to ensure they understood and applied training and best practice.
● We reviewed the staff rotas for 91 days covering a period from September to November 2023. We found during 2 day shifts, neither staff were medicines trained. For 1 day shift 1 staff member had not been medicines trained and the other staff member's medicine training had expired. On 6 occasions, the staff member allocated to do the medicines had not been competency checked, despite undertaking their medicines training in April this year.
● Although these staff were not administering medicines and a manager told us, "We always have a floating staff around (at Rainscombe Bungalow) and they would go over and do the medicines" as we had been told that people regularly went out during the day, there was the risk that no staff were available to come over from Rainscombe Bungalow to give medicines. It also raised the risk of medicines errors happening.

The lack of ensuring there was always a suitably qualified and competency assessment staff member to give medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015.

● There were some good practices in relation to medicines administration. Such as people's medicine administration records being completed properly without any gaps. This indicated people received the medicines they required.
● Staff had worked with professionals to reduce people's medicines and this had been successful.
● People's medicines were stored appropriately and regular audits were carried out to help ensure that no medicine errors had taken place.

Systems and processes to safeguard people from the risk of abuse

At our last inspection we found a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had failed to report or recognise potential abuse. At this inspection, we read that where staff were concerned that abuse had occurred, they had notified the relevant authorities. The provider was no longer in breach of this regulation.

● People were safe from the potential risk of intentional harm as staff were able to identify situations which may constitute abuse and knew how to report them appropriately.
● One person had unexplained bruising on their arm and staff had referred this incident to the local authority safeguarding team as an allegation of abuse. They had also notified the person's relative. A relative told us, "You can tell by her behaviour if she is not settled. She seems content and happy."
● Staff had undertaken safeguarding training and told us, "It's about the wellbeing of the client and protecting him from any form of risk or accident or abuse" and, "Any worries you have to report it to your manager. Any emergency, I would call 999."

Preventing and controlling infection
● At our last inspection we had some concerns about the lack of good infection control practices by staff. We had also found that the hot water tap in the kitchen was broken. At this visit we did not identify any concerns in relation to infection control.
● People lived in a house that was clean and well-maintained. Staff were seen to do cleaning and hoovering

through our visit and work surfaces and people's bathrooms were kept dirt-free.

Learning lessons when things go wrong

● Where people had accidents or incidents these were recorded in people's daily care notes and the information transferred onto an accident form which was reviewed by the manager.

● Very few incidents occurred at the service. Where they had, they had been recorded correctly and staff had taken action in response to them in line with people's care plans.

● Accidents and incidents were audited regularly by the manager.

Requires Improvement

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 our last fully comprehensive inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- People were cared for by some staff who had not received relevant training in evidence-based practice. We reviewed the training matrix which included the training records for 11 staff who worked at the service.
- We found that 2 staff who were medicines training had yet to be competency assessed by the manager. This was despite them completing their training in April and July 2023. This meant the manager could not be assured these staff were following best practice.
- Further staff had not undertaken relevant training, or their training had expired. This included, 4 staff having not undertaken Deprivation of Liberty training, 5 falls prevention, 4 fire extinguisher use, 3 fire safety awareness (1 of whom regularly covered night shifts) and 7, first aid training.
- Staff may not always understand best practice in relation to people with a learning disability and/or autistic people. Two staff members had not undertaken epilepsy or autism training. Since July 2022, all health and social care providers have been required to provide training for their staff in learning disability and autism, including how to interact appropriately with autistic people and people who have a learning disability, at a level appropriate to their role.
- Staff did not always receive support in the form of robust supervision or reflective practice with managers. We read that staff regularly received supervision, however when we reviewed the notes from these supervisions and found they were very generic. The manager had written the supervision and staff signed to say they agreed with it.
- Where mistakes had occurred, reflective practice took place. But again, staff had just signed to say they would follow recommended practice. There was little evidence to show that staff had reflected on their actions so as to engage in a process of continuous learning.

