Mitchell's Care Homes Limited

Head Office

Inspection report

Unit 3 Shawlands Court
Newchapel Road
Lingfield
RH7 6BL

Tel: 07929330093

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14 May 2023
17 May 2023
19 May 2023
20 May 2023
21 May 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 responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Head Office is a supported living service providing personal care to people with a learning disability and/or autism. Some people also have physical disabilities and a mental health diagnosis. Support was provided across 21 different supported living settings where people had their own houses or rooms. As part of our inspection, we visited 11 of the supported living homes. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time of our inspection 57 people were receiving a regulated activity.

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
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People were not being protected from abuse including financial, physical, emotional and verbal abuse. The risks associated with people's care were not reviewed and updated to reflect the most up to date information. Staff were not always familiar with the risks around people's care. Medicines were not always being managed in a safe way. There were not enough staff to support people safely. People were not always being treated in a kind and dignified way at all homes although we did see some caring interactions from some staff.

Right Care
Health care support was not always being sought for people and where it was, staff were not always following the guidance provided. Staff had not always received appropriate training and supervision to support people in the right way. People were not always being encouraged or given choices around healthy and nutritious meals. People and families were not always being involved in the reviews of care.

Right Culture
There was a lack of robust oversight of care by the provider. Where audits were being undertaken, they were not always picking up on shortfalls. Relatives and external professionals fed back concerns about the lack of actions and communication from the leadership team. Relatives did not always feel complaints would be responded to. Where feedback was sought actions were not always taken to make the improvements. The provider and leadership team were not encouraging an open culture within the staff team and were not always leading by example.

Rating at last inspection and update
The last rating for this service was good (published 16 January 2020).

Why we inspected
The inspection was prompted due to concerns received about people not being protected from abuse and unsafe care and unsafe staff levels. A decision was made for us to inspect and examine those risks.

We undertook an inspection to review the key questions of safe, effective, caring, responsive and well-led.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report.
The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

Enforcement and Recommendations
At this inspection we have identified breaches in relation to people not being protected from the risk of abuse, people not being protected from unsafe care including risk mitigations and the management of medicines. We also identified breaches in relation to the failure to ensure the principles of the Mental Capacity Act were consistently followed, staff not being appropriately trained and supervised, and people not being supported appropriately with their health care needs. We also identified a breach relating to the lack of robust response to complaints, lack of person centred care and staff levels. We identified breaches relating to the lack of robust oversight by the provider and people not being treated in a caring and dignified way.

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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

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

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

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 responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well led findings below.

Head Office

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.

Inspection team
The inspection team was made up of 7 inspectors.

Service and service type
This service provides care and support to people living in 21'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

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 a registered manager in post however they were on leave. We were supported on the inspection by the Nominated Individual and the senior management. We fed back to the registered manager once they had returned from leave.

Notice of inspection
This inspection was unannounced.

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 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 visited 11 homes and spoke with 27 people and 3 relatives. We spoke by telephone, with a further 23 relatives about their experience of care their loved one received. We received feedback from 5 health and social care professionals. We spoke with 32 members of staff including care staff, the registered manager, quality managers, and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records including 16 people's care plans, daily care notes, staff rotas, multiple medication records, safeguarding records and complaints. We reviewed a variety of records relating to the management of the service including 16 staff recruitment files, training and supervision.

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

● The provider had not protected people from abuse and neglect. Prior to the inspection we were made aware of alleged incidents of abuse. Whilst the provider took immediate action, we identified further instances of where people were not being protected from the risk of abuse. Although staff had received safeguarding training, they were not always recognising or reporting abuse. One person told us they were often the target of another person's frustrations and they had hit them. Staff told us these incidents did occur and that the previous week the person had hit out at the person raising concerns with us. This had not been reported as a safeguarding and there was no record of this in the victim's care notes. The provider told us another incident had occurred with the same person after our visit.

● Relatives fed back on whether their loved ones were safe. Comments included, "He doesn't look so relaxed", "She is not particularly safe" and "She is safe, but it's almost like they're doing the bare minimum."

● We observed a person at a heightened state of anxiety. A member of staff was physically restraining the person by holding their arm with one hand and using their other arm around the person's waist. There was no guidance in their care plan around staff restraining in this way. We also noted the person was frequently being told they were naughty which we saw was upsetting the person.

● There was a risk that people would be unlawfully restrained. Guidance for staff was to, "Catch and stop" (a person if they were to run out of the home. However, staff were not clear on what this meant. There was a risk staff would physically restrain the person without the appropriate training, authority or consent to do so safely.

