Mitchell's Care Homes Limited

Rainscombe Bungalow

Inspection report

Rainscombe Farm
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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?	**Requires Improvement**
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 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 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. People were not supported to live independent lives or access meaningful and person-centred activities. Risks were not being managed well and health care professional advice was not being followed in relation to people's care.

Right Care
People were not protected from abuse and neglect from staff. There were not always sufficient levels of staff deployed to ensure safety of care. There were not sufficiently trained or supervised staff to meet the needs of people. Incidents of anxiety and epilepsy were not always recorded in sufficient detail to look for trends and themes. Staff were not always kind and respectful towards people. People were not always given choices around their care.

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. The provider and staff did not recognise how to promote people's rights, choices or independence.

Rating at last inspection and update
The last rating for this service was inadequate (published 31 May 2023).

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

We have found evidence the provider needs to make improvements. Please see the safe, effective, caring, responsive and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement and Recommendations
We have identified breaches in relation to 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, lack of person-centred care 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 the registration.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Rainscombe 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 2 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 however an application had been submitted. In this report we will refer to the 'manager'.

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 spoke with 1 person about their experience. We spoke with 3 relatives, 1 advocate and 3 external professionals. We spoke with 9 members of staff including the provider, senior management team, the manager and care staff. We reviewed a range of records. This included 6 people's care records and multiple medication records. We looked at 3 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 inadequate. At this inspection the rating has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

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

At the last inspection we found risks associated with people's care was not being managed in a safe way. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had not made sufficient improvements and remained in breach of regulation 12.

● At the previous inspection we found risks associated with people's skin integrity were not being managed well. We found 1 person's pressure-relieving mattress was not being set correctly based on their weight. At this inspection this concern remained and on both visits to the service the mattress was not set correctly. This meant the effectiveness of the pressure-relieving mattress was reduced.
● Where people were at risk of malnutrition this was not being managed in a safe way. We saw from 1 person's weights they had lost a significant amount of weight between April and August 2023. This had not been identified by the provider or manager at the service and it was only when a visiting professional raised this in August, action was taken. A visiting professional told us, "The graph [weight chart] was startling and they had not picked up on that."
● Where a risk had been identified, staff were not always following the strategies in place to reduce the risk of harm to the person. There were 2 people at risk of choking and were required to have pureed meals based on guidance from a speech and language therapist (SaLT). Staff were frequently pureeing unsuitable foods for both people including, salads, cakes and pastries. They were also being given bread dipped into soup which is not suitable for people on a pureed diet unless specifically advised by the SaLT. There was out-of-date guidance for staff taped to the wall in the person's room and there was a risk staff would follow this. This meant that people were placed at further risk of choking. We asked the provider to address this immediately.
● There were people at risk of constipation however there was no formal monitoring of their bowel movements. According to 1 person's bowel charts they had not opened their bowels for a period of 12 days. There was no investigation into whether this was a recording issue or whether the person was constipated. One external professional told us, "It should be a good practice and best practice to record bowel movements." Constipation can be a life–threatening issue for people with a learning disability who are at heightened risk from complications if it is left untreated. This meant not monitoring this left people at further risk.
● People were at risk of getting an infection as infection control practices were not always robust. One person's chair in their bedroom smelled strongly of urine. Another person's commode had not been cleaned after use and their toiletries had been left on top of the commode toilet seat which increased the risk of cross-contamination.

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

● Environmental safety checks were being undertaken including legionella checks and fire safety checks.

Learning lessons when things go wrong

At the last inspection we found accident and incidents were not always being reviewed and analysed to look for themes and trends. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had not made improvements and remained in breach of regulation 12.

● As at the previous inspection, 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 found in 1 person's care plan they may have a seizure when at a heightened state of anxiety. There were several references to the person having seizures in the care plans. There was no analysis of this to determine the possible cause of the seizure to reduce the risk of them occurring. The seizures were not always being recorded as an incident so there was a risk this was not being flagged by the manager. The manager told us, "I haven't recorded them as incidents. I wasn't aware I needed to." However, this same concern was raised at the last inspection.
● A member of the provider's team told us all incidents of heightened anxiety were recorded electronically on behaviour charts. However, as on the previous inspection, these lacked detail on what preceded the incident that led to the anxiety. For example, 1 incident recorded [Person] was sat in the lounge and holding and slapping their head and crying loudly. There was no detail on what the person had been doing prior to this that may have led to the person reacting in this way. There was no analysis of the incidents to look for trends, themes and triggers to try and reduce the risk of incidents. This meant the provider was failing to do all that was reasonably practicable to mitigate the risk of future occurrences.