The lack of appropriate support, training or professional development for staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Other staff had undertaken a wide range of training and also training specific to the needs of people they cared for. Some staff had undertaken the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
- A staff member who had recently started at the service told us they had had a 3-day induction. They said, "The first day was theoretical and the second and third days, practice. They taught me everything – how to be with the clients, how to communicate with them and how to do personal care."

Adapting service, design, decoration to meet people's needs

● People's care and support was provided in a safe, clean and well-maintained environment. Since our last inspection, the environment in which people lived had improved. People's rooms had received more personalisation and there were now blinds and curtains up at windows which was not the case in April 2023.

● However, the environment could improve to make it more homely. We saw 1 person turn off the overhead lights in the evening when they were relaxing. We spoke with the manager about introducing some side lamps or softer lighting to make the lounge area more homely for this time of day.

● The service had been adapted to suit 1 person's changing needs in that a downstairs shower room had been built. This meant they no longer needed to climb the stairs to have a shower which would have been unsafe for them.

● In addition to the shower room, an additional room was being constructed alongside the lounge area. This would give people an additional area to sit in and staff told us it would become a type of sensory space.

Supporting people to eat and drink enough to maintain a balanced diet

● People received support to eat and drink enough to maintain a balanced diet. Since our last inspection, staff had introduced weekly menu-planning with people. Each Sunday people sat with staff and selected, using a range of pictures, what they would like included in the menu that week.

● Despite the menu planning however, people could decide on the day what they wished to eat and from people's daily care notes it was clear people received a range of food.

● People were able to eat and drink in line with their cultural preferences and beliefs. One person would only eat certain meat for cultural reasons and we read this was provided to them.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● There was evidence of people receiving input from healthcare professionals, such as the GP, psychiatrist or speech and language therapy team. One person was seen to have swelling in their cheek and staff took them to the accident and emergency department. It transpired they had an infection from recent dental work and antibiotics were prescribed.

● People were referred to health care professionals to support their wellbeing. One person's mobility had deteriorated and an occupational therapist had advised staff on equipment and ways of providing care to the person to reduce any risk of them being harmed. This person was recorded as losing their balance and having a fall. The accident record showed that staff had made an appointment with the GP for a check-up.

● People were supported to attend annual health checks and screening. A healthcare professional told us, "We do an annual review. We plan a home visit to do this. I usually find they (staff) know about their residents."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People had lived at Rainscombe House for a number of years and as such they had been assessed by their funding authority prior to moving in. Regular reviews of people's care plans took place, in addition to a review by the person's social worker.

● Staff assessed people routinely to check for any changes in their needs, using national standards to measure this. This included weighing people on a monthly basis, or inviting the GP to review a person's medicines or their health status.

● Staff took time to complete functional assessments for people who needed them, for example where one person whose mobility had reduced and another who could become anxious.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Staff were following the principles of the MCA. Everyone had gone on holiday at the beginning of November 2023. We saw from their records that in advance of the trip staff had carried out capacity assessments and best interests meetings to determine whether the holiday was in line with their needs. In addition, staff had sought involvement from professionals involved in people's care.
- Other capacity assessments and best interests decisions had been taken where people were being deprived of their liberty. Such as having one-to-one staff when involved in external activities, or living at a service where the front door was locked.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last fully comprehensive inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence; Ensuring people are well treated and supported; respecting equality and diversity; Supporting people to express their views and be involved in making decisions about their care

At our last focused inspection, we found a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always shown respect or dignity or supported with their decision-making capabilities. We had similar concerns at this inspection.

