Mitchell's Care Homes Limited

Rainscombe House

Inspection report

Rainscombe Farm
Dowlands Lane
Smallfield
Surrey
RH6 9SB

Tel: 01342844772
Website: www.m.ch.co.uk

Date of inspection visit:
24 April 2023
25 April 2023

Date of publication:
02 June 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

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

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

Right Support:
People were not supported in their independence, to achieve goals, make their own decisions or learn new life skills as staff were not following national guidance in relation to Right support, right care, right culture.

Although staff followed the principles of the Mental Capacity Act 2005, people were not supported to have maximum choice and control of their lives. However, staff did not always 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 always supported by a sufficient number of staff, or staff who were aware of how to recognise potential signs of abuse and as such report these. People received the medicines they required. Medicines were stored neatly and safely.

Right Care:
People were not always treated with respect and dignity as the provider had removed window coverings from the ground and first floor windows.

People were not always cared for by staff who took time to engage with them and staff did not always follow people's care plans in relation to their eating and drinking requirements. People were cared for by staff who did not always support them to follow good infection control practices.

Right Culture:
The provider had created a culture within the service which had resulted in people not receiving good quality, person-centred care. People and staff were not encouraged to get involved in the running of the service.

There was little evidence that guidance or training was being rolled out to managers and staff to help

improve people's lives. The provider worked with the GP and other external agencies in respect of people's care.

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

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 25 April 2023).

At our last inspection we recommended that the provider make improvements to their recruitment processes. We found improvements had been made at this inspection.

Why we inspected
The inspection was prompted due to concerns received about people not being protected from the risk of abuse, concerns around safe staff levels and lack of robust management oversight. A decision was made for us to inspect and examine those risks.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from Requires Improvement to Inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Rainscombe House on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to recognising and reporting potential safeguarding concerns, staffing levels, recognising risks to people, respect and dignity and good governance.

We have also made 1 recommendation to the registered provider in relation to medicines practices.

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 the 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.

Special Measures
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.

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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Rainscombe House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by 1 inspector.

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

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

At the time of our inspection there was not a registered manager in post, although the provider told us an existing manager would be submitting an application to register.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used information provided to us by a whistleblower to focus on specific aspects of this service and the care of people.

During and following the inspection
People living at Rainscombe House were not able to verbally communicate with us. We did general observations of each person and their interactions with staff. We spoke with 3 staff, which included a manager from another of the provider's services and 2 care staff. We reviewed the care documentation, in varying detail, for 3 people. We looked at health and safety information, 2 staff recruitment files, audits and staffing arrangements. We also looked at the minutes of in-house meetings and training information. Following our inspection, we received feedback from social care professionals.

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 inspection in March 2023, we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

- People were not always cared for by a sufficient number of staff to ensure their needs were managed in a safe way. On the days of this inspection, staffing numbers were in line with what we had been told. This was 2 staff members all day and the provider said they never went under the required numbers. Yet, when analysing the rotas from 1 January 2023 to 9 April 2023, we found 3 occasions when there was only 1 staff member on duty for the whole day and 4 occasions when there was only 1 staff member for half of the day.
- Insufficient staff on duty meant an increased risk of people being harmed as staff told us 1 person required 1:1 staffing every day and we read 2 people needed staff support to eat due to their increased risk of choking.
- We also noted some staff worked a long day and also a waking night without a break in between or had been on shift as the waking night and went straight into a 12-hour shift during the day.
- On our first day of inspection, 1 staff member worked all day and was also the waking night. We did not see them have a break at all during our inspection. They told us, "It's fine, I only do 2 or 3 nights and I have been covering due to COVID." However, this meant this staff member worked 24 hours in one go.
- When we reviewed the rotas, we found on another 2 occasions between 1 January 2023 and 9 April 2023, 1 staff member worked 2 full days and 2 waking nights on the trot. On a second occasion they worked a waking night, followed by a full day and then another waking night. Working long hours with a lack of rest breaks or time to recuperate between shifts can cause fatigue. This may lead to an increased risk of errors and as such put people at risk of harm.
- Insufficient staff also meant people's opportunities to go out were restricted as everyone needed 1:1 staff when leaving the service. Although we were told people went out every day, daily records showed this was not happening.

The failure to consistently ensure there was the correct number of staff on duty was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We checked the records for the waking night staff and saw there was always 1 waking staff member on duty.
- On occasions people would join others from the provider's neighbouring service which enabled them to go out with staff working there.

At our last inspection, we recommended the provider review Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This gives information on the checks to be carried out prior to staff employment.