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

Systems and processes to safeguard people from the risk of abuse

At the last inspection we found people were not being protected from abuse and neglect. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, there had not been sufficient improvements and the provider remained in breach of regulation 13.

● Although relatives felt their loved ones were safe, we found people were not protected from the risk of abuse and neglect. As found at the last inspection, staff had received safeguarding training, but they were not always recognising or reporting abuse. A visiting professional told us they witnessed a person expressing they wanted to harm themselves. This had not been recorded in the person's notes or recorded as incident by staff or reported to the local authority.
● There was a risk, at times, people were being given too much 'as and when' anti-psychotic medicines to manage their anxieties. We saw from 1 person's 'as and when' medicine chart, they had been given 9 doses of anti-psychotic medicine in November 2023. The majority of this was given whilst the person was on holiday with staff. Not all of these incidents had been recorded either in the care notes or on an incident

form and for those that were recorded, there was not sufficient detail to ensure staff followed the person's 'Personal Behaviour Support' plan before they administered the medicine.

● One visiting professional told us, "[Person] would need a lot of preparation before going on holiday. Their [staff] go to with her agitation is PRN [as and when medicine]. I would expect [person] routine to be kept the same as much as possible on holiday." There was a lack of recording to show whether the person's routine had been maintained or risk assessed.

● The provider's safeguarding policy stated guidance around when the 'as and when' medicine should be given, should be reviewed and updated if the person is not in their usual environment. We found this had not been done for this person or another person whose 'as and when medicine' was also given more frequently whilst on holiday with staff. Again, there was a lack of recording to show whether the person's routine had been maintained or risk assessed.

● At the previous inspection in April 2023 we fed back the service felt cold. On day 1 of this inspection, we found the home was colder, the windows were open in people's bedrooms and people's hands were very cold to touch. A member of staff told us the radiator in the lounge was not working properly however we found all areas of the service were cold. One person had been supported to bed and was sleeping however no bed covers had been placed over them until we asked staff to address this.

● Concerns around the coldness of the service were recorded in the daily notes from two visiting professionals prior to our inspection. One told us, "[Person's] hands were freezing and [member of the provider team] just said, 'So are mine'. It was cold there. It was cold in there and they had the window open. The front door was open, and it was broken, and they were not doing anything to support people to keep them warm." Despite this being raised, sufficient action had not been taken to ensure people were living in a warm environment.

● On day 2 of the inspection, we were told the heating had broken down and whilst they had called for an engineer to fix this just prior to us arriving, staff left the kitchen and laundry windows open.

● The provider's policy stated, "Failure to provide access to appropriate health, care and support…..., the withholding of the necessities of life, such as ……. heating." We found the provider was subjecting people to neglect as they had not ensured the service was appropriately heated.

● We observed 1 person push a member of staff's hand away from them and flinched when the member of staff stood up next to them. We raised this with the manager who told us this is a normal behaviour for the person. However, when we checked the person's care plan, there was no reference to this behaviour, and we did not observe the person behave in this way to any other member of staff. The manager did not ask us for any more information relating to this and we have reported this to safeguarding.

Failure to ensure people were protected from abuse or neglect was a repeated breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Using medicines safely

At the last inspection we found medicines were not being managed safely. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, whilst there had been some improvements, the provider remained in breach of regulation 12.

● Whilst most people received their medicines as prescribed, there were elements of the management of medicines which were not undertaken in a safe way. On day 1 of the inspection, people were assisted out to an activity. Staff were unable to take 1 person's medicine with them, which was due whilst they were out. A member of staff told us this was due to there not being an appropriate container to store the medicine as the service next door was using this. This meant there was a risk the person would miss their prescribed medicine.

