SHC Rapkyns Group Limited

Rapkyns Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Rapkyns Nursing Home provides nursing and personal care for up to 60 people living with a learning disability, physical disability or complex health condition. Accommodation is provided in two buildings on the same site and comprises the main building, Rapkyns Nursing Home, and a smaller building, Sycamore Lodge. At the time of this inspection, Rapkyns Nursing Home was empty, so this inspection is solely about what we found at Sycamore Lodge. Sycamore Lodge is a service that provides residential care and support for up to 10 people with a learning disability and/or autism, with some challenging behaviours. At the time of our inspection, six people were living at the service. Accommodation is provided on one level. Communal areas include a lounge area and dining room, with access to gardens and grounds. All rooms have en-suite facilities.

The provider and its associated locations have been subject to a period of increased monitoring and support by commissioners. Investigations are ongoing by the local authority, police and partner agencies at some of the provider's locations, including Rapkyns Nursing Home. However, the police investigation is ongoing and no conclusions have been reached. Our inspection did not examine specific incidents and safeguarding allegations which have formed part of these investigations. We have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and will report on what we find.

At the previous inspection in July 2018 we found six breaches of regulations in relation to the safe management of risks, person centred care, consent, staff training, failure to display ratings and governance. At this inspection we found four breaches continued and one new breach of regulation was found.

Rapkyns Nursing Home has not been operated and developed in line with the values that underpin the Registering the Right Support and other best practice guidance. Rapkyns Nursing Home was designed, built and registered before the guidance was published. However, the provider has not developed or adapted Rapkyns Nursing Home in response to changes in best practice guidance. Had the provider applied to register Rapkyns Nursing Home today, the application would be unlikely to be granted. The model of care provided is not in keeping with the cultural and professional changes to how services for people with a learning disability and/or autism should be operated to meet their needs.

People's experience of using this service and what we found
The service didn't always apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.
The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons. There were identifying signs, intercom, cameras, to indicate it was a care home. Staff wore clothing that suggested they were care staff when coming and going with people. Some people were not treated with dignity and other people were not being supported to be as independent as they could be

with communication.

Some people were at risk because aspects of their care were not managed safely. Staff did not have consistent guidance or knowledge around supporting people with their individual needs. An incident had not been reported immediately when a person had been found with unexplained bruising. Medicine management had deteriorated since our last inspection, and medicines were not always managed safely. Lessons had not always been learned from or embedded into practice. Risks found at this inspection had been identified to the provider following inspections of some of their other services.

Staff did not have all of the required training to carry out their role such as positive behaviour training. Peoples health needs had not always been managed well. There were inconsistencies in the management of constipation, epilepsy, hydration and pain management.

Staff did not always address people in a dignified way, people's information was discussed in front of other people and individuals. Some people's communication needs were not met in a personalised way.
Care plans were inconsistent, and some information was missing. Activities were not always structured to support people with their anxieties.

Leadership at the service was not effective. The manager was not present during our visit, a senior support worker was in charge of the shift but lacked knowledge about people. The previous inspection rated the well led domain as 'Requires Improvement'. At this inspection the rating has reduced to Inadequate. Some of the breaches from the last inspection remain. Auditing and oversight had been ineffective in identifying the concerns we found at this inspection. When areas of improvement had been identified action had not always been taken in a timely way to make improvements.

We observed some interactions which were caring and kind. Staff engaged with people at a pace they preferred, and some staff understood people very well. Some staff had a good rapport with people and were relaxed and used humour effectively. People told us they enjoyed the food, although not all people were offered appropriate communication aids to make choices. People went out throughout our inspection to do various activities and the provider was trying to improve personalised engagement.

Rating at last inspection and update
The last rating for this service was requires improvement (published 12 February 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection sufficient improvement had not been made and the provider was still in breach of regulations.