- Some staff were not always providing care that was genuinely person-centred. At our last inspection, we saw some staff show little interest in people or spend little time engaging with them. We saw some similar incidents during this visit. One staff member in particularly spent very little time engaging with people, instead preferring to stand in the kitchen observing.
- People's privacy or dignity was not always promoted or respected. On our second day of inspection, 2 staff were providing personal care to 1 person in the downstairs shower room. However, staff showered the person with the door to the shower room wide open. This was despite us being in the vicinity. We raised this immediately with the manager.
- People were not always supported in a caring way. One person's mobility had deteriorated and they could no longer use the upstairs bathroom. From 28 July 2023 to 1 December 2023, staff had strip washed this person in a small downstairs toilet. We asked staff if they had considered taking this person to Rainscombe Bungalow where they would have had access to a downstairs shower room. We were told it would be too far for the person to walk and the person would not tolerate a wheelchair. Despite this, we were later shown pictures of this person using a wheelchair when on holiday. Additionally, staff could have driven the person as the driveway went round to the back entrance to the service. The provider had installed a downstairs shower room for this person which was being used from 1 December 2023.
- Staff did not use person-centred planning tools and approaches or support people sufficiently to plan their care. We read that on our first day of inspection all 3 people's care plans had been reviewed with them and a house meeting had been held. This was despite us being there from 10:30 to approximately 15:00 and 2 people being out for the afternoon. This indicated to us that people had not been given the input from staff that was needed to truly engage and involve them in reviewing their care plan or making decisions about their care, through meetings.

The lack of respect and dignity shown to people was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At our last focused inspection, we found people had no blinds or curtains up at their bedroom windows, leaving people without privacy. At this visit we saw that people had curtains at their windows and as such their bedrooms were more homely.
● Some staff were attentive, kind and caring towards people. These staff showed an interest in people and were affectionate towards them. One person had a cold on our first day of inspection and staff showed concern towards them, ensuring they were warm and comfortable.
● People's preferences (i.e. gender of staff) were identified and appropriate staff were available to support people as the staff rota always included female as well as male staff.
● A relative told us, "She seems happy there and is always happy to go back after visiting me. She always looks well when I see her." A second said, "She was happy and well when I last saw her."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last fully comprehensive inspection we rated this key question Requires Improvement. At this inspection has remained Requires Improvement. This meant people's needs may not always be met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life support

At our last inspection we found the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not receiving person-centred care. At this inspection we found similar concerns.

● People's care records may not always help them get the support they needed as staff did not always keep accurate, complete or legible records. Although some people's care plans had improved in places and risk assessments had been linked to people's individual care needs people's daily notes were poorly written. We reviewed the care notes for a period of 3 months, from September to November 2023. There were numerous occasions when the spelling in notes was poor, the care notes were out of order so difficult to read and they lacked detail, instead being very task-orientated in the way they were written.
● Although some life history information was recorded about people, this was contained in old paper care plans and the information had not been transferred to the electronic system now used by staff. This meant that new staff would not have easy access to this information to help them get to know people as an individual.
● Some people had not consistently seen improvement in their care. Staff were not always following information recorded in people's care plan. One person could become agitated. We asked staff how they would respond to this. We were told, "We try and calm her down, offer her a drink and give her some space. If that doesn't work, she has PRN (as required) medication." We asked how long staff would wait before giving her the PRN and were told, "About 5-10 minutes." This was not what was recorded in the person's positive behaviour support plan.
● One person was on medication for their digestive system and yet staff did not regularly record their bowel motions for signs of discomfort or illness. Although this person could tell staff if they were in pain, the lack of consistent recording meant staff could not look for trends or themes or when this person may need professional intervention.
● People were not supported with any aspirations to live a quality life of their choosing. We were told people had been allocated a key worker (a staff member who worked closely with the person) and that they key worker system had improved people's care. Yet, there was no evidence that key workers set goals with people. This meant people were not supported to strive or make an effort to achieve something.
● People had shortened care plans in their bedrooms in pictorial format. However, some pictures were not up to date as they did not reflect how people's rooms looked now.
● No improvement had been made to developing end of life care plans for people. These were still not completed for people despite this being an action to be completed by September 2023.

