Mitchell's Care Homes Limited

Rainscombe Bungalow

Inspection report

Rainscombe Farm
Dowlands Lane
Smallfield
Surrey
RH6 9SB

Tel: 01342841501
Website: www.m.ch.co.uk

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28 April 2023

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Rainscombe Bungalow provides accommodation and personal care for up to 6 people who have a learning disability and or are autistic. At the time of our inspection, there were 6 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.

Right Support
The provider had failed to ensure they met the principles of Right support, right care, right culture. This meant people who used the service were not able to live as full a life as possible and achieve the best possible outcomes. People were not protected against risks associated with their care. Health care professional advice was not always being followed in relation to people's care.

Right Care
People were not protected from abuse from staff. There were not sufficiently trained or supervised staff to safely meet the needs of people. Incidents where people displayed their distress were not always recorded in sufficient detail to look for trends and themes. Staff were not always kind and respectful towards people.

Right Culture
There was a lack of management and provider oversight to review shortfalls of care to make improvements. The provider did not focus on people's quality of life, and care delivery was not person centred. Staff did not recognise how to promote people's rights, choice or independence.

Rating at last inspection and update
The last rating for this service was requires improvement (published 09 May 2023). At the time of this inspection we received additional concerns that related to the safe care of people.

Why we inspected
The inspection was prompted due to concerns received about people not being protected from the risk of abuse, concerns around safe staff levels and lack of robust management oversight. 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, caring 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 changed to inadequate based on the findings of this inspection.

Enforcement and Recommendations
We have identified breaches in relation to people not being protected from abuse, safe care and treatment and the lack of trained and appropriately supervised staff. We also identified breaches in relation to the staff not being caring and respectful, lack of meaningful activities, and a lack of robust management and provider oversight at this inspection.

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

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

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Rainscombe Bungalow

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 team was made up of 3 inspectors.

Service and service type
Rainscombe Bungalow 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 Bungalow 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 no registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was 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 sought feedback from the local authority and professionals who work with the service. We used this information to plan our inspection.

During the inspection
We spoke with 1 person about their experience. As other people were not able to verbally communicate with us, we observed care and interactions between them and staff. We spoke with 14 members of staff including the provider, senior management team and care staff. We reviewed a range of records. This included 6 people's care records and multiple medication records. We looked at 6 staff files in relation to recruitment, training and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Prior to the inspection safeguarding allegations concerns were raised with us. Whilst the provider took immediate action as soon as we made them aware, we identified further instances where people were at further risk of abuse and neglect.
- On the day of the previous inspection in March 2023 all people were taken out of the service after we arrived later in the morning. According to staff we spoke with, this activity was not planned. We found people had been sat in the company vehicles for several hours being driven around before they were brought back to the service. It had been recorded 1 person had gone to the cinema however staff confirmed this did not happen and the person was taken for a drive for a prolonged period of time. One member of staff said, "I had concerns about staff just sitting in the van (with people)."
- Although staff had received safeguarding training, they were not always recognising or reporting abuse. Staff we spoke with had a lack of understanding of the signs to look out for when people with a learning disability could be experiencing abuse and may not be able to communicate this. This could include unexplained injuries and self-harm. We noted multiple incidents on care records where a person was self-harming, this had not been reported as an incident by staff and no investigation had taken place to determine the reasons for this.
- We noted from another person's care notes there were unexplained bruises near the person's armpit. This had not been reported or investigated to determine the possible cause of this. This was despite the service safeguarding policy stating signs of physical abuse could be unexplained bruising. A member of staff told us of another person, "I have noticed bruises on (person) and wondered how it happened. I don't always trust the staff with people."
- People were not always protected from the risk of unlawful restraint. One person required to be sat in their wheelchair when eating their meal at the dining table. This was due to there not being an appropriate chair for them which was on order. We observed the person was secured with a lap belt in their wheelchair for the entirety of both days of the inspection despite the person being able to walk. A member of the providers team told us the person was able to walk and that, "(Person) likes to be moving around."
- On another occasion we saw in the care notes a person had an episode of anxiety. Staff recorded; 'high-level intervention' was required with no further detail on what this intervention was. This was not investigated by the provider to determine whether the high-level intervention was appropriate. This was despite the service safeguarding policy stating physical abuse could be, "Restraint or inappropriate physical sanctions."