● People at 1 home fed back to us their concerns about being a victim of physical and verbal abuse by other people living with them. One person told us, "(Person) will grab our food and drink when we are eating it. Pulled (another persons) hair last week or the week before. I'd prefer to sit downstairs but I don't feel safe with (person) around, so I stay in my room."

The registered manager had sought advice from health care professionals in relation to the person's increased anxiety. However, there was no positive behaviour support plan in place to guide staff on how to appropriately respond to the person when at heightened state of anxiety.

● The provider had failed to provide appropriate training to staff for people that were at a heightened state of anxiety. This placed the person, other people and staff at risk of abuse. One person had managed to leave their home and enter a neighbouring home and destroy furniture. There were people at the home that were not able to mobilise which placed them at risk of harm. We saw multiple other incidents involving the same person where they had injured themselves and staff, with staff not appropriately trained to know how to respond.

● We asked staff their understanding of safeguarding and the signs to look out for. They told us, "Safeguarding is to protect me and my client." We asked whether having bruises on the person's body could be an indication of abuse. They said, "No, no, no type of abuse." This meant there was a risk staff may not

report unidentified bruising as a safeguarding concern. Care notes of 1 person identified they had large bruising over their face. Whilst the care notes stated they had handed this over to the team leader there was no additional information or any investigation into the possible cause of this injury or whether this had been reported to the local authority.

● People were not protected from the risk of financial abuse. At one of the homes there were people who had their own vehicles. There was no robust oversight or audit that petrol or diesel charged to the person's finance account were used for travel people had undertaken. Staff were required to complete a record of the mileage when the vehicle was used for the person. However, 1 member of staff told us they did not do this for 4 people at one of the homes. The registered manager told us of this home, "I didn't think it was necessary but it's a good auditing tool. "……we didn't put this in place and should have done." This meant the provider was not assured the vehicles were only being used solely by their owner.

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

Staffing and recruitment

● Prior to the inspection concerns were raised to us about the staffing levels. People we spoke with told us there not enough staff to support them. Comments included, "Sometimes I don't get my 1 to 1 hours as there's not enough staff here", "They don't have enough staff. I don't get to do any activities, nobody does here," and, "They promised me and promised me to go for (appointment), but there weren't enough staff to take me…. I don't like when things change."

● A relative told us of the home their family member lived in that required 2 staff to support them, "It's unusual for there to be 2 staff members." Another relative told us, "(Family member) needs 1 to 1 support which they couldn't possibly provide. When I take (family member) back, usually there are only 2 staff….so how can they look after everybody properly and safely?"

● We identified significant concerns of unsafe staff levels that placed people at risk of harm. At the end of each shift, staff were required to complete handover forms with details of what staff had been on duty. We found multiple instances across 10 of the homes where there were fewer than the required numbers of staff on duty.

● At one of the homes there required to be 2 members of staff on duty during the day based on 4 people's funding arrangements. We saw from the staff handover forms between 21 April 2023 and 16 May 2023 there were 7 occasions where there was only one member of staff on duty. When we arrived at the inspection there was only one member of staff supporting all 4 people whilst the other member of staff was food shopping for the home.

● The provider failed to ensure there were sufficient staff to ensure they were able to take a break. At one of the homes the person was required to have 24-hour support with a member of staff. The member of staff supporting this person told us they took 1 hours break on each shift however this was with the person who they would still be expected to support if needed. At another home 2 people required support from 2 staff during the day due to the person's periods of high level of anxiety. However, when one member of staff took a break there were no other staff available to cover this break leaving the person with just 1 member of staff that placed them, the person and other people at risk.

● At another home the care plan for 1 person stated they were required to have all male carers due to the risks they posed to female carers. Staff also confirmed this with us however we saw the person was frequently supported by female staff at night. We noted the person was frequently awake at night and required support from staff.

● We saw from staff rotas staff at times worked long hours without a break raising their risk of fatigue. For example, at 1 home 1 member worked a night shift then a full day shift following by another night shift at the service. An external professional fed back, "Staff appear to be working long days both early and late shifts at

risk of burnt out which could again lead to agitation."