This service has been rated requires improvement for the last three consecutive inspections and has deteriorated to inadequate in the Safe and Well led domains at this inspection.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement:
We imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services

and actions to improve, and to inform our inspections.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.
If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Rapkyns Nursing Home

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 Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and one nurse with a specialism in learning disabilities.

Service and service type
Rapkyns Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. There had been no registered manager in post since August 2017. Two previous managers had applied to register with CQC but did not continue their applications. The current manager had been in post since September 2018 and is currently applying to register, they were not present during our visit.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection-
We spoke with one person and one relative about their experience of the care provided. We spoke to eleven members of staff including the senior care worker, care workers, domestic staff, involvement and engagement lead, autism and positive behaviour specialist lead, another senior manager, the safeguarding lead and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We made observations of care to help us understand the experiences of people who could not talk with us.

We reviewed a range of records. This included five people's care records and medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection –
The provider sent us some additional information after the inspection. This included information about how relatives had been involved in feeding back about activities and action the provider had taken to follow up on some people's health needs we had raised as a concern during our visit. We contacted three relatives about their experience of the care provided and received feedback from two.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

Inadequate: This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to assess risks and mitigate risks to people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 12. There was improvement in respect of weight management.

- People were at risk because there was a lack of clear guidance around supporting people with epilepsy and staff were unclear who had epilepsy. Care plan information lacked detail and instruction for staff to follow or how to recognise seizures. One person's 'seizure management form' described what the person may do when having a seizure and another document dated 19 February 2019 said, '(Person) has previously had a suspected seizure, staff to monitor to observe any unusual behaviour.' It was not explained what 'unusual behaviour' may be.
- In April 2019 the person had a seizure. Daily records stated a staff member had looked in the person's records for information about previous seizures but could not find any mention of this or the person having epilepsy. The staff member had to contact the manager to obtain clarification from 'someone who knew the person'. This demonstrated staff did not have a good knowledge of people they supported. The daily records did not reflect what the seizure management form described about what the person may do when having a seizure. Information had not been updated since this incident for staff to recognise seizures which may occur in the future.
- At the beginning of the inspection the senior in charge of the shift told us they thought the person had a seizure the previous month but was unsure if they had epilepsy. Other staff were not sure if people had epilepsy. There were only six people living at the service, but staff were not able to tell us about their needs in respect of epilepsy. There were no associated risk assessments, this meant staff were not fully informed on how to support people in relation to their epilepsy.
- An entry in the communication book in April 2019 said, 'Please can someone make (person) appointment to see doctor as not had a bowel movement for four days. Eating okay, drinks lots and passing urine okay, walking a lot so need to get it checked out.' The provider did not know if this had been followed up with the doctor and there was no documentation to confirm this.
- People with a learning disability can be prone to bowel problems such as constipation. One person had an elimination care plan used to help manage bowel problems and staff recorded bowel movements.

However, a risk assessment around continence or bowel movements had not been implemented which meant staff had no guidance as to when further medical treatment from the doctor should be sought and this information was not included on the bowel chart.

● Most staff had a good understanding of how to support people with their bowels. Whilst the lack of information within people's documentation is largely a recording issue the risk was elevated due to the high use of agency staff caring for people and the lack of knowledge the senior carer had who was in charge of shifts.

● People were not always supported well by staff to reduce the risk of harm. We observed one person pick up a full mug of hot drink and spill the contents which narrowly missed them, staff were unaware this had happened. We fed this back to the provider as a concern as the person could have been scalded.

● We were told by staff and the person's relative a person could self-harm when they were feeling unwell or in pain. They had been prescribed when required (PRN) medicine for pain relief. There was no clear guidance when the PRN medicine should be offered to the person who was unable to verbally say when they were in pain. The person had been having more incidents of self-injurious behaviour which could have been linked to pain and discomfort. They had only been given pain relief once in the last three months. There was no pain management tool for staff to refer to, to recognise when the person may be in pain.