● On day 2 of the inspection, we saw this medicine was recorded as being given at 14.00 on day 1 however we did not leave the service until 14.21 and the person was still out on an activity. This meant, there was a risk, there was not sufficient time between doses as staff were not accurately recording when it was given. This meant that medicines were not given in a timely manner which could affect the effectiveness and increase the possibility of side effects.
● The temperature of the medicine room was not always being appropriately monitored. The medicine cabinet was kept in the office which was the only room that was very warm and as a result there was a risk medicines were not being stored in line with manufacturers' instructions. A member of staff told us the temperature in the room needed to be kept below 25 degrees. However, we noted the thermometer in the room on day 1 of the inspection was showing a temperature of 26 degrees.
● There were people who required half of a tablet with each dose of their medicine. Staff were using a pill cutter to halve the tablet. However, they were leaving the remaining half in the pill cutter rather than storing it in sealed container. This had also been identified by a member of the provider's team however they had not taken any steps to address this until we raised it. This meant medicines were not stored safely or securely in line with best practice guidelines.
● Although staff were given medicine training and had been competency assessed, this was not always effective in ensuring good practice. We also found 1 member of staff giving medicines was not familiar with why the person required the medicines. The same member of staff was also not on the designated list of staff to administer medicines. The provider's representative told us, "They [staff] need to know what medicines they are giving people."

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

Staffing and recruitment

At the last inspection there were not sufficient staff to support people in a safe way. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we did find staff levels had improved however there remained concerns and the provider remained in breach of regulation 18.

● There were not sufficient staff deployed to manage people's needs in a safe way. We saw from rotas, for the majority of time there were 5 staff in the morning and 4 in the afternoon determined as safe levels by the provider. This was an improvement from the last inspection. However, during day 1 of the inspection, 5 people went out and 1 person was left at the service who required to be repositioned by 2 staff. Of the 2 staff remaining, 1 carer had not been trained to reposition and the other was a member of the provider's team who had not received up to date moving and handling training. A member of the provider's team told us the carer frequently stayed on their own at the service with the person who needed repositioning. This meant they were repositioning the person on their own and putting them self and the persona at risk of harm and injury.
● In the afternoon staff levels reduced to 4. The manager and staff told us this impacted on how frequently people could be supported on activities in the afternoon particularly as 1 person was funded to have a carer to be with them during the day and 2 staff whilst they were out. This left 5 people, all requiring 1 member of staff each to be with them when they went out which restricted external activities. A member of staff told us, "I think 5 [in the afternoon] would be good. We have some clients who are 1 to 1 at all times. So, if we have 1 with [person] then it's just 3 for the others." Although the manager said they could plan for a floating member of staff to assist with activities this would have to be planned as opposed to any impromptu external activities people might like to take part in.

● At night-time, staff reduced to 2 carers. We noted in 1 person's care plan staff were required to sit outside the person's room to 'monitor' them. It stated this was required as the person may get up to use the toilet and due to their poor vision, they could hurt themselves without staff support. We also noted from the care notes there were multiple times the person went to the toilet in the night or was awake with staff in the communal areas. On one occasion it was recorded the person was up all night and it was recorded they had bruises on their face that may have been as a result of falling. However, 2 staff were also required to reposition a person through the night.

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

At the last inspection the provider was not operating a robust recruitment process. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found there had been improvements and the provider was no longer in breach of regulation 19.

● Whilst the provider was now seeking character and employment references for staff both. These were not always from the prospective staff member's most recent employer. In 1 instance the reference was not sought from a health care employer where it might have been more appropriate to do so. We fed this back to the provider who told us they would address this. We did see 2 references were present for each member of staff.
● In other areas the provider operated effective and safe recruitment practices when employing new staff. This included obtaining a full employment history, health questionnaires and checks with the disclosure and barring service (DBS). DBS checks are carried out to confirm whether prospective new staff had a criminal record or were barred from working with people.

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

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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

Staff support: induction, training, skills and experience

At the last inspection we found staff had not received adequate training, knowledge and competency checks. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, this had not improved, and the provider remained in breach of regulation 18.

- At the previous inspection we found not all staff had received appropriate training in relation to their role. This remained a concern. There were people that required puree meals however none of the staff had received training in how to prepare this. We saw staff providing inappropriate meals to people on a pureed diet. All the staff we spoke with were unclear on what was safe to prepare for a pureed diet. The provider has confirmed training has now been provided.
- The provider sent us an updated training matrix and we found not all staff had received their mandatory training. For example, there were staff regularly working at the service who, according to the schedule, had not completed any of the mandatory training including autism awareness, first aid and epilepsy awareness. This was of particular concern as 1 of the members of staff told us they were at times the senior on shift. This was also confirmed from an audit where they were recorded as, "The person in charge."
- As in the previous inspection, 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. This meant the effectiveness of the training was reduced. We found multiple areas of poor practice by staff including the management of risk, medicines and the understanding of the principles of Right Care, Right Support and Right Culture. A member of staff told us, "I would like more training." This meant the training provided did not always support staff to meet the care needs of these they cared for.
- Supervisions remained ineffective 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 of the supervisions for staff were around training and messages from the head office. The manager told us, "It's [supervision] an opportunity to teach and guide in the right manner, my general feeling is that they have gained knowledge." However, they had not considered supervisions to be an opportunity to reflect and review individual staff progress or areas for personal development.