The failure to ensure there were sufficient staff to meet people's needs was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider did not operate safe recruitment practices when employing new staff. Eight of the staff files did not contain a full employment history for the member of staff. Where employment was listed there was not always detail on where they worked other than the type of work they completed. 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 reference before the member of staff started work. Eight files only had 1 reference. This included 1 reference for a member of staff from their family member. The policy stated that 2 references needed to be provided with 1 being from the most recent employer. The provider had not proactively sought references in this way to assure themselves the member of staff was suitable. The registered manager said of the recruitment checks, "Sometimes we will find things we haven't done, and we need to get that sorted."

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.

Assessing risk, safety monitoring and management
● Risks to people were not appropriately assessed, or measures taken to enable people to live safely in their home. We observed from their care plan 1 person liked to regularly use their garden swing. However, when we observed the person using the swing it tipped upwards risking injury to the person. There was no risk assessment in place in relation to this.
● We saw in 4 other people's care plans information about their seizures however there were no risk assessments in place in relation to this with guidance for staff. One member of staff told us they were not sure how they would support a person with a seizure but that they would refer to the care plan. However, there was no guidance or risk assessment in this person's care plan. This meant people may not be safely supported.
● Another person was recorded to have hallucinations however there was no risk assessments in relation to this and staff lacked knowledge on how to support the person with this. The lack of assessments with guidance for staff on how to reduce the risks to people meant they may not be supported with the appropriate and safe care.
● Where risks assessments were in place staff were not always following the guidance which placed people at risk. We saw from their choking risk assessment 1 person was required to have their meal cut into small pieces and to be observed by staff when eating their meal. We saw the person's meal was cut into large pieces and staff left the person to eat their meal on their own for the majority of the time. The provider has told us this has now been addressed with the member of staff.
● Staff told us 1 person was unsteady on their feet when they went out and we saw this was recorded in their care plan. The person told us they felt 'scared' of walking long distances. Despite this there was no risk assessment in place with guidance for staff in relation to this on how best to support them.
● People's personal behaviour support plans (PBSP) lacked guidance for staff on how best to support them when they were at a heightened state of anxiety. For example, 1 person's PBSP frequently referred to the person's previous setting. It gave very little information regarding what staff can do to minimise the escalation to the next level. The guidance often just referred to praising good behaviour and ignoring negative behaviour. It did not consider how to prevent the person's anxiety increasing in the first instance.
● The provider had failed to assess the risks associated with the environment at the home they lived in. We

observed 1 person having to lift their walking aid above the raised doorstep whilst trying to hold on to the side of the door frame. The person expressed to us they had raised concerns about this before as they feared for their own safety. The provider had not undertaken a risk assessment in relation to this or taken steps to provider safer access to the person. The provider has told us they are taking action in relation to this.

● At the same home we heard a person falling in their bathroom. The person told us they had found the bathroom slippery and had raised concerns about this with staff, and there was no handrail to hold on to. The provider had not taken to action to risk assess this or provide a handrail despite the provider also being the landlord of the property. The provider has confirmed they have now addressed this.

● Staff were not supporting people with positive risk taking which was impacting on their day to day lives. One care plan detailed the risks associated with 1 person if they went to the shops or the pub. This included guidance for the staff on how best to support the person. Staff however told us they chose not to take the person to the shops or to the pub because of the risk. We found this was impacting the person's quality of life. A relative told us of this, "It would appear (person) isn't accessing the community as much as they could."

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

Learning lessons when things go wrong

● There was a lack of robust management around accidents to minimise risks to people's safety. The provider told us all incident and accidents were reported to them, analysed and preventative actions recorded. We saw from numerous incident forms very few actions were recorded from the provider's team.

● For example, we saw 5 significant incidents had been recorded for 1 person. These had all been signed off by the registered manager with the same statement of, "Staff to monitor and report any further concerns." There was no additional information on measures taken to prevent further occurrences. The registered manager told us, "We look at trends and stuff like that. Sometimes the other managers support me with that." However, we found no evidence that lessons had been learned.

● Staff were recording incidences of distress, but this information was not being evaluated to identify possible triggers and there had been no changes to peoples' s care and support.

● There were numerous incidents recorded on daily notes across all homes that had not been reported to the registered manager or provider. This meant there was a risk that any learning required may not be recognised and acted upon. The registered manager told us, "Generally I am confident they are reporting." However, we found this was not the case.

The failure to ensure incidents and accidents were robustly assessed was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● The provider failed to ensure medicines were managed in a safe way, which placed people at risk of harm. At 1 home we noted 1 person's medicine had been taken out of their labelled packaging meaning it was not clear who this belonged to. The member of staff on duty was also not aware to whom this belonged and relied upon a person to tell them. Although the member of staff had been signed off as safe to administer medicines, they told us they were not confident with information they saw on people's medicine administration records (MAR).