● At this inspection, we found improvements had been made. Recruitment checks for the 2 staff whose files were reviewed had been completed. This included application forms, providing references, evidence of their right to work in the UK and Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● Prior to the inspection safeguarding allegations concerns were raised with us. Whilst the provider took immediate action as soon as we made them aware, we identified further instances where people were at further risk of abuse and neglect.
● We read of 3 occasions where staff noticed unexplained bruising on 1 person. Although this was recorded in the person's daily notes, staff had not reported or carried out investigations to determine the possible cause of these bruises. This was despite the service safeguarding policy stating signs of physical abuse could be unexplained bruising. This meant there was a potential people could continue to be intentionally harmed.
● Following a visit to the service by social care professionals, they told us, "We are concerned regarding physical abuse and provider neglect for [person's name] in Rainscombe House."
● People were not always protected from the risk of restraint. One person's care plan recorded they would put a mug beside the kettle in the kitchen to indicate they wished a drink. Yet, each time this person got up from their chair and headed towards the kitchen area, staff asked them to sit back down.
● We spoke with staff about their reporting responsibilities. Staff said they would report any concerns to their line manager, but they were unable to tell us where they would report any potential signs of abuse outside of the organisation. For example, to the local authority safeguarding team or CQC.

The failure to recognise or report potential signs of abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● People were not always kept safe from the risk of harm as staff did not follow people's care plans. Two people required a 2-plate and 2-cup system when eating and drinking. Guidance was clear in that one piece of food, or a small amount of liquid should be given to the person at a time, to reduce the risk of them eating or drinking too quickly and potentially choking.
● People were given a snack during the afternoon. We saw that 1 of these people was given cut up apple and banana. Staff had put all of the pieces of fruit together on a plate in front of the person, rather than using the 2-plate system for them as recommended by a healthcare professional. This resulted in this person being at increased risk of choking.
● At dinner time, this same person was given their meal following the 2-plate system, however, staff put large amounts of the meal on the plate in front of them each, rather than 1 piece. Again, this meant, staff put this person at increased risk of choking.
● When people were being given their medicines, 1 person who was on a 2-cup system, was seen drinking 3 cups of water one after the other. Each cup contained around 100ml and the person drank these down very quickly. This increased their risk of choking as healthcare professional advice was that they were to have a small amount of liquid transferred from their main cup to a drinking cup.
● Staff were expected to carry out a weekly fire test check, but when reviewing the records for this, we found staff were not doing this consistently. Between 18 January 2023 and 12 April 2023, there were 3 occasions when staff did not carry out the test. This potentially left people at the risk of harm if the fire system failed between tests.
● Accidents and incidents were recorded on the electronic care planning system. Although regular audits

and analysis of accidents and incidents was completed, these had not identified the unexplained bruising found on one person. This meant people could be being intentionally harmed and the provider would be unaware of this.

The failure to follow guidance and leave people at the risk of harm was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other people did have good guidance in place in relation to their potential risks. For example, one person had epilepsy and there was a care plan specific to this person's needs in relation to this.
● Other safety checks were carried out on the premises on a regular basis and staff were able to tell us what they needed to do in the event of a fire and people had to be evacuated.

Using medicines safely
● People received the medicines they required and in the main, medicine practices were safe. However, we found a gap on 1 person's medicines administration record (MAR) chart on the first day of our inspection. We checked the blister packs and found the medicine had been given, but the MAR not signed. Following our inspection, we were provided with evidence of a supervision held with the staff member involved.
● In addition, we found the staff on duty were not trained in medicines administration. One staff member did not want to undertake medicines training and the other staff member was still in training. As such, they were reliant on a senior carer coming over from the provider's neighbouring service to give people their medicines. Staff rotas showed this was not the first occasion this had happened and as such increased the risk of medicines errors occurring, such as above. During their supervision, the staff member had reported that they were, "In a hurry" as they were, "Rushing" back to the neighbouring service to do something.
● Information was available for 'as required' medicines should people require them to reduce their levels of anxiety. We found people were not being over-medicated as there were few occasions when people were being given these PRN medicines.

We recommend the provider reviews their staffing rotas to include a fully trained and competency assessed staff member on shift able to administer medicines safely.

Preventing and controlling infection
● We were somewhat assured that the provider was supporting people living at the service to minimise the spread of infection. We observed 1 person going to the toilet numerous times throughout the day. There was no sink in the toilet and the person had to wash their hands in the utility room sink just outside the toilet door. Although we saw in the majority of cases, staff supported this person to wash their hands after being to the toilet, on 3 occasions we did not see this happen. One of the times was when they were about to be given their medication. The lack of support with correct hand washing procedures increased the risk of the spread of infection between people.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. The hot water tap in the kitchen was broken, leaving only a working cold water tap. We tested the tap in front of the provider's manager to demonstrate it was broken. This increased the risk of bacteria and the spread of germs to people as crockery and cutlery could not be cleaned properly.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
Staff were following latest government guidance in relation to visiting.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
● Capacity assessments and a best interests decisions were in place for people in relation to any potential restrictions, such as the locked front door.
● Staff had received training in the MCA. Staff told us, "People have the right to choice."

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 inspection in March 2023 we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People did not live in a service that provided a positive culture or supported them to realise goals or skills to enable them to live a good and fulfilling life.