Failure to investigate and report instances of alleged abuse was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing risk, safety monitoring and management; Preventing and controlling infection

● Risks associated with people's care were not always managed in a safe way. One person was at risk of developing pressure sores as they were unable to move independently. The person's pressure mattress was set at 150 kilograms (kg), yet their last recorded weight was 51 kg. This meant the effectiveness of the pressure mattress was reduced.

● The person's bed rail risk assessment stated they required to be repositioned whilst they were in bed with no information on how frequently this needed to be done. According to the April 2023 care notes there were nights the person was repositioned once and other nights where the person was repositioned every 3 hours. This lack of guidance increased the risk of the person developing a pressure sore.

● Where a risk had been identified staff were not always following the strategies in place to reduce the risk of harm to the person and other people. According to their risk assessment, 1 person should not travel in a vehicle with other people due to the risks it posed if the person experienced a heightened state of anxiety. We were made aware by staff and confirmed in care notes several occasions where the person travelled in their vehicle with other people.

● The positive behaviour support plans in place for people failed to have sufficient guidance for staff on how to support people when they were in a heightened state of anxiety. For example, in two of the plans it states staff were to move person to a room when a particular anxiety was displayed but lacked information for staff on how this needed to be done. Staff we spoke with also lacked an understanding of how best to support these people. One member of staff said of a person, "If (person) is anxious we take them outside." This meant there was a risk the appropriate support was not provided.

● The environment was not always set up to ensure people's safety. Two people's toilet seats were secured at an angle from the toilet bowl meaning when the person sat down there was a risk, they would pinch their skin and injure themself. We asked the provider to address this which they subsequently confirmed was done.

● The laundry room was left unlocked on both days of the inspection and people could access hazardous materials including washing powder. One person showed us into the laundry room and told us they were aware of the danger of the circuit board in there and which was accessible to people. The provider confirmed the room was able to be locked and have reminded staff to do this.

● People were at risk of getting an infection as infection control practices were not always robust. Two people's mattresses smelled strongly of urine that also included their bedding. Urine had soaked through to the underside of the mattress causing staining to the bed frame. A sling used to support a person with moving also smelled strongly of urine. There was also faeces smeared over 1 person's toilet seat.

● There was an unlocked bin in the communal garden with people's soiled continence aids. We also saw used COVID-19 tests had been left on the windowsill by the front door which people frequently accessed.

The failure to ensure risks to people's safety were robustly assessed was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● 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's infection prevention and control policy was up to date.

Visiting in care homes

The care homes approach for visitors was in line with current government guidance.

Learning lessons when things go wrong

● Incidents were not always recorded in detail and analysed to look for trends. This meant there was little opportunity for lessons to be learned when things went wrong.

● We noted in 1 person's care plan they may have a seizure when they have a heightened anxiety. There were several references to the person having seizures in their care plans. However, there was no analysis of this to determine the possible cause of the seizure to reduce the risk of them occurring.
● A member of the provider's team told us all accidents and incidents were recorded on the electronic care notes. They told us only 3 incidents and accidents had occurred this year. When we reviewed the daily care notes we noted other incidents had occurred that had not been recorded as an incident. This included 1 person who had a seizure which resulted in a fall and injury to their head and another person with an unexplained bruise.
● Where incidents were recorded there was a lack of detail on how this occurred. For example, it was recorded by a member of staff who had not observed the incident, that 1 person fell and had injured their hand requiring hospital treatment. There was no detail on who observed the fall, where it occurred or how staff supported the person when it happened. We reviewed the daily notes for the day the incident occurred, although it mentioned the person had an incident of heightened anxiety there was no reference to the injury. This meant there was no opportunity to review this and put in place actions to reduce further incidents.
● The member of the provider's team told us all incidents of heightened anxiety were recorded electronically on behaviour charts. However, when we reviewed these, they lacked detail on what preceded the incident that led to the anxiety. There was no analysis of the incidents to look for trends, themes and triggers to try and reduce the risk of incidents. This was despite a member of the providers team telling us, "The acting manager will look for themes, trends and triggers."
● Another person had occasional seizures. A member of the provider's team told us the manager at the home needed to review and flag all incidents to review. We noted staff had recorded 2 seizures for the person this year that had not been flagged as an incident.