● Staff and a regional manager told us staff were not expected to routinely check the stock counts of medicines. We also confirmed from the MAR at all the homes this was not happening. At 1 home 1 person's medicines did not tally with how many there should have left. For example, there should have been 21 tablets left for their skin medicine but there were 22. There should have been 30 tablets for their epilepsy but

there were 32. This meant there was a risk the person did not receive their medicine when required. We fed this back to the quality manager who was present at the inspection.
● At the same home staff were routinely giving a person a medicine, that had no prescribing label, and staff had handwritten this medicine on the MAR. A member of staff told us the person's family member had provided this however they had not checked with the family member whether this had been prescribed for the person to confirm it was safe to give them. We fed this back to the regional manager who was present at the inspection. They told us the medicine had been obtained from the person's family over the counter. However, they have since asked the GP for a prescription for the medicine.
● At all homes staff told us they have to ring head office before they gave any 'as and when' (PRN) medicines to people. We saw staff had regularly recorded having to do this on people's care notes. Although we did not identify any impact from this, this meant there was a risk this could delay medicines being given to the person. One member of staff told us, "Yes it can delay."
● There was a lack of guidance for staff on when PRN anti-psychotic medicine needed to be offered to people. In 1 person's care notes it states staff should follow the PSBP guidance and if all this fails including calling the police, then to offer PRN. However, this demonstrated a lack of understanding of their anxiety by suggesting they were in control of this.
● We saw at 1 home staff had signed as already administering medicine at 20.00 however it was only 19.10 at the time of looking at the MAR. We also noted the member of staff had signed in advance of the person having their medicine the following morning and evening. They told us this had been error however there was a risk the person would not receive their medicine the following day as staff may believe this had already been administered.
● There was a lack of guidance on people's MAR for when medicines need to be given and how the person best took their medicine. One person required medications daily but there was no information on what time of day. The same person also required a medicines patch (a medicated adhesive patch, which is placed on the skin to deliver regular doses of medication). Staff were not recording where they applied the patch so they could alternate this to avoid irritation to the person's skin. The MAR also stated this needed to be changed every 72 hours however staff were recording on the MAR this had been changed every day which could reduce the effectiveness of the medicine and could mean the person is overdosed with the medicine.

The failure to ensure robust medicines management was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Other relatives fed back they felt their loved ones were safe. Comments included, "I am not concerned about (family member) safety. We know he is safe" and he always seems happy to go back."

Preventing and controlling infection
● The majority of the homes were clean and tidy. When people required personal care staff wore the personal protective equipment and disposed of them appropriately.

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 good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People were not being supported to access the health care services they needed. Relatives were not always confident that staff were supporting their loved ones with health appointments. Comments included, "(Family member) is supposed to see a chiropodist every 6 weeks and that does not always happen when it should", "[Family member] complained about toothache a few months ago. The manager was meant to arrange an appointment but that did not happen, and I had to arrange an appointment myself," and "One time an appointment was made with the GP and the accompanying staff member did not know why they were there and could give no history."
- A person's care notes identified they had complained of a pain in their groin on 2 consecutive days. There was no record of any action taken and staff confirmed with us they had not sought external health care advice but did state the person felt better.
- Where people attended appointments or had healthcare concerns this was not always fully recorded to ensure this could be monitored. One person had a health condition. The GP had stated they required to have their fluid intake recorded however staff told us this was not routinely undertaken. This put the person at risk of their health deteriorating. The provider has taken action to address this. A relative told us, "I don't get any updates as to what he's been doing, healthcare and appointments."
- Another person had a skin health condition and staff were required to monitor this and to contact the GP if they were concerned. There was no routine recording of the persons' skin condition and there was no health care plan in place in relation to this. There was no guidance for staff on what they needed to be mindful of when checking the person's skin.
- At another home there was no evidence 2 people had been supported with the dentist or optician since January 2021. We noted 1 of the people also had a health condition where staff were required to support the person to a GP appointment. The provider told us the person would have to pay for private treatment however there was no record of this in their care plan or evidence staff had supported the person to look for alternative treatments.
- Staff were at times not clear on people's health needs. We saw from a Speech and Language (SaLT) letter in September 2021, 1 person was required to have a modified diet. One member of staff told us they believed the person was still on the modified diet, yet another told us this had changed. There was no evidence this had been reviewed by the SaLT and their care plan updated. This meant the person may not be appropriately supported.