● Staff did not demonstrate an approach in line with Right support, right care, right culture. Although we were told following our last inspection that the guidance was being rolled out to staff and there was work underway to improve people's opportunities, we did not see any changes on this visit.

● There was a lack of openness and transparency by the provider during the inspection. We were told by them there were never less than the required staff levels at the service. However, on review of the rotas we saw there were occasions where there were low staff levels.

● Despite staff being present throughout the day of inspection, they rarely engaged with people. We saw people sitting at right angles, to the television from 13:30 until 19:00 on the first day of inspection. The only time they moved from their seats was to go to the toilet or the dining table. Staff seldom spoke with people during this whole period. The provider's visiting manager told us they had noticed the lack of activity with people and spoken with staff about this. Staff told them they were waiting for the senior staff member at the provider's neighbouring service to come over and tell them what to do.

● During people's snack and mealtime, staff did not make any effort to talk with people. One staff member stood, leaning against the wall with their arms folded watching people eat when they had their snack. At dinner time, staff supported people to eat, but did not talk with them.

● People were not supported with their independence or decision-making capabilities. One person regularly got up from their seat but each time staff asked them to sit back down. We queried why and were told this person was at risk of touching the kettle which may be hot. This person's care plan noted they indicated their wish for a drink by putting a mug down beside the kettle. The care plan recorded staff should empty the kettle after each use to reduce the risk of the person burning themselves and as such make it safe for the person. We did not see staff do this.

● When people had their snack in the afternoon, we did not hear them being asked what they would like. Two people were given 5 dry crackers and the third person, fruit.

● We did not see people engaged in any activities for the time we were at the service. We were told at our previous inspection 1 person went with a staff member each morning to collect other staff. However, on our second visit, we were informed this was not the case. Records showed people occasionally went to a local centre for a dance or arts session, other than that their activity was limited to going out on drives or to the supermarket.

● People were not shown respect or dignity by the provider. No one had blinds or curtains up at their

bedroom windows and although the service was in the countryside with no surrounding houses or buildings, this left people without privacy or the option of being able to close their curtains at night. Following our last inspection, we were told curtains had been ordered and due to be delivered on 4 May 2023. However, on our second day of this inspection, we were told the people's windows had been measured the previous week and that curtains would be ordered. We asked the provider to take urgent action to give people some privacy until blinds/curtains were fitted. We saw privacy film had been put at people's windows on our second day of inspection. The provider told us they would discuss with people what they wished on their windows.

The lack of ensuring the privacy of people, or supporting their autonomy, independence and involvement in the community was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were not being supported to lead meaningful and empowered lives. There was a lack of management and provider oversight to ensure people were receiving person-centred care. This meant people were potentially being discriminated against due to their disability.

● There was a lack of adequate systems in place to robustly check the quality of care. Audits of accidents and incidents concluded there were no areas for development or improvement. This was despite us identifying 3 occasions when 1 person was found to have unexplained bruising and a fourth occasion when 1 person had caused bruises to their arms.

● Other audits were tick-box forms and did not recognise improvements needed in the service. For example, there was a lack of daily notes/activities audits to see how people were spending their time.

● Where people were found with unexplained bruising or had caused bruises to themselves, there was no evidence of duty of candour being followed and either relative's or people's representatives being informed.

● People were not involved in the running of the service and as such unable to influence change. Although there were residents' meetings these were not an effective way to gain people's feedback. It was noted there was very limited responses from people yet the conclusion from meetings was, "All service users are currently happy to stay at Rainscombe Bungalow and House and are receiving good care on a daily basis." No consideration was given on how to enable people to contribute individually.

● Staff did not always feel supported in their role. They told us they did not feel comfortable raising things with management or the provider as they were worried about retribution.

● Staff meetings and staff supervision were limited. Staff meeting minutes showed that meetings lasted 30 minutes only and consisted of management giving out information to staff. There was no evidence of staff being able to give their views.

● Supervision records consisted of pre-completed forms which contained information about individuals living at the service or training information. Again, there was no evidence that staff were given the opportunity to discuss their role or voice any concerns or training requirements.

● The service had been without a registered manager since April 2022. At our previous inspection, a manager had applied to register for the position but their application was unsuccessful. Following that inspection, we were told a manager already working for the provider would be applying to register.

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

The lack of robust management oversight, governance and support of people and staff to be involved in the

service, as well as a lack of consideration of people's equality characteristics was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Working in partnership with others

- Following our last inspection, we were told that national guidance and training was being rolled out to management and staff and staff were committed to improving people's life's. At this inspection, we saw little evidence of any changes having been made but staff spoke about plans to increase people's opportunities in relation to activities.
- We saw since our last inspection that people's background histories had been included in their care plans. These gave important information for staff who may not know people so well.
- The service worked in conjunction with people's representatives and the GP in relation to people's care.