● Some people needed support to manage behaviours that could challenge to help themselves and others remain safe. Positive behaviour support plans were in place to provide guidance to staff about how they could recognise and respond to a trigger to a person's behaviour which challenged. However, some information was missing from additional risk assessments and care plan documentation relating to behaviour.

● One person's care documentation said they should not be left alone with other people due to behaviours which could harm others. We observed the person left alone with another person in the dining area whilst staff had gone into the kitchen. The person took a drink that had been left on the table, drank it then threw the empty cup across the floor. When staff heard the noise from the cup hitting the floor they came back into the dining area.

● One person had a choking risk assessment which stated staff should perform back slaps and then abdominal thrusts in the event of a choking incident. The person' had a spinal condition which was not mentioned in the risk assessment and associated risks had not been considered. A staff member said, "I hadn't even thought of that, something needs to be put in (to the risk assessment)."

● Records, such as servicing and testing relating to the management of premises, including the safety of equipment, had been completed and were up to date. There were detailed emergency action plans in place in the event of a fire and learning from fire drills had been recorded. Some rooms were unoccupied, staff regularly flushed water through the unused outlets to ensure water was not contaminated from lack of use.

Using medicines safely

At our last inspection we recommended that the provider referred to guidelines on the safe administration and management of topical medicines.

At this inspection no improvement had been made and we found other areas of concern.

● Prescribed topical creams were held in people's rooms. Documentation was signed after each use and a further check completed to ensure creams had been signed for when administered. There were some missed signatures for some checks. One person's body map to identify where they required their cream had not been filled in correctly.

● One medicine administration record (MAR) chart was dated incorrectly which had not been identified by staff until we pointed this out.

● 16 out of date tablets were found mixed in with in date medicines. Audits had not included checking dates of medicines to ensure they were still effective.
● Two people had been prescribed PRN medicine, but no protocol was in place for staff to follow to avoid the risk of overdose when taken simultaneously with existing medicines. No harm had come to people as PRN medicine had been infrequently used. The provider told us after the inspection they had sought advice from the doctor which would be included on the protocol they planned to put in place.

The above evidence demonstrates that the provider had failed to provide safe care and treatment. This is a continued 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
● There had been a recent incident where a person was found to have unexplained bruising. Although medical treatment had been sought for the person, the incident had not been reported internally to senior management for three days or reported to the local authority. Incident records had not been completed by staff. The nominated individual said, "It was disappointing the issue with (person's) black eye had not already been reported." During our inspection the provider took action to report the incident.
● Other incidents had been notified to the appropriate bodies correctly.
● Most staff understood the process for reporting safeguarding and keeping people safe although one agency staff member told us they did not know how to report any safeguarding concerns.
● During the inspection we met with the safeguarding lead who said, "I am making it quite clear that things should be reported ASAP. I deal with secondary stuff like analysing and advising. I am hearing a lot that all info comes to me first then I decide [if it's reported] but this is not the case. If I get asked for advice I do get back to them within the day or without delay."

Learning lessons when things go wrong
● Lessons had not been learned effectively. Staff had not raised concerns immediately with senior management when a person was found to have unexplained bruising.
● The safe management of risk was raised as a concern in our previous inspection in July 2018. We have found that the breach of regulation relating to risk continues at this inspection.
● The management of health needs such as epilepsy was an issue we have found at other locations run by the provider. We found the same issues at this inspection, which meant lessons had not be learnt, shared or embedded into practice.
● Bowel management and behaviour management had been raised with the provider at their other locations, but this had not led to improved care at this service.

Staffing and recruitment
● Staffing levels were enough to meet people's needs and were flexible according to people's dependency levels on any particular day.
● The service was reliant on agency staff to ensure safe staffing levels. A relative said, "There is always staff around and always staff available to take (loved one) out."
● Staff records showed that new staff were recruited safely. Relevant Disclosure and Barring checks were completed, references obtained from previous employers and employment histories checked.