● People were not always appropriately supported with health appointments. A person had refused to attend a hospital appointment for a scan. The quality manager told us they had been liaising with the local authority learning disability team in relation to this however they were not able to provide evidence of this. There was no evidence of the use of tools such as social stories to prepare the person for appointments despite their care plan stating this was done at their previous setting.

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

● There were people who were supported appropriately with their health needs. We saw some people had been supported to visit the dentist and the opticians.
● Other relatives also fed back their loved ones had appropriate support with health care. Comments included, "(Family member) was also supported to East Surrey for an appointment with the neurologist" and "We have meetings with our (family member), the provider and psychiatrist."

Staff support: induction, training, skills and experience
● The provider had failed to ensure suitably qualified and skilled staff were deployed to meet people's needs. Agency staff were providing support to people with a learning disability, autism and mental health needs but they had not received training in relation to this. They also lacked an understanding of what these conditions were. This meant there was a risk people were not going to receive appropriate support.
● We spoke to substantive staff who also lacked an understanding of people's specific health needs. One person had a rare genetic condition that affects the nervous system. The member of staff supporting them was not aware of this condition and told us, "I can't remember but it sounds familiar." People had other rare conditions however this was not included in staff training. One member of staff told us, "Im still in the phase of training, I think they could give us more training on a person's care needs." This meant staff were not fully equipped to support people with these conditions.
● Relatives felt staff were not appropriately trained. Comments included, "I wonder sometimes how many of the staff are suitably qualified", "People (staff) on the ground are so lovely, but they haven't been given the information or training (about their family member's needs)" and "I feel staff training needs to be looked at."
● During our inspection we found shortfalls in the practices of the staff, registered manager and provider including assessing people's capacity, the management of risk and safeguarding processes. This meant the training provided was not effective in ensuring the most appropriate care was being given.
● Although the provider confirmed staff had received breakaway training (designed to help 'at risk' staff groups remove themselves from potential harm) staff still had a lack of understanding of how to apply this. One member of staff was supporting a person where this training might be required. They could not recall the training or whether they had received this. This meant there was a risk the staff member may not use appropriate break away techniques if required.
● Supervisions were not effective in identifying poor practice at the service. 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. All the supervisions for staff were either identical pre-completed forms with information either about people or guidance from the provider. One member of staff told us, "I've not had supervision. I've not been told how often I should be having them." A relative told us, "The staff do not seem to be checked on or monitored, which is a concern."

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 eat and drink enough to maintain a balanced diet

● Staff were not always encouraging people to maintain a healthy diet or respecting people's choices with meals. We observed some people were given nutritious choices of meals, but this was not consistent across all homes.
● A person was frequently provided the same meal of fish dishes for supper. There was nothing in their care plan around the person's preference for fish and staff confirmed this with us. They told us as they bought the person food in bulk as this was a way of using the food without wastage. This meant there were limited options for staff to offer this person.
● People were not always supported to make their own meals despite people telling us they would like to. People were also not given a choice to buy individual food related to their preferences. Our observations during the inspection were that the meals provided to people were all processed and there were no fresh fruit and vegetables.
● One person was provided with a microwave meal of pasta along with frozen vegetables. They were not asked if they wanted this, and the person was seen to tip the majority of their food in the bin. The person's care notes make reference to when they liked their meal, they would eat it all. Staff were not aware of the person's preferences with food. Their care plan stated they did not like salmon however staff told us they would still offer the person this.

As people's choices and independence was not considered this is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were people who told us they were happy with the meals provided. There were relatives who felt their loved ones were supported to eat healthily. Comments included, "There is always fruit available when we go there" and "She is quite happy with the food."

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.

● Where decisions were being made for people, there was not always evidence their capacity had been assessed. For example, 1 person had a lap belt when in their wheelchair. There was no capacity assessment in place for the person or evidence of any discussion had taken place to determine this was in the person's best interest. Two people had bed rails and there was no evidence their capacity had been assessed in relation to consenting to this restriction.
● Where people had other restrictions placed on them there was no assessment of their capacity to

determine whether they were able to consent to this. A person was restricted from having sweet treats. The person told us they did not understand why this was. There was no capacity assessment or evidence of any best interest meeting in relation to this.

● Restrictions were being placed on people without their consent. Staff told us they woke a person up in the morning at the relative's request regardless of how they slept the previous night. Staff told us the person had full capacity to make their own decisions and they felt should be able to make their own decisions about when they wanted to get up. There were no records in the care plan to confirm the person had consented to being woken up each morning.