The failure to ensure accident and incidents were reviewed and actions taken to reduce them was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not managed in a safe way, which placed people at risk of harm. One person had been prescribed a short dose of medicine for an infection. Guidance on the NHS website states the medicine needed to be given with food to avoid nausea. We saw from the person's notes the medicine was given with water. The morning dose was given two hours before they were given breakfast.
● Another person was required to have their medicine at least 30 minutes before their food, however we saw it regularly recorded that they were given the medicine with their meal. We also observed this on the second day of the inspection when the person was given their medicine with their evening meal.
● On the second day of inspection we also observed all people were given their evening medicines whilst they were eating their dinner. We asked a member of staff if all medicines needed to be given with food and they stated they did not. The member of staff lacked an understanding of what medicines needed to be given with food or not.
● We observed a person's prescribed thickener was stored in a kitchen cabinet. This meant there was a risk other people may be harmed by the accidentally swallowing the powder. We fed this back to the providers management team.
● One person was prescribed an emergency medicine in the event the person had a seizure. All staff on duty confirmed they were not trained in how to administer this. This meant the person may not receive their medicine when needed. We spoke to the providers management team who took immediate action to contact the external professional to review the prescription. They subsequently confirmed the medicine was to be given in a different format and that staff had now been trained to give this.
● The medicine administration records (MAR) lacked guidance on how people's medicines were given. One

person was at risk of choking and required all medicines to be in liquid form or dispensed into a liquid. However, the person's MAR stated the person was required to swallow the capsule whole which placed the person at risk of choking if staff were not aware of how they took this.
● Another person was prescribed a transdermal patch (a medicated adhesive patch that is placed on the skin) to assist with a respiratory condition. The MAR did not have any information where it should be applied. Staff were not recording where they were applying the patch or whether they were alternating the position of the patch to reduce the risk of skin irritation. This meant there was a risk that a member of staff may apply the patch in the wrong place.

The failure to ensure medicines were administered in a safe way was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were not sufficient staff to manage people's needs in a safe way. The provider told us 5 staff were required to be on duty on the morning and 4 in the afternoon. Included in this, 1 person was funded to have a member of staff allocated solely to them through the day. There were 4 other people at high risk of falls. During the inspection people were often sat together in the same room. When a person stood up and started walking staff would steer the person back to a chair to sit back down so staff to keep them in the same room as the other people.
● In the afternoon staff levels reduced to 4. On the second day of the inspection, we observed staff struggled to support people in any meaningful way. Two staff would take 1 person to have their personal care which left 2 staff to support the other people. Again, we saw staff encouraging people to stay seated all in one room together. One member of staff told us, "Five (in the afternoon) would be more sufficient, it's a bit hectic."
● We noted from a person's care plan they required a member of staff to sit next to them in the vehicle as they had a history of taking their arms out of their seatbelt. Staff confirmed with us the person was taken out in the vehicle on the day of the last inspection in March 2023 with only the driver and no other member of staff. This placed the person at risk as there was no staff to prevent them from removing their seat belt.
● The provider told us there were never less than the required safe levels of staff and that, "Under no circumstances is the rota jeopardised." When we reviewed the staff rotas for 2023 there were multiple days where there were less than the required safe levels of staff including, 15 days in January, 8 days in February (out of the 10 days of February rotas provided), 14 days in March and 6 days in April. There were days where there were only 3 staff on duty instead of the required 5. A member of staff told us, "Some days we have 3 (staff) and (provider) said we would just have to manage. I feel like I am doing the job of 3 people." This placed people at increased risk of harm.

The failure to ensure there were sufficient staff deployed at the service was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not operate safe recruitment practices when employing new staff. Four recruitment files did not have a full employment history. There was no evidence the provider had sought this information to assure themselves of reasons for the gaps in employment. This was despite the providers policy stating they required a full employment history.
● Appropriate references had not always been sought for staff. Two files had no references. Another file had references that related to the previous employment at the service with a two-year unexplained gap. A fourth member of staff's references had no information on who provided them and how they knew the member of staff. The policy stated that 2 references should be provided with 1 being from the most recent employer. The provider had not proactively sought references in this way.

● Although the provider had undertaken Disclosure and Barring Service (DBS) checks on all staff, they were not waiting for the response to the DBS before the member of staff commenced work. We saw 1 member of staff was rostered to work at the service before the DBS response and there was no risk assessment in place in relation to this.
● Health questionnaires were not always being completed for staff. This was despite the service policy stating health questions are asked at interviews where the applicant is required to be fit and mentally able to undertake the tasks, and where those tasks are an intrinsic part of the job.