Preventing and controlling infection
● Staff had access to protective equipment such as gloves and aprons. Cleaning duties were completed by two domestic staff who came to the service on different days. When domestic staff were not on shift other staff completed cleaning duties.

● The service was clean and tidy and free from any unpleasant odours.
● Infection control audits had been completed in May 2019 to check the service was clean which minimised infection control risks.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

Requires Improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

At our last inspection the provider had failed to provide suitably qualified, trained or competent staff. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 18. At our last inspection staff had not been offered Makaton training, at this inspection we found there had been some improvement and some staff had received training in this area.

Staff support: induction, training, skills and experience

- Not all staff had received essential training to help support people. The Autism and behaviour lead said, "The manager had booked staff to go on positive behaviour (training), but other things meant they couldn't do it. We are trying to improve training for staff but as a small team it can be difficult." An agency worker said, "I got induction here, first day shown around buildings and went through care plans. I've worked here three weeks, I had training with the shift leader they told me what to do (to manage one person's behaviour). I haven't been told how to support (another person) to stop self-harming."
- Training was split into core, mandatory and personal development. Agency staff had their own induction. New staff spent time shadowing other staff and completing essential training before working on shift.
- Training records indicated most staff had completed training although there were some gaps. Not all staff had completed training in basic life support, conflict management, end of life care, equality and diversity, health and safety, infection prevention, nutrition awareness, and pressure ulcer prevention.
- A senior manager said, "What we should be doing is having a staff member who has the training on shift but this is not always possible because this is a small team and there is agency use. We have introduced an allocation sheet this week with the idea that the shift leader will match up training of staff to the people and shifts."

The provider had failed to provide suitably qualified, trained or competent staff. This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A safer staffing tool had recently been implemented although had not been used at the service. The tool highlighted staffing numbers, agency numbers, balance of staff gender, training, drivers, and staff trained in medicines. The provider planned to complete rotas in conjunction with the safer staffing tool to enable the

manager to have better oversight and analyse how staff were allocated.
● Staff received regular supervision from the manager and annual appraisals.

Supporting people to live healthier lives, access healthcare services and support
● Health needs were not always supported well. Follow up actions when health concerns were identified were not easy to obtain or track and staff were not always able to tell us how people's health needs had been managed.
● One person had refused to have a medical check and had a known condition. This had not been followed up or discussed as to whether it was in the person's best interest or if there was another way to support the person with this.
● One person had problems with their hip and had a trike (A trike is an adapted bicycle which is made specifically for the needs of the person. A trike has many benefits including fun, fitness, used for therapeutic activity, and can benefit muscle strengthening, muscle activation and motor control). They had not been assessed by the physiotherapist to see if using the trike would help or make their condition worse. After the inspection the provider told us they had followed this up with the person's doctor who was making a referral to other health care professionals.
● Some people had been identified as at risk if they did not receive sufficient fluids or drank excessive amounts of fluids. Fluid monitoring charts had not been put in place, so staff could not be sure that fluid consumption was healthy.

The provider had failed to monitor and respond appropriate to risk around people's health. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● Information to help people decide what they wished to eat was not provided in an accessible format. There were no pictorial or other visual aids for people to refer to. The senior carer said people will make choices in their 'own way'. This is an area that requires improvement.
● Food for the lunchtime meal was prepared at another of the provider's locations then transported to the service in a heated trolley.
● Some people had guidance from the speech and language therapist (SALT) to help them to eat more safely. Staff prepared and assisted people with their food following the recommended guidance.
● Some people told us they enjoyed the food on offer. One person said, "I enjoyed my lunch it was spaghetti bolognaise with garlic bread. I normally have that for lunch and like it". A relative said, "(Loved one) needs encouragement, the food is absolutely fine. When (loved one) left home they would only eat half a dozen things, but generally speaking the food is good and varied. They do nice things like BBQs for family or if it's a birthday there's a special tea, its homely."
● People who were at risk of losing weight were monitored regularly and supported to increase their weight. Dietician and further advise from the GP was requested in a timely way.