● We saw from 1 person's care plan they were responsible for paying £50.00 for the 'house' food shopping. There was a risk people would be subsidising other people's diets depending on their needs and preferences as the person was not allowed snacks due to their health condition. There was no capacity assessment in relation to finances within their care plan. This was also the case for multiple other homes where they had the same arrangement.

● The majority of staff were not able to explain the main principles of the MCA and were not able to tell us how and when the MCA should be put into practice to ensure restrictions to people's freedom were monitored. One member of staff told us it meant, "People have got challenging behaviour and they don't know what they are doing." This did not demonstrate a clear understanding of their responsibilities under the MCA.

The failure to ensure the principles of the Mental Capacity Act 2005 were consistently followed was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

- People said they did not always feel listened to. One person said they were told they could not meet with friends as staff wanted them to go to another person's appointment with them. They told us, "I was forced to go out and I didn't want to."
- People fed back to us how unhappy they were as the provider had removed some of their personal items from their home without being asked. Although they said they now had these items back this left them feeling upset, and not feeling relaxed in their own home. We fed this back to the nominated individual who told us they would meet with the people.
- People were not always treated in a kind and caring way. There were times at the homes we visited where staff did not engage with people they were supporting. At 1 home a person was not spoken to or communicated with for a period of 2 hours. The person was left sitting on the sofa with no interaction from anyone. One relative told us, "I often think though when I go, the staff hardly talk to me, so how much do they talk to (family member)."
- We observed staff were supporting a person with their meal. Staff did not interact with the person at all. Two members of staff were supporting another person and were continuously repeating the person's name rather than interacting with them.
- We observed a member of staff giving medicine to a person in a syringe and applying their creams in the lounge in front of us and other staff. The member of staff did not attempt to ask the person if they would like to go somewhere more private which would have been more dignified for them.
- Staff at times were recording people's care notes in a disrespectful way. We saw in 1 person's care notes the person's continence aid was, "Wet and heavy because of s**t." In another person's note it referred to the epilepsy monitor as a baby monitor and beds rails were referred to as cot sides. These terms were not appropriate for an adult and did not support people's dignity. In another care note it referenced people were not going to have a smear test as they were a virgin. This was a completely unnecessary and undignified comment relating to people. There was also frequent reference in people's care notes of them going on, "Home leave" rather than 'visiting their families.'
- People were not always supported with their independence skills. One relative said, "I would like to see (family member) have more independence." We saw from their care plan a person was able to eat independently. However, staff told us they would not allow the person to do this as the person would make a mess. At the same home it was recorded the person enjoyed making their own meals however there was no evidence staff were supporting the person to develop these skills. An external professional fed back to us

there was, "No evidence of encouraging skills development."
● One person preferred to have a bath than a shower. Records showed the person was not supported to have any baths which was their preference. This did not demonstrate respect for their views and choices.

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.

● Whilst we found some poor interactions, there were kind and attentive staff at some of the homes we visited. Comments from people about these staff included, "The staff are very nice, and very caring" and "I love the staff we have here." Relatives' comments included, "The care workers are kind and caring" and "(Member of staff) is lovely; she is a mother figure, and she really cares about them."
● At 1 home a person frequently needed reassurance they were liked by staff, and we observed staff doing this. This helped the person feel more relaxed. At another home there was a pleasant rapport between 1 person and a member of staff. We saw they got on well and had friendly banter.
● At 2 other homes we saw friendships had formed between the people living there. At 1 of these homes people referred to each other as 1 family and we observed them sharing humour and participating in an activity together. When a person became upset staff were quick to reassure them and offered to blow dry the person's hair as they knew this would relax them.
● There were people who were more independent and took pleasure in undertaking household chores. One person was seen to do their own laundry and fold their clothes away. At another home staff were supporting 2 people to make their own cooked breakfast with both people taking the lead.
● One member of staff told us at 1 of these homes, "I think it is so important that we encourage people to be as independent as possible, even if it is around what cup they would like. I think this is only respectful to the person. It is important not to undermine the person." Another told us, "We are in people's homes as their guests, this is something I never forget."