The failure to ensure robust checks were undertaken before staff were employed was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 our last inspection we rated this key question requires improvement. This inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Training was not always effective in ensuring staff were competent to provide appropriate care. We saw some staff had received online training in epilepsy, learning disabilities and autism. However, not all staff we spoke with understood the needs of people with these conditions. For example, 1 member of staff when asked about autism told us, "I heard about autism, but I don't think I can remember what it is." Another told us they did not know about epilepsy and relied on other staff knowing. This meant that people may not be provided with the appropriate support. One person communicated using Makaton (a language programme that uses symbols, signs and speech to enable people to communicate) however no staff had been trained in this.
- People were not always supported by staff that had undergone a thorough induction programme to give them the skills to care for people effectively. A member of the providers team told us induction for staff needed to include training and shadowing a more experienced member of staff until they were competent. However, staff we spoke with told us they had not shadowed other staff. One member of staff told us, "I did not do any shadowing. I went straight into care."
- Staff had not always completed the service training before they were rostered to work. One member of staff started work in August 2022, yet they had not completed their online training until 2023. Another member of staff who was rostered to provide care had not completed any of the service mandatory training. This meant the provider could not be assured of their competence to do their job and they would not be aware of the most appropriate support for people.
- Other staff completed a series of online training before they started work. We saw this training consisted of multiple topics which for the majority of staff were completed in over a couple of days. One member of staff told us this had been difficult to take in and said, "They give me training online about maybe 40 – 50, it was too much. It was so much."
- Another member of staff told us they could not speak, read or write English to a sufficient standard. They told us another member of staff assisted them with the online training and read people's care plans to them. They told us they were unable to write care notes and relied upon members of staff to do this for them. The provider told us when the member of staff was employed there was no requirement to check their understanding of the English language. This meant they could not be assured the member of staff was able to perform their role to the appropriate standard.
- Staff supervision was not effective in identifying poor practice at the service. All of the supervision records for staff were identical pre-completed forms with information either about people or information from the provider. A supervision should be an opportunity to monitor and reflect on practice; review and prioritise work with individuals; provide guidance and support and identify areas of work that need development.

The provider failed to ensure there was adequate training, knowledge and competency checks which is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Where people received healthcare treatment, this was not always accurately recorded and followed up to ensure this could be monitored. A member of the provider's team told us a person was taken to hospital in March 2023 as they had observed they were holding their chest and that, "It just did not look like (person)." However, the incident report referenced only that the person was sweating and making gasping noises. No attempt was made to contact the emergency services for immediate advice. Instead, the person was taken to hospital by staff, where they waited several hours to be seen by medical staff. There was no update in the person's care plan on how the person needed to be monitored.

● One person was at risk of falls whilst walking. The care notes stated the person was required to wear a helmet as advised by the occupational therapist (OT). However, staff kept the person's helmet on even when they were sat in their wheelchair for prolonged periods of time. We saw the person indicating they wanted to take it off. We raised this with a member of the provider's regional team who told us the guidance from the OT was not clear. It was only after we raised this, that they took steps to get clarification from the OT on when exactly the person was required to wear their helmet. This meant there was a risk the person was having to wear a helmet continuously when it was not necessary.

● There was a delay in referring people to appropriate health care professionals. According to a person's care plan they required a fork mashable diet. According to the guidance from the International Dysphagia Diet Standardisation Initiative, the foods to avoid included bread and flaky pastries. We saw from the person's care notes they were frequently given pastries and bread at mealtimes. We raised with the providers team, and they stated the person had not been reviewed by the speech and language therapist (SaLT) since 2018. They told us they would request an urgent review.

● Staff were not always following the guidance from external professionals. One person had a medical condition where an excess of fluids could impact their health. According to their care plan, a health care professional advised staff needed to record daily drinks to ensure it did not exceed 1.5 litres. Staff were not always recording the person's fluid intake and as such it was not always possible to determine if the person had exceeded the recommended amounts.

The failure to ensure people's health care needs were effectively monitored was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs

● A person was admitted to the service before the provider and staff had time to fully assess their needs. We saw from a pre assessment of the person's needs there was at times incorrect reference to another person receiving care. It was noted on the assessment the person had periods of high anxiety but no detail on what the triggers to this anxiety was. This meant the provider could not be assured they were fully able to meet their needs before they moved in.