The continued lack of person-centred care was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were some good aspects of people's care plans. They included people's preferred routine, how they wished their personal care and when they liked to get up or go to bed. We noted people liked to have a shower both in the morning and evening and read from the daily notes this was happening. In addition, it was evident from the notes that people were not made to get up at a specific time in the morning.
● People's care plans were reviewed regularly and where changes were noted, their relatives were informed. People's relatives were involved and 1 person regularly went to spend time with their family member.
● Staff used handheld devices which enabled them to update care activities in real time and staff held handover meetings each morning where they could exchange information about people and arrange suitable staffing arrangements for the day. A staff member told us, "I read the care plans first (when I started here), they have shown me what I have to do every day."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

At our last inspection we found the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not receiving person-centred care in line with Right support, right care, right culture. At this inspection we found similar concerns.

● We expect staff to enable people to live their lives in line with Right support, right care, right culture. This means supporting them to live a meaningful life and give people opportunities to lead as normal a life as possible. Although there had been some improvement since our last inspection, people were still not consistently being supported to develop socially or independently. A professional told us, "I did note there was not a lot going on to occupy [person's name]."
● People could not always take part in activities that were tailored to them as an individual. People still regularly attended activities as a group. One person's care plan stated that going to day centre sessions was important them and yet, they had not been to the day centre for over 2 years. A relative told us, "She used to go out more. I worry about her not doing enough."
● A second person's care plan noted going to the cinema was what they liked to do. During our review of 3 months' worth of this person's daily care notes, we did not find any occasions when they had gone to the cinema.
● People's activities still consisted mainly of drives out to do grocery shopping. One person spent 15 days of a month watching television and listening to music at the service and a further 8 going for a drive. We noted they had been taken to Brighton for the day but had not left the van on arrival as staff had determined they were unsafe to get out due to reduced mobility. A further person went on 9 drives during the same month and on another 8 days staff had not recorded they had taken part in any activities at all.
● People's activity planners did not always reflect what they did. Two people's activity charts showed they should go to a local farm each month, however their daily notes recorded this had only happened on 1 occasion. One person's planner noted they were going to the YMCA for a dance session on the afternoon of 28th November 2023. But their daily notes stated they stayed indoors and watched television all day.
● At times, activities were planned but there appeared insufficient staff to support people in their activities. On 2 December 2023, 1 person was going to a Christmas market, a second out for a coffee and the third person was staying at home to play board games. Yet, there were only 2 staff on duty. A relative told us, "They are doing less than they did pre-COVID, but they are gradually upping activities."
● In early November, everyone went to a holiday resort for the weekend. There was no evidence to suggest that people had expressed their choice in this holiday; instead it was decided by staff. Despite the resort

having a wide range of activities for people to participate in, staff had chosen to spend the second day of arrival driving people around an external safari park and then grocery shopping. This suggested the activities were led by staff due to ease, for example, with people staying in the vehicle. A relative said, "I'm not sure how much she enjoyed the holiday. Staff did not say much about what she had done."

● Staff still failed to understand the concept of Right support, right care, right culture. A manager told us, "It is about how we look after those people, the individuals we are supporting. We give them the right support, the right number of staff. We give them more choice and their independence." Yet, they were unable to give us any real examples of where they felt they were meeting this.

The continued lack of person-centred care to help ensure people lead fulfilling, independent lives was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some improvements had been made since our last inspection. This included 2 people regularly going out for buggy rides and occasions when people went out to the pub early evening. A staff member said, "I think everyone has the opportunity do whatever they want to do."

● We were shown pictures of people assisting in the kitchen with baking or making their lunch and on our first day of inspection 1 person was involved in doing this with staff. Other pictures showed people helping clean their house or doing their laundry.

Meeting people's communication needs; Improving care quality in response to complaints or concerns
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication

● Staff did not always ensure people had access to information in formats they could understand. Staff had erected a board in the kitchen area where they displayed the activities for the day as well as what was on the menu. Pictures of foods were not sufficiently detailed enough for people to understand them. For example, on our second day of inspection, the main meal was fish pie and yet the picture did not match that of fish pie.