The provider failed to ensure there was adequate training, knowledge and competency checks which is a repeated 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

At the last inspection we found people's health care needs were not effectively being monitored. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, this had not improved, and the provider remained in breach of regulation 12.

● As in the previous inspection, where people received healthcare treatment, this was not always accurately recorded and followed up to ensure this could be monitored. A health care professional had recommended 1 person to have caffeine-free drinks due to a health condition. We found the person was regularly being given drinks of tea which were not decaffeinated. It was only after we raised this the provider purchased caffeine-free tea.
● Another health care professional asked staff to record and monitor the impact of reducing a medicine for excess salivating. When we checked the person's care notes, there was no record of any impact recorded of the reduction of the medicine. This meant there may not be accurate information to feedback to the professional on the review with them and may impact the ability to plan individualised care.
● Staff were also required to be recording how often the person was anxious about wearing head protection. We observed the person being anxious about wearing this however staff were not recording this. Staff we spoke with were not aware they had to do this.
● We saw in the care notes 1 person had their tooth removed in September 2023. The guidance from the health care professional was the person should not have hard food on the day following the procedure. Notes recorded however the person was given chips for their evening meal. This may have caused discomfort for the person who would not have been able to communicate this. This could have also caused post procedure complications.
● The provider reported a safeguarding concern to the local authority in August 2023 as staff had not been following health care advice. Despite them being aware of this concern, the provider failed to put processes in place to monitor staff were now following the correct guidance from professionals.

The failure to ensure people's health care needs were effectively monitored was a repeated 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

At the last inspection 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. At this inspection, this had not improved sufficiently, and the provider remained in breach of regulation 9.

● Care and support was not always planned and delivered in line with current evidence-based guidance. Although the provider had tools to assess the changing needs of people, these were not being updated when required.
● For example, the manager told us 3 people had lost weight over a period of a several months, yet their nutritional risk assessments did not reflect the weight loss. There was no assessment of the MUST tool (a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition). It was not until we

pointed this out that the MUST tool was reviewed for people.
● As found at the previous inspection, there were people who had lived at the service many years and whilst there had been an assessment of their needs and choices this was not reviewed regularly with the person. Each assessment just stated the person was unable to participate.
● Since the last inspection, whilst there had been some improvements with the décor, the service environment was not always set up to meet the needs of people. There were people who were visually impaired and those whose mobility had reduced. There were no handrails around the home to support the people to access the service independently.
● Whilst there was now a separate sensory room, there were no sensory lights or curtains in there at the time of this inspection. We saw from the care plan; the sensory lights would greatly benefit 1 person that lived there.
● Although a sensory board had been placed in 1 person's bedroom who was visually impaired, this had been blocked by a chair, so they were unable to access this.

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 repeated 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
● People were not offered choices of drinks and meals. On day 2 of the inspection there were people asking for hot drinks. Staff were giving people cold drinks and told us this was because they had a hot drink that morning. Staff said there was no reason they could not have been given the hot drink they had requested.
● We asked a member of staff how people chose their meals and 1 told us, "I might present two or three things and ask them to choose what they might like." We did not see this in practice.
● There were 2 people who were offered and refused their evening meal. Staff did not offer an alternative hot meal but instead offered 1 person puddings instead. The meal provided to people on a pureed diet also looked unappetising.

We recommend the provider offers people a choice of nutritious meals and drinks.

● There had been some improvements in the meal experience. The tables and chairs in the dining had been arranged so people could choose to sit on different tables. Where people required support with their meal staff were providing this. For example, where people required to have a 2-plate system [food from 1 plate slowly placed on another plate to prevent the person eating quickly] staff were supporting them with this. One person was given a plate guard to assist them to eat independently.
● The non pureed meal looked appetising and was cooked from scratch and we saw 1 person enjoying this meal whilst other people had been taken out for dinner.
● There was information available for staff on the types of food people preferred. One person had specific 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.