At our last inspection the provider had failed to obtain consent in line with the requirements of the Mental Capacity Act 2015. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Everyone living at the service either had a DoLS authorisation granted by the local authority or an application submitted pending authorisation.
● The manager used a DoLS tracker to monitor current and pending authorisations which were regularly followed up with the local authority to check the progress of the application.
● Appropriate decision specific Mental Capacity Assessments were in place and best interest decisions made when people were restricted. For example, when people used lap belts or other restrictive equipment like harnesses to help them stay safe.
● Staff had a good knowledge of any specific conditions attached to authorisations and could describe how conditions should be met although this had not always been added into the care plans.
● Some documentation in people's care plans was not appropriate. For example, consent to care and consent to be photographed forms had been signed on behalf of people by their relatives although they were not the lasting power of attorney (LPA). An LPA is an individual appointed to make decisions on behalf of a person with no capacity. This is an area that requires improvement.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care
● Assessments were made in respect of people's health. The service was using nationally recognised, evidence-based guidance, to assess people's health, such as Waterlow charts to ensure peoples' skin was healthy.
● Assessments had been completed in relation to falls, skin integrity and MUST. (Malnutrition Universal Screening Tool is used to assess if people are malnourished, at risk of malnutrition or obesity).
● Care records documented that people were supported by a range of healthcare professionals, such as GPs, physiotherapists and specialists for specific health conditions.

Adapting service, design, decoration to meet people's needs
● The service provides accommodation for people on one level. Corridors and communal areas are spacious, enabling people who use wheelchairs to navigate easily.
● Rooms were personalised and tailored to meet people's needs. Rooms had 'en suite' bathrooms that were large enough for people to have a shower using specialist equipment.
● There were accessible garden areas for people to enjoy.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

Requires improvement: This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- Although we observed some good and caring support not everyone was treated in a respectful way. Staff did not always talk to people in a dignified way. Some people were spoken to in a childlike manner even though they were adults.
- We observed staff refer to a person as, 'good boy'. Two staff said, "Shall we get you ready for Mummy? your Mummy is coming". There was no information in the person's care plan to say this was how they preferred to be addressed or communicated with.
- Two staff stood in front of a person who was sitting on the sofa and discussed if the person's pad had been changed. Other people and staff were close by. Another staff member asked a person if they needed a 'wee'. Again, this was in front of other people and staff and not dignified.
- We observed an agency worker supporting a person with one to one support. The agency worker looked unsure how to occupy the person and when they became agitated the agency staff did not intervene but observed from the opposite side of the room. A fitness ball was placed in front of the person who showed little interest in engaging with it. The lack of organised activity to keep the person engaged when they were in the service was reflected in the person's daily records. We have reported on this more in the responsive domain.

Staff did not always address people in a dignified way which had gone unchallenged by the provider. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- People appeared relaxed and happy with staff. A person and staff member were laying on a large bean bag and interacting. The person looked comfortable, at ease and enjoying the interaction. A relative said, "The staff are really kind to (loved one) and make the effort to understand them and try to find ways to avoid triggering their behaviour. They are caring and work with (loved one) well. I just think the staff are very caring"
- Some staff knew people very well and told us in detail about their likes, dislikes and preferences. A staff member said, "(Person) likes you to sing with them and put DVDs on. I do that with them. Another person likes their TV, so I'll support them to watch Netflix."
- Some people were supported to pursue their interests. One person enjoyed watching horror films, during the inspection staff had put a horror film on for the person which they were engrossed in.

● People had decorated their bedrooms in a personal way. People had many personal objects and decorations in their rooms.

Ensuring people are well treated and supported; respecting equality and diversity

● Staff respected people's needs around personal space but remained close by should they need any support. One person chose to spend time in their bedroom with their door open. A staff member supported another person in the lounge, they maintained a dialogue with the person in their room. Their conversation was playful and humorous. The person enjoyed the interaction and responded enthusiastically to the staff member.