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question outstanding at this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs

● Relatives told us they were not always involved in reviews of their loved one's care. Comments included, "We have been to review meetings, but they are a bit haphazard, they are not regular", "We haven't had a review for at least a couple of years. I am an active parent and like to be involved", "We want to be involved in his care, but I don't think they take it on board" and "The family have not been involved in creating his support plans and have never seen any of his support plans or been asked for feedback on these."
● Information in people's care plans was not always reflective of their preferences and needs. One member of staff told us it was important for a person to have particular radio station on every day. However, this information was not in their care plan. Another care plan stated the person was completely continent and independent with toileting, but their care notes described the person had been incontinent and required assistance. This meant staff may not provide the right level of care and in line with people's needs, wishes and preferences.
● Care plans lacked detail around people's life histories to help give staff a real sense of the person they were supporting which would have a positive effect on their relationship with them.
Staff we spoke with did not have a knowledge of people's life histories. One member of staff knew the person's immediate family but told us, "I don't really know anything else." Another told us, "I don't know anything about his background." A relative told us, "I think some staff don't particularly want to know her or want to engage with her." Having a good understanding of a person's history can also help staff to understand why they behave a certain way and ensure the persons needs are met.
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 had not always considered people's individual needs to communicate with people in ways they understood. We did not observe staff using accessible ways to communicate with people during our visits. One relative told us, "They (staff) sometimes seem to not always explain things well to her. It's about the way you communicate with her to make sure she understands."
● One person's care plan stated staff should use 'Now and Next' photo cards and photos for communication. However, staff we spoke with at the home told us these communication aids were not

used.
● In another person's care plan an occupational therapist had recommended the use of a communication aid on the person's electronic tablet. However, a service quality manager said this was not used as the software needed to be installed again. There was no evidence this was being addressed.
● Some people communicated with us using Makaton (a simple and easy way of communicating using signs, symbols and speech) and it was clear from their care plan this was how they communicated. We did not see staff communicating with people using Makaton. One member of staff told us they did not use Makaton but that, "I understand what (person) wants." One relative told us their family liked to use this way of communicating but that, "Staff don't ever do Makaton with (family member)."

Care and treatment was not provided in a way which met people's individual and most current needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; End of life care and support
● The provider had not considered the guidance around Right support, Right care, Right culture which advises social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence, and good access to local communities that most people take for granted.
● People told us they did not always have the opportunity to go out. Comments included, "I get disappointed when outings get cancelled for various reasons" and "I don't go out by myself anymore, but it is something I'd like to work towards doing." Comments from relatives included, "She doesn't do much. They don't take her out", "(Family member) always sat there on their own on the sofa bored" and "He gets his 1:1 hours, but I don't think they utilise those hours as activities" and (Family member) does very little."
● People were not supported with meaningful and person-centred activities. According to 1 person's care plan they liked to go out each morning and it was important for staff to stick to this routine. Of the 24 days the person was at home in April 2023 there were 12 occasions where the person did not go out. We saw from daily notes when the person did go out this was, at times, just a drive in the service vehicle, to pick up other staff that were coming on duty.
● A person told us they really enjoyed going to a day centre. According to their care plan they were supposed to be supported to go 2 to 3 times a week. However according to their care notes, they only attended 4 times in January and February, 3 times in March and 7 times in April 2023.
● Records did not demonstrate people were having a full and active life. Some people's care notes showed their activities were often limited to getting takeaways, shopping and going for a walk. Comments from relatives from this home included, "The only issue is the activities. They need to do more", "We want (family member) to do more", "(Family member) needs longer walks and I don't just mean in local Park. (Family member) needs a whole afternoon out with a picnic" "and "Activities? They are all down to me. I think there is too much telly watching by staff. I would like activities to not always be my job."
● Whilst there were no people nearing the end of their lives, there was very little evidence of any discussions that had taken place with people, or their families should this change. Where end of life care plans were in place these were generic and did not reflect the person's life. We saw from 1 care plan the person was a Christian and went to church every Sunday however their end-of-life care plan stated they did not practice any religion.

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

● There were people who attended day centres and educational settings on a regular basis. Those people who were more independent also enjoyed meaningful and person-centred activities. There were also people

that had been supported on a holiday from 1 of the homes.

Improving care quality in response to complaints or concerns

● People and relatives did not always feel confident in raising a complaint. One relative told us, "If you want to complain about (provider), there is nowhere to go to get a proper response. It is hard to complain, it is scary. They can be quite intimidating."

● Other comments from relatives included, "There are very good at doing that, promising things and it doesn't happen", "I have spoken to (provider), and she has been good at getting things sorted but unless you speak to her, nothing gets done [about concerns]", "(Provider) are very hit and miss. They have always been slow to act on concerns" and "They did not provide an appropriate and timely response (to our complaint) and it feels that issues we have raised have not been prioritised."