● Staff had 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, health treatment and bed rails.
● Staff had undertaken MCA training and were able to explain their understanding of the Act. A staff member told us, " It's about someone being able to make a decision on their own. Getting information and retaining it longer enough to make a decision. We must assume they are able to make their own decisions. Support them to make decisions."

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 inadequate. At this inspection the rating has remained 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

At the last inspection we found people were not treated in a kind, respectful and considerate way. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, this had not improved, and the provider remained in breach of regulation 10.

● As identified at the previous inspection, people were not 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. We saw from meetings with staff this had also been identified by the management team. Insufficient action had been taken to address this.
● During day 1 of the inspection, 1 person's face was wiped with a cloth by a member of staff which visibly startled the person. Without speaking to the person, they were then moved in their wheelchair into the lounge.
● There was a lack of consideration for those people who were distressed with sudden loud noises. On day 1 of the inspection, a maintenance person started drilling in 1 of the bathrooms and a leaf blower was being used in the garden. It had not been considered both of these jobs could have taken place when people went out on their external activity to reduce the stress this caused particularly to 1 person that was vocalising in an anxious way.
● The chairs in the dining room had no rubber feet on and subsequently each time a person stood up their chair quickly there would be a loud screech noise. The television in the kitchen was also playing loudly and it was difficult to hear people speak. This was also a concern raised by a visiting professional.
● Staff did not approach people in a considerate and caring way. One person was anxious and was crying. Rather than reassuring the person, a member of staff said repeatedly, "[Person], stop crying, stop crying" as they needed to place medicine in their mouth. Another person was falling asleep during their meal. The member of staff started clapping their hands in front of the person's face saying, "[Person] wake up, why are you sleeping?"
● Another person was calling out for their family member which was ignored by staff. Staff said this was normal for them however there was no record in their care plan this was a normal behaviour for them. One relative told us, "When I was there, there was 2 members of staff there, they didn't give me the impression they cared, they were just standing and smiling."
● Staff had not considered the needs of autistic people in relation to their routines that were important to

them and, according to their care plans, not liking having to wait. A provider's representative told 2 people they were being taken out for a meal and asked staff put the people's coats on. However, it was a further 40 minutes before people were assisted outside

● The recording of care was not always undertaken in a respectful way. There were multiple references to people 'refusing' either an activity or care, rather than staff recording the person chose not to participate. There was guidance written in 1 person's care plan around a person's medical condition, but the guidance referred to a child's diagnosis and made references to 'tantrums.'

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

● 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

At the last inspection we found people were involved in decisions around their care. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, this had not improved, and the provider remained in breach of regulation 10.

● As found on the previous inspection, people on the whole were accepting of the way they lived their lives at Rainscombe Bungalow. However, we found people's individual wishes and needs were not considered. Instead, we found people's wishes and wants were secondary to how the service was run based on staff routine. We saw from care notes most people were supported to bed before the night staff came on duty at 20.00. We saw most people were supported with their morning personal care before the day shift came on duty the next day. It was unclear if people wished to get up early and go to bed early or if they wished to sleep until later on in the morning

● There was no evidence in care plans people and relatives (where appropriate) were involved in the planning of their care. Although people's rooms had been painted, they 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 as identified at the last inspection. Despite their care plans stating, "… I have my own bedroom which has been adapted to my tastes." One visiting professional told us, "Bedrooms are plain and not how I would want them to be."

● We noted from the staff diary 5 people were to be taken to have their hair cut on the same day. There was no information to suggest people had been asked if this is what they wanted or why they all had to go at the same time. We saw from daily notes 1 person declined to have their hair cut when they got to the hairdressers.

As people were not considered and involved in decisions around their care this is a repeated breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

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

At our inspection in March 2023, we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant people's needs may not always met.

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

At the last inspection we found people were not supported with meaningful, person-centred activities. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, although there had been some improvements the provider remained in breach of regulation 9.