● One person enjoyed singing songs which helped divert their attention when they became anxious. Some staff were aware of this and at various times during our inspection we observed this happening. A relative said, "(loved one) is unique, with great sense of humour. Everyone welcomes them back and say we've missed you (when they returned from home visits). I feel very secure in the knowledge they look after (loved one) well."

● We observed a staff member sit with a person, with the person's feet up on their lap. We were told the person enjoyed touch and the staff member engaged with the person calmly and gently.

● Some people had cultural beliefs which were recorded in care plans. Staff supported people to attend places of worship.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

Requires improvement: This meant people's needs were not always met.

At our last inspection the provider had failed to provide person centred care and people did not receive personalised care that met their needs and preferences. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 9. There had been improvement in the language used in people's records which at our last inspection had been derogatory. During our inspection people engaged in various activities which was an improvement from our last visit.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Information was not always presented in a way that made it easy for people to understand.
- In the dining room a white board had the names of staff on shift but with no pictures. This would not have been easily understood by people. There was a list of activities with people's initials, this indicated the board was more for the use of staff rather than people. There were no pictures of meal choices to help people make decisions.
- Care plans were not written in a way that met people's preferred methods of communication, therefore, people could not be involved in reviewing their care plans. Some documentation did include pictures of reference, but the majority of documentation contained only writing that people would have found difficult to understand.
- There was no evidence to show how, or if, people were involved in reviewing their care plans. Although relatives told us they had been communicated with well and involved if their loved ones needs or support had changed.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Some documentation was missing or had not been cross-referenced to other parts of the care plans. There was a more significant risk due to the number of agency staff and the senior staff member's lack of knowledge around people's individual needs.
- At our previous inspection we found a person who had particular health conditions and epilepsy. They did

not have any information in their care plan about this and staff did not have a good knowledge of their condition. At this inspection we have found similar concerns which we reported on in the Safe domain. This meant that people might not receive personalised care that met their specific needs.

● Peoples preferences, likes, and dislikes had been recorded but the support people received from staff did not always reflect what the care plan said. For example, one person's care plan stated they liked to play with soft sensory items and these should be offered. The person enjoyed intensive interaction involving staff clapping their hands. Although we observed a staff member doing some intensive intervention with the person by clapping their hands, throughout the morning there was nothing else offered to the person for engagement until lunchtime. The autism and positive behaviour specialist lead said, "I am working with staff to do intensive interaction with (person). The staff didn't know about this before. (Staff member supporting person) needs to be shown where the sensory toys/equipment is and taught more about this".

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

● On the days we inspected people went out to do various activities. Some people had planned to attend a day facility called Redwood House, which was close by on site and run by the provider. During our visit we were told it was closed due to staff sickness, so people did other activities. A relative said, "(Loved one) goes to day centre, meetings with (nominated individual) about what they aim to do much better. Another lady who is trained in autism, met with us to talk about what (loved one) likes in great detail. They are definitely trying to do things (loved one) likes to do, (loved one) makes his feelings known."

● Further improvement was required to make activities meaningful and engage people more. A staff member told us inconsistent staffing meant joined up work did not always occur. They gave an example of when they had tried to introduce an in-house activity that people may enjoy. They had left instructions for other staff to explain what to do. No action had been taken when they returned to work.

● The autism and positive behaviour specialist lead had introduced a 'now and next' system to support a person to structure their day to help manage anxieties. This consisted of a daily visual planner which was broken down into 'now and next' cards. This helped the person communicate their feelings and provide structure and engagement which was often a cause of frustration resulting in behaviour which could challenge. Some staff had started to use the system but there remained a high use of agency staff, so this had not been consistent.