● Complaints were not always recorded and responded to appropriately. People fed back to us they had made complaints to the registered manager about the conduct of the provider. Although this was being investigated by the local authority there was no record of this in the complaints folder. There was an email to 1 of the people affected from the provider however there was no evidence other people affected had been written to and apologies made.

As complaints were not always recorded and responded to appropriately this is a breach of Regulation 16 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 good. 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

- People and relatives fed back their concerns about the leadership of the service. Comments included, "I find head office completely unreasonable and difficult to communicate with", "It is almost frightening to ring the office because you might get a rude answer," and, "There has never been anyone reliable at the office."
- The provider and registered manager had failed to demonstrate a set of values they expected staff to embody when supporting people. As previously reported under Caring, the provider had entered 1 home without gaining consent from people living there. During this the provider removed people's personal items without consulting with people first. This did not demonstrate respect for people's rights and did not promote a positive culture.
- There was a note from the provider in staff communication book in January 2023 telling staff they needed to turn off the heating in the house as bills were too high. Again, this was without consulting with people who were paying the bills.
- Staff communication records showed the provider had told staff, "Social services are visiting the homes without any notice. Please ensure that the homes are presented immaculately as well as the service users doing activities, etc." This was not encouraging staff to ensure this was done regardless of who may be visiting the homes.
- People were not being supported to lead meaningful and empowered lives. There was a lack of management and provider oversight to ensure people had access to activities there important to them.
- During the inspection concerns were raised with us from relatives and people about the demeanour towards them by a senior member of the management team. We also observed this demeanour whilst at one of the homes towards staff. We fed this back to the nominated individual and the member of staff about how this behaviour could impact others.
- The governance in place was not robust in ensuring audits identified the shortfalls we identified at the inspection including the lack of activities. The registered manager told us they had no concerns with activities and said, "I am really proud…we do a lot for people. I have no concerns for my service users." This was despite the nominated individual telling us they had already identified the lack of activities before we inspected.
- Neither the provider or registered manager had identified the concerns around staff levels, staff not always taking breaks and working long hours. The registered manager told us, "We do our best to make sure staff levels are kept up. Staff don't feed back concerns about staff levels."

● The providers mission statement on their website stated, "We are committed to providing each service user with a support plan that promotes his or hers ongoing development in a stimulating environment, in which each individual is supported in progressing along their bespoke care pathway towards greater independence." We found this was not the case.

The failure to ensure robust and effective quality assurance systems were in place was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; 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; Working in partnership with others

● People were not involved in the running of the service and as such were unable to influence positive changes. The registered manager confirmed the last survey that was undertaken with people was 2022 and there was a low response of just 4 responses. This was because the survey was undertaken online, and most people would have not been able to access this. The registered manager had recorded surveys needed to be undertaken in an easier read format for people however no action had been taken to do this. The registered manager told us, "We could do more to empower people more to be included in the running of the service."
● Relatives were invited to complete a survey in May 2022 however again there was very little response to this. One of the actions from this was to, "Improve going forward; we need to ensure Team Leaders are having regular contact with families and record on MCM." However, feedback from relatives was that communication was still poor. One relative said, "Sometimes I just don't think they listen."
● Staff were not always given the opportunity to attend meetings to feedback on improvements they would like. The registered manager confirmed there had only been meetings at 2 of the 15 homes. They told us, "Unfortunately not all Team Leaders are doing them regularly and I will be ensuring going forward from June 2023 all Team Leaders are doing staff meetings on a monthly basis."
● We saw a staff survey in October 2022 which again had a very low response, one of the actions was, "To improve going forward; we need to ensure staff feel they have a say in the running of Mitchells through gaining feedback in staff meeting." This had not been actioned which meant there were lost opportunities to get valuable feedback from staff.
● Where incidents and accidents had occurred, we noted from the records 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. There was also no evidence of any learning from these incidents.
● The local authorities who funded the care for people at the service told us they had not been made aware of the low staff levels at or all of the incidents with people. We saw 1 person had over 32 incidents between December 2022 and 20 May 2023. The funding authority told us they had not been made aware of the majority of these.

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

● Staff we spoke with were mostly positive about whether they felt supported. Comments included, "I am supported by everyone" and "We have a very good team, we all help each other which is very good for the client. I am very happy to be in this company."