- Right support, right care, right culture guidance (RSRCRC) focuses on people being enabled to live a meaningful life and as such we expect services to give people every opportunity to reach goals, try different things and lead as normal a life as possible.
- Since the last inspection external activities had increased for people. However, this was not consistent and not always fully planned. For example, people were supported to a local activity centre where they could participate in dancing and sports. However, we saw from daily notes these sessions were not booked in advance, as recommended by the centre, and therefore people had been turned away on several occasions as it was fully booked. One relative told us, "I want to see a sustained thing to keep [person] engaged."
- We saw from the care notes people were supported with board games and arts and crafts. However, they were the same games and crafts, and no indication people chose the games they would like to play or offered a variety. This was also identified as a concern by the manager as recorded in the staff meeting minutes. A visiting professional told us, "Activities are really very poor, they [staff] don't consider what board games [person] could engage with."
- There was little opportunity to participate in 1 to 1 activities either in or outside of the service. There was a lack of evidence people's particular interests and passions had been considered when planning for meaningful activities. One relative told us, "I wish they could take [person] out more."
- Whilst it was positive to see all people had been supported to go on holiday to a forest setting, there were activities included in the cost of the holiday people did not participate in, the main one being swimming in the large indoor dome. The manager told us people who went did not like swimming, so it was not clear why this holiday destination was chosen. The majority of on-site activities were walking.
- Professionals also felt activities could improve, with one professional telling us, "When I am there, staff are just sat on the phone, never really anything going on. Staff do the bare minimum. They don't engage with residents. [Manager] does the most. She is more on it."

The provider failed to ensure activities and were provided in person centred way which was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs 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.

At the inspection in March 2023, we found people were not supported with information that was accessible to them and staff were not using alternative forms of communication. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, this had not improved, and the provider remained in breach of regulation 9.

● Most of the people that lived at the service were not able to fully communicate verbally. Whilst there was some information in people's care plans on how people expressed themselves, this was limited. There was a lack of guidance for staff around how they were able to understand people's alternative way of communicating in a meaningful way.
● Although we saw there were picture aids to support people to make choices, we did not see staff make use of these. There were people who were able to use some Makaton [a communication tool with speech, signs, and symbols to enable people with disabilities or learning disabilities to communicate] however we did not see staff communicate with people in this way.
● Whilst there was some information available in a way people may have understood such as in picture format, this was not displayed where it was accessible for them.
● We saw from 1 person's care plan; they should be encouraged to wear their glasses. We did not see staff encourage the person to wear them and there was no record in the care notes the person was declining to wear them.

The provider failed to ensure information was provided in a way that was relevant to people which was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support
● Care plans contained some information on the likes and interests' people had but this was not consistent. There was information missing on people's preferred routines and their life histories. Relatives we spoke with were able to tell us more information about people's life histories, but this had not been included in people's care plans. This meant there was a risk staff would not provide person-centred care. One member of staff told us, "I have never been told [person's] life history. It would be important to know."
● Whilst all relatives felt the manager understood people's needs, they were not able to comment on whether staff did. We found there was not always sufficient and up to date guidance in the care plans around the specific needs of people. This meant there was a risk staff would not deliver the most appropriate care. For example, 1 person required support with their eye care however there was no guidance in place or information around the impact of not providing the appropriate care.
● One external professional told us, "Currently they [staff] don't understand X needs. They used to about a year ago but not anymore. I have never been so concerned as I am now."
● Carers' daily notes lacked personalisation and were brief and repetitive. There was little variation between entries, and some entries were more detailed than others. Care notes were not person-centred and did not offer a description of what the person's day was like.
● The manager told us people were allocated a key worker [a member of staff who coordinates all aspects of care and communication for the person, their family members and carers, and the services that are

involved.] However, there was no evidence the staff who were allocated this role were involved in this way.
● There was little opportunity for people to learn new life skills or achieve goals no matter how small. A relative told us they would like their family member to learn new life skills. They said, "Help teach [person] to do things themself.".
● As in the previous inspection, people had end of life care plan templates in place although none were completed with much detail despite there being people at the service who were aging. Most recorded whether the person had a 'do not resuscitate' or ReSPECT recommendations in place, rather than specific details around a person's or their loved ones wishes at the end of their life.

The provider failed to ensure care and treatment was provided in a person-centred way which was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● There was a complaints procedure in place which explained what people could expect if they were concerned or unhappy about any aspect of the care provided. However, improvements could have been made on how this was communicated to people in an accessible format.
● External professionals told us they had raised some concerns at the service including, 1 person not being not having their routine adhered to and another told us they raised concerns about 1 person's weight loss not being identified by staff. These had not been formerly recorded as complaints.

We recommend the provider records all concerns and complaints with details of how these have been addressed.

● No complaints had been recorded at the service and relatives told us they would feel comfortable speaking to staff if they were unhappy about anything.