● Daily records and one to one notes for the person did not always demonstrate good engagement which had resulted in behaviours which could challenge others. The person had 12 hours of one to one time, but records did not demonstrate this was utilised effectively. For example, on the 19 June 2019 the only activities the person did in a 12-hour period were a walk at 11am, bus ride at 2pm and watched a movie at 8pm. There were recordings of behaviours at 10am, 6pm and 8pm which indicated the person was not being engaged in meaningful activity whilst in the service. The person's weekly planner said there should be 20 minutes of 'intensive interaction' AM and PM. There was no description of what this was and the one to one records did not make reference to this. We observed times of limited interaction during our visit as reported in the Caring domain. The autism and positive behaviour specialist lead said, "One to one hours are not recorded by staff, they do record clinical things like personal care or pad changes but not recording social activity."

The above evidence demonstrates that the provider had failed to ensure people received personalised care that was specific to them. This is a continuing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people used Makaton to communicate which most staff had been trained to use. (Makaton is a language programme using signs and symbols to help people to communicate).

● Some staff had a good understanding of how to communicate with people in their own specific way. We observed a staff member communicating with a person using Makaton which the person had adapted to suit their own communication needs. The staff member interpreted what the person was saying well and offered reassurance to the person when they asked what time certain events would happen.
● The involvement and engagement lead told us the key worker system was not fully implemented. Once established it would make staff responsible for supporting people with continuous assessment, growing links with other individuals, maintaining good oversight of individual's needs, and sharing information with other staff on progress and outcomes for people.
● People were being supported to become more independent. Goal setting had been introduced which included setting goals and looking at outcomes. Some people's monthly goals included making their own drinks, doing their own laundry and making their own sandwiches. Longer term goals had also been identified such as improving communication and increasing participation in outside activities. One person's one to one records and care notes did not evidence staff had been supporting them with their short team goals and long-term goals had not been actioned. This is an area that requires improvement.
● The involvement and engagement lead told us they had tried to focus more on personalising the support people received rather than only focusing on a clinical approach to care. They had met with some people's relatives and invited them to share views on social activities and give their feedback about how activities could be improved for their loved one. One person's relative said (person) loved planes so the person was supported to go and look at planes. Another person had liked to swim so this had been re-introduced.

Improving care quality in response to complaints or concerns
● The complaints procedure was in an accessible format and included up to date, relevant information of how people or other individuals could complain.
● There were no open complaints at the time of our visit. A relative said, "We did talk to the management about the agency staff. None of us knew if they were reading enough and didn't know the young adults like regulars would. On the whole I'm confident things are moving up." Another relative told us they felt comfortable if they needed to complain and another relative said, "I would definitely (complain if needed) and am confident it would be acted on."

End of life care and support
● There was nobody receiving end of life care at Rapkyns Nursing home.
● Relatives had been involved in end of life care planning. Where plans had been discussed but not put in place this was noted that decisions would be made at a later stage when people felt ready.
● Most staff had received training in end of life care to support people should there be a need in the future.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

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.

At our last inspection the provider had failed to establish systems or processes that operated effectively to improve the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 17

Continuous learning and improving care

- The service had been rated requires improvement by the Commission three consecutive times previously to this inspection.
- At our last inspection we had identified six breaches of regulation. At this inspection we found the provider had made some improvements and they were no longer in breach of regulation 11 (Need for consent) or 20A (Requirement as to display performance assessments), but other regulations continued to be breached and we found a new breach of regulation.
- Some of the concerns we have found are concerns we have found at the providers other services. This did not demonstrate learning had been shared effectively or embedded into practice.
- Systems were not effective to ensure compliance with regulations and were not always effective in assessing, monitoring and improving the service.
- Quality audits had not been effective in identifying the shortfalls we had found during our visit such as missing information in care plans, medicines, healthcare needs not being followed up or documented, and people's dignity not always being respected.
- Six people out of a possible 10 were living at the service at the time of our inspection. Although this was a small number of people the quality of the service had not been well managed, and risk had not been properly mitigated or addressed.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- A manager had not been registered at the service since August 2017. A new manager had been appointed in February 2019 and was currently registering with the Care Quality Commission (CQC). They were not present throughout our inspection.
- On the first day of our visit a senior support worker greeted us and said they were in charge of the shift in