● According to the person's assessment they often expressed themselves through screaming and vocalising. Despite this, the provider still agreed to admit the person knowing they were already supporting people whose known triggers to their anxiety according to their care plans included 'Others in the home making a noise.' One person expressed to us how hearing the noise from the person made them feel anxious and we heard them also discussing this with a member of the providers team.

● The provider failed to consult people at the service, in line with nationally recognised best practice guidance, Right support, right care right culture and the REACH standards (which states that people with a

learning disability and/or autism should be able to live the lives they choose). There was no evidence the provider consulted or had discussions with people already living at the service to gain their views prior to admitting new people. This meant they were not involved in decisions about their needs and preferences.
●. There were people who had lived at the service for many years and whilst there had been an assessment of their needs and choices this was not reviewed regularly.
● The service environment was not always set up to meet the needs of people. There were people who were visually impaired. There were no handrails around the home to support these people to access the home independently.
● There were no separate sensory spaces, other than people's bedrooms, where people could move to when they were at a heightened state of anxiety. The only communal spaces at the service were a large living room and the kitchen. The lounge just contained three worn sofas and a television and had nothing else to support people with their sensory needs.

As the provider had not ensured an assessment of the needs and preferences for care and treatment of people was undertaken appropriately and the environment was set up to meet the needs of people this was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● During the inspection we observed people being supported with their dinner in a very disorganised way. We observed a member of staff trying to give medicines to people at the same time as they were eating. Two people were given their meal but were struggling to scoop the food onto their spoon due to their sight impairment. They did not have adapted plates and cutlery to support them with this so staff had to support them. We also noted people were not given a drink with their meal. A member of the provider's team subsequently told us they had ordered adapted cutlery and plates for people.
● According to the care notes people were provided with a variety of fresh food cooked from fresh and we saw staff preparing meals from scratch.
● Nutritional assessments were carried out as part of the initial assessments when people moved into the home. These showed if people had specialist dietary needs. People's weights were recorded and where needed advice was sought from the relevant health care professional.
● There was information available for staff on the types of food people preferred. One person had a specific cultural diet and staff provided this.

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.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

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.

● At the previous inspection in March 2023 we observed staff restrict someone's movement whilst they were in their wheelchair. Staff said a healthcare professional had suggested using the person's handling belt (a belt used to assist with people being transferred) on the legs of their wheelchair to restrict the space the person had when putting down their legs. At the time of the inspection there was no capacity assessment or best interest decision in relation to this restriction. The provider has provided evidence this had now been completed.
● Staff followed the principles of the MCA with all other potential restrictions. Capacity assessments had been carried out and best interest decisions made to help ensure that the least restrictive practices were taking place.
● These processes had been followed where people had lap belts in their wheelchair, sensor mats and bed rails.
● Staff had undertaken MCA training and were able to explain their understanding of the Act. A staff member told us, "Don't assume that just because they (people) may lack capacity you cannot ask them things."

Inadequate

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 inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People were not always treated in a kind and caring way. We noted several occasions where staff placed a person in their wheelchair in the corner of the kitchen with their back facing away from people. This meant they were unable to interact with staff and people.
- During the mealtime staff were not speaking with people when they were supporting them. One person was being given spoonfuls of food by a member of staff stood behind them rather than sitting next to them which was undignified for them.
- When a person stood up from the table a member of staff approached them and wiped their mouth and face with a cloth without asking the person if they were happy for them to do so.
- Two people slept in beds which smelled strongly of urine, and which would not have been pleasant or dignified for them.
- We observed 1 person's bedroom door slammed loudly when it was opened. This person was also visually impaired. The provider had not considered this may alarm the person or other people. We asked the provider to address this.
- People were not always treated with respect and dignity. The provider confirmed to us they had removed the curtains from people's rooms and the communal areas 9 months before the inspection without giving people notice. These had not been replaced at the time of the inspection. This meant people's dignity had not been protected as it was possible to see inside their bedroom window from the communal garden. One person told us they did not like this. One member of staff said, "There should be curtains to give them some privacy in their rooms."
- We spoke to the provider about this who told us this had been an oversight but that as there were no neighbours to the property, they believed this was not a concern. We asked the provider to address this immediately. By the second day of the inspection temporary privacy film had been placed at the windows. The provider told us they would discuss with people what they preferred to have at the windows and would order this.

As people were not treated with dignity and respect this is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We observed occasions where staff did act in a caring way towards people. One person expressed their anxiety and staff gently rubbed their hands and reassured them.
- One person's cultural needs were important to them, and staff supported the person to celebrate religious

festivals.