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 inadequate. At this inspection the rating has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At the last inspection there was a failure to ensure quality assurance and governance systems were effective. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider remained in breach of regulation 17.

● As in the previous inspection, people were not being supported to lead meaningful and empowered lives. There was a lack of management and provider oversight to ensure Right Care, Right Support and Right Culture was being considered in line with the guidance. The provider, manager and staff failed to ensure autistic people and people with a learning disability were living an ordinary life as any other person. The manager told us, "Changing the culture and cycle is the big one because you are trying to change people's [staff] habits. That's the biggest challenge."
● There remained inadequate systems in place to robustly check the quality of care. Although maintenance issues were being reviewed, there were no formal audits of staff's approach to care.
● In June 2023 the provider had commissioned an audit by an external consultant that covered all aspects of care delivery. There were lost opportunities to follow up the consultant's findings as multiple areas identified for improvement had not been actioned. For example, it had been identified nutritional tools needed to be assessed and reviewed for all people and end of life care plans needed more information. At the time of the inspection these had not been regularly reviewed.
● Records relating to people's care were not routinely checked for accuracy and completeness. The manager told us they were not formerly auditing care plans or care notes, an area where we found concerns. Since this inspection the manager had undertaken care plan audits however, they recorded no concerns found. There were no specifics on what they have reviewed yet each audit was signed off as stating more 'factual and more detailed' information was needed with no further information.
● The provider told us they were now recording 1 person's seizures as incidents. However, the example they sent us included a record of another person having a seizure. This was recorded as '[Person] had seizure' and 'Was content'. This was clearly an error in recording by staff as the person is not known to have seizures. This had not been identified before the provider sent us this document.
● Since the last inspection, there had been improvements on the recording of mileage undertaken for a person who had their own vehicle. However, we saw on the November form, staff had recorded 30 miles for a journey to a day centre only 16 miles there and back. Again, this had not been picked up the provider

before this was sent to us.
● There were missed opportunities to reflect and make improvements on care. We saw the manager had reflective sessions with staff when some incidents occurred. The records of this lacked detail and despite there being a section on the form to review the progress of this, there was no information.

The failure to ensure quality assurance and governance systems were effective was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● We found some improvements were made in relation to audits being completed. For example, we saw from a provider audit in June 2023, new weighing scales, a new office printer and labels for food needed to be ordered. We saw this had been done.
● At the previous inspection we found electrical equipment was accessible to people in the laundry. This had now been addressed and was now boxed in.
● Relatives and staff we spoke with were complimentary about the manager. Comments included, "[Manager] is good, approachable and polite", If you want to talk to the manager, they are open to talk to" and "Good atmosphere here and I feel supported."
● 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 was now informing the CQC of significant events including safeguarding and injuries.

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

At the last inspection, the provider was failing to ensure to be open and transparent when things went wrong, to act on feedback and the failure to work in partnership effectively with other agencies. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, the provider remained in breach of regulation 17.

● As at the previous inspection, people were not involved in the running of the service and as such not able to influence positive changes. Although there were residents' meetings this was not an effective way to gain people's feedback. It was noted there were very limited responses from people yet the conclusion from the meeting was noted most people were happy. Despite us stating this at the last inspection, it still had not been considered to hold individual meetings using the person's most appropriate way of communication methods would be more effective.
● 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 relatives or people's representatives had been contacted on each occasion. There were also incidents not being recorded and as such relatives may not have been made aware. This was a concern raised at the previous inspection.
● Staff meetings took place, but these were limited to the day staff and there was no record of any meaningful discussions with staff to gain their input on the safety and quality of care. Staff we spoke to told us meetings were to advise them of any training needs. They did not appear to consider this an opportunity to be involved in the running of the service. One member of staff told us they would like more frequent meetings and said, "We have meetings but not so regular. I feel like we have flash meeting in the morning."
● Relatives were positive about the manager and felt they knew their loved ones well. However, they fed back they would like more communication. Comments included, "I would like to know more like maybe every month", "I would like a bit more update" and "I like to know what's happening, what X been doing,

what's happening and what X has planned. No one comes back on a 1-1 feedback thing." However, 1 relative did say, "Every time I raise something they address it."

● Whilst there were external professionals who felt the communication with the service was positive, there were others who felt this could be improved. One told us they had a planned telephone appointment however staff were not aware. They said they did not receive a call back as promised. Another told us the service was, "Underwhelming and under inspiring."

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