the absence of the manager. We raised concerns with the nominated individual about this staff member's ability to manage the shift and support other staff.
● There was a high use of agency workers and documentation was not always a reliable source of information. It was important staff could go to a senior member of staff for support and guidance. The provider had not identified this issue until we reported our concerns. This meant people were at risk of receiving inappropriate care and treatment.
● The provider had displayed its rating from the CQC which is a requirement. Notifications that the provider were required to send to us by law had been completed and sent to the CQC as needed.
● Previous to the last inspection at Rapkyns Nursing Home, the facility that provided nursing care to people with a range of health needs, including Huntington's disease, had closed for refurbishment. Sycamore Lodge comes under the registration of Rapkyns Nursing Home and accommodates up to 10 people with a learning disability and/or autism, in a separate unit on the same site. At our last inspection the provider said they planned to apply for a separate registration for Sycamore Lodge. We asked the nominated individual what the plans were in relation to Rapkyns Nursing Home and when this might be re-opened. They told us they did not know what the future plans were, although it was unlikely a separate registration for Sycamore Lodge would be sought.
● The manager held risk meetings with members of the staff team. At the risk meeting in May 2019 various things were discussed such as behaviour management, recruitment, training, health needs, safeguarding, and care plans.
● Although areas of improvement were identified action had not always been taken swiftly to improve. For example, the visual activity planner and 'now and next' template was discussed but still not fully embedded, and issues with care plan documentation were identified but had not been resolved.

The evidence demonstrates that the provider had failed to establish systems or processes that operated effectively to improve the quality and safety of the service. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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
● We found some issues with the day to day culture such as how people were spoken to in a childlike manner and people's dignity was not always upheld. Some senior staff and other staff had not challenged their colleagues who used inappropriate language or spoke about personal things in front of people and other individuals.
● Staff sought consent from people when supporting them with everyday tasks.
● Some staff fed back positively about the new manager. One staff member said, "Managerial support is brilliant and the support of personal issues for staff. The manager has brought in a communication book and introduced new forms which are more appropriate such as handover sheets. The manager is approachable and open." A relative said, "A few years ago they did team leaders which was a disaster. This new manager is much more in charge, its happy, its cohesive, it's much better. She's not been there long but seems to be going well. If we email her, she responds".
● The provider understood their responsibilities in regard to the duty of candour which involves being open and honest with people and their relatives when something goes wrongs. A relative confirmed they had been informed immediately when their loved one was found to have unexplained bruising. Another relative said, "I have a weekly update, an email on a Sunday. Any incidents I'm telephoned straight away."

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

● People, staff and relatives were involved in the service. The manager had arranged informal family meetings (coffee and cake afternoon). This was an opportunity for information to be shared about what was happening at the service and a time for relatives to feedback any concerns or suggestions they may have. A relative said, "The service started a relative's group, but the times didn't suit me, but they did send the minutes. They also send out a newsletter about what's going on."

● Questionnaires were sent to relatives to obtain feedback about the service their loved one received. Some questionnaires had been returned in May 2019, and comments included, 'I would like to say staff changes have occurred frequently at Sycamore but now there seems more stability which is great. I do feel there needs to be more decorations in the home.'

● The service worked in partnership with other healthcare professionals and sought advice when specialised support was required.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure people received personalised care that was specific to them. Regulation 9.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff did not always address people in a dignified way which had gone unchallenged by the provider. Regulation 10.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to do all that was reasonable practicable to mitigate risks. Regulation 12.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care Treatment of disease, disorder or injury	governance Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish systems or processes that operated effectively to improve the quality and safety of the service. Regulation 17.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to provide suitably qualified, trained or competent staff. Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Impose a condition