● Staff did not always communicate with people in a way that met their needs. One person used their own version of Makaton (a form of sign language), but we did not see staff communicate with this person in this way. We reviewed the training matrix and saw that of the 11 staff working at the service, only 3 had undertaken Makaton training. A staff member who had undertaken the training told us, "We use it to give [person's name] choice. She doesn't use the proper Makaton, but uses her own signs."

● The service had a complaints policy although it was not written in a way that people would understand. This was displayed on the board in the kitchen area; however it was not in pictorial format.

● No complaints had been received by the service since our last inspection. A relative said if they had any worries, "I guess I would phone the manager."

The lack of providing people with information in a way they would understand is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 our last focused inspection we rated this key question Inadequate. At this inspection the rating for this key question has remained 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection, we found the provider in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to a lack of management oversight and governance within the service. We had similar concerns at this inspection.

● People did not lead inclusive or empowered lives because of the ethos, values, attitudes of the management and staff. There continued to be a poor culture within the service. This was evident by the way staff showered 1 person with the door wide open. The manager told us, "We saw this staff member do this before and I held supervision with them. It's disappointing that they have done it again." This showed us supervision was not effective.
● When we spoke with the nominated individual at inspection feedback we discussed the culture within the service. They told us it was something they were working on. They said, "We have been addressing the culture through supervisions. Care should be done in a preferenced and caring way. The culture is definitely changing. It starts at the bottom and then it will work its way up." This showed a failure to understand the need to change the culture at senior management level in the first instance, so they could lead by example and cascade good practice down.
● People were not supported to lead meaningful lives in line with Right support, right care, right culture. The lack of a person-centred approach towards people was evident from the way some staff behaved towards people, for example, the staff member who rarely engaged with them at all as well as staff not considering someone's dignity by washing them in a toilet for 4 months.
● Although we spoke with the manager about Right support, right care, right culture at our last inspections, there was no evidence that this guidance had been cascaded out to staff, particularly new staff working at the service. This meant people continued to have unfulfilling lives.
● Staff and management were not always open and transparent with us. At our last focused inspection the hot water tap in the kitchen was not working. On the first day of this inspection, this was the same. A staff member told us, "It's on a timer, so [person's name] does not get burnt if they turn it on. It comes on after about 30 seconds." After standing in front of the tap for around 2 minutes we spoke with the staff member again. They told us, "Well, what we do is turn it on, then we clean down the worktops and by the time we've finished, the water is coming through." We wait around 5 minutes but water did not come out of the tap. On our second day of inspection the hot water tap was working properly.

● Secondly, on 3 December 2023, we heard that the staff member on night duty was an agency staff and as such they were not medicines trained. A staff member told us, "It worries me as if [person's name] had a seizure they would have to call someone from the bungalow as they could not give epilepsy medicine." We asked a manager what had happened which resulted in having an agency staff member on duty and were given 2 different versions of events. They initially told us the staff member due on duty had not turned up, so they had had to arrange agency at the last minute. But then changed their explanation to say the night staff member had arrived, but had been asked to cover the shift at the bungalow instead.
● On a third occasion, staff told us they were advised by a care professional that the person with reduced mobility could not walk to the bungalow to have a shower as it was too far for them to walk. They also said they had not been offered a wheelchair for this person. We spoke with the professional who confirmed this was not the case and when asked if a wheelchair was needed for the person, staff advised them that the person would not tolerate a wheelchair.
● Governance processes were not effective in holding staff to account or to ensure staff delivered good quality support consistently. Following our last inspection, the provider had arranged for full audit of the service to be carried out by an external company. The consultant had identified multiple areas for improvements during this audit and yet, many of these areas had not been actioned. For example, writing end of life care plans for people.
● We were shown an example of the manager reviewing daily care notes for people. However, this was not through a formal process and instead the manager had just recorded within the electronic notes, 'have checked [person's name] notes from [day]'. There were no specifics on whether the notes were appropriate or staff needed to take any action to improve them.
● The nominated individual carried out 'non-conformity' audits and although they had identified areas that required action, there was no process to record when the action needed to be completed by and how they would follow up on this.
● The manager was unable to assure themselves that staff had undertaken their training as the training matrix they held was not up to date. We found gaps in the matrix, but the manager, when asked, was able to provide us with evidence of completed training. A staff member told us they had undertaken emergency epilepsy medicines training and yet, the training matrix recorded this was schedule for January to March 2024.
● Senior staff did not always understand or demonstrate compliance with regulatory requirements. Although, unexplained bruising to 1 person had been reported to the local authority's safeguarding team, they had failed to notify us as part of their statutory requirements.
● There was a lack of registered manager at the service who had the skills, knowledge and experience or an understanding to promote and support a well-led service. A new manager had been recruited to the post, but had yet to submit their application to register.
● A manager told us improvements had been made saying, "We are doing reflective practice and supervisions and activities have improved. People are offered more opportunities; paperwork has improved and staff know what they need to complete. The environment is coming together really nicely." Yet, from our visits, it was evident that people's quality of life was not being enhanced.