Supporting people to express their views and be involved in making decisions about their care

● People on the whole were accepting of the way they lived their lives at Rainscombe Bungalow. However, we found that people's individual wishes and needs were not considered. Instead, what we found was that people's wishes and wants were secondary to how the service was run based on staff routine. We observed in the evening people were left waiting in turn in the kitchen for staff to deliver personal care in a particular order before night staff came on duty. Staff did not ask people whether they wanted their personal care at that time.

● There was no evidence in care plans that people and relatives (where appropriate) were involved in the planning of their care. Most people's rooms were not personalised and lacked the homely feel. People were not involved in how their rooms were decorated and did not have an opportunity to choose their curtains or furniture.

● We saw in care notes a relative contacted the service to ask staff about what the person would like to buy with money the person had been given as a gift. Staff had made the decision about what needed to be bought rather than discussing it with them.

● On the first day of inspection 1 person was left in bed from the time we arrived at 13.30 until we left early evening. We noted from the care notes for that day the person was left in bed until they had a shower and supported back to bed straight after. There was nothing to suggest why the person needed to be in bed for that length of time. We also noted in the care plan the person liked to listen to calming music in their room as they found it relaxing. However, the television radio had been put on a rock music channel.

As people were not considered and involved in decisions around their care this is a breach of Regulation 10 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 inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- People were not supported to lead meaningful and empowered lives. There was a lack of management and provider oversight to ensure people had access to activities that were important to them. We noted from the care plans people were often just taken for a drive or the shops. This was not in line with people's weekly activity planners that included buggy rides, sensory sessions and live music.
- There was a lack of openness and transparency by the provider during the inspection. We were told by them there were never less than the required staff levels at the service. However, on review of the rotas we saw there were regular occasions where there were low staff levels.
- The provider was not supporting an open culture within the staff team. Staff fed back to us they did not always feel confident in reporting things to the provider or the senior management team.
- Systems to check the quality of care were inadequate. We saw that audits were taking place by the provider. However, these lacked detail around what had been reviewed. An audit in January 2023 concluded there were no areas for development or improvement. This was despite all of the concerns we identified during the inspection.
- The provider told us they audited people's finances however this was not effective in identifying shortfalls. For example, one person had their own vehicle and we noted from the receipts staff provided for the purchase of petrol, this did not correlate to the journeys staff recorded the person took in the vehicle.
- People's care notes did not accurately record activities people participated in. For example, on the previous inspection in March 2023 we identified through discussions with staff only 1 person was taken to the cinema that day. However, staff had recorded 3 people had attended the cinema. Other people had been taken for a drive and to the park however 2 staff recorded 2 different park destinations which were a considerable distance apart. We had identified that this same day people had been left in vehicles for long periods of time. Staff told us they were instructed to do so to avoid people being present at the previous inspection.
- Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The provider had not always informed the CQC of significant events. One person sustained an injury to their head that required stitches. This had not been reported to CQC.

The failure to ensure quality assurance and governance systems were effective was a breach of Regulation

17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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 involved in the running of the service and as such were unable to influence positive changes. Although there were residents' meetings this was not an effective way to gain people's feedback. It was noted there was very limited responses from people yet the conclusion from the meeting was noted that, "All service users are currently happy to stay at Rainscombe." It had not been considered that meetings using the person's individual means of communication method would be more effective.

● Where incidents and accidents had occurred, we noted from the records that families were not always contacted. There were frequent incidents of high levels of anxiety for people yet there was no record that relatives or people's representatives had been contacted on each occasion.

● The local authorities who funded the care for people at the service told us they had not been made aware of the long-term absence of a registered manager at the service. They also told us they had not been made aware of the low staff levels at Rainscombe Bungalow.

● Some staff told us they did not always feel supported or valued. One member of staff said, "(Manager) doesn't let people (staff) grow. They don't want to share their knowledge." Other staff told us they felt supported by the management team.

● We saw the last staff meeting was held in December 2022 and included staff from 2 of the provider's other services. There were 13 staff present at the meeting which lasted 30 minutes. Staff were asked for feedback on a recent holiday they went on with people. However, there was no record of staff being invited to contribute or feedback on any aspects of people's care or the general day to day business of the service.

The failure to be open and transparent when things went wrong, to act on feedback and the failure to work in partnership effectively with other agencies is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.