The continued failure to have good quality assurances processes in place, or to learn and improve from our previous inspection, was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We found some improvements had been made in relation to auditing the service. New medicines, health and safety and fire audits had been introduced and we saw these were completed regularly. The area manager told us, "I have started to develop my own action plan working with the external audit as well as the provider's CQC action plan, together with my own observations."

● The manager had requested their local pharmacy carry out a medicines audit and this showed no actions were required.
● The manager, through daily meetings with staff, reviewed people's activities for the day and checked that staff were reading and signing the communications book. This book contained information relevant to people, for example, when they had important appointments or messages needed to be relayed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics, Working in partnership with others; 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
● People were not given sufficient opportunity to express their views about the care they received despite the provider telling us in their action plan following the last inspection they would improve on how they obtained people's views and wishes. Although there were residents' meetings they were not an effective way of gaining people's feedback. It was noted there were very limited responses from people yet the conclusion from all meetings was, 'based on the meeting all services users are currently happy at Rainscombe House'.
● In turn the provider had not worked hard to create a learning culture where staff felt valued and empowered to suggest improvements. Meeting minutes lacked evidence of staff being able to contribute. Instead the notes indicated management gave staff information, reminders and updates only.
● The nominated individual told us that through their new auditing portal it would give them the opportunity to develop better ways of obtaining feedback from relatives. A relative told us, "I have just received a form to give my feedback. Generally I am happy, but I would like staff to telephone me more to keep me updated. They said they would, but it has not happened."
● Where people experienced accidents, incidents or changes to their health, staff notified their relative. We read where staff had seen unexplained bruising on 1 person they had telephoned their family member to tell them of this. A relative told us, "They contacted me when she needed dental work."
● The service worked with health care professionals such as the speech and language therapy team, the GP, and the registered learning disability nurse. Although we were told by 1 professional, "Whenever I call, I am told to speak to the provider at head office. This is not ideal as they are not involved in the day-to-day care of people."

We recommend the provider continues to work on ways of improving their systems to involve people, relatives and staff in the running of the service.

● Staff told us they felt happy with the support they received and that the manager was approachable. A staff member said they had supervision with their line manager where they discussed residents and training needs. She said, "I am happy with the support I receive in my role." In turn, manager's felt supported by the provider. We were told, "I am supported by senior management. They are very good."
● Staff worked with local professionals to support people. A professional said staff were very supportive in reducing people's medicines and that this process had, "Worked well."
● A relative told us, "I am happy that [manager's name] is back. I like her and so does [person's name]. Good communication is back again and we have regular chats."
● Senior staff were involved in provider engagement groups as well as accessing local support. Managers told us they used Skills for Care (a national training provider for adult social care services) to access training for staff. The area manager said, "I have already booked a couple of the managers on their courses."
In addition, the manager told us, "We attend webinars and I do training. I read documentation to keep up my knowledge and we have manager's meetings."