SHC Rapkyns Group Limited

Rapkyns Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We undertook an unannounced focused inspection of Rapkyns Nursing Home on 7 and 8 December 2017.

We undertook a comprehensive inspection of Rapkyns Nursing Home in July 2017 where we identified three breaches of legal requirements and judged the service to be 'Requires Improvement' in all domains. The breaches of legal requirements related to gaps in staff training, supervision and appraisal, a lack of personalised care and ineffective quality monitoring systems. The provider submitted an action plan which detailed the steps that would be taken to achieve compliance.

We brought forward this focussed inspection of Rapkyns Nursing Home due to an increase in concerns raised by partner agencies about risk and quality at the service highlighted by routine monitoring visits and safeguarding alerts raised. At this inspection we focussed on the 'Safe' and 'Well-Led' domains only and checked whether improvements planned by the provider to meet legal requirements in these areas had been undertaken.

The service had been the subject of multiple safeguarding investigations by the local authority and partner agencies. As a result of concerns raised, the provider is currently subject to a police investigation. Our inspection did not examine specific incidents and safeguarding allegations which have formed part of these investigations. However, we used the information of concern raised by partner agencies to plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection.

At this inspection the team inspected the service against two of the five questions we ask about services: is the service safe and is the service well led. We were unable to improve the ratings for these Key Questions as we found a continued breach of Regulations. We also identified new risks to people living at the home regarding their care and treatment. Therefore the service remains at 'Requires Improvement' in these areas and overall.

Rapkyns Nursing Home is a care home that provides both nursing and residential care for up to 60 people. 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.

Rapkyns Nursing Home accommodated people across two separate units. Rapkyns Nursing Home supported people living with Huntington's Disease. Sycamore Lodge provided care to younger people with a learning disability and/or autism. At the time of this inspection there were 30 people living in Rapkyns Nursing Home and nine people resided at Sycamore Lodge. People had access to communal areas within the home and Sycamore Lodge bedrooms were complete with en-suite facilities. Sycamore Lodge was adapted to meet the need of people who also had complex physical needs and was fitted with overhead hoisting equipment throughout.

Sycamore Lodge has not been operated and developed in line with the values that underpin the Registering the Right Support and other best practice guidance. Sycamore Lodge was designed, built and registered before this guidance was published. However the provider has not developed or adapted Sycamore Lodge in response to changes in best practice guidance. Had the provider applied to register Sycamore Lodge 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.

These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service should be able to live as ordinary a life as any citizen, but this was not always the case for people. Sycamore Lodge is geographically isolated on a campus within the provider's own care village setting. Most people's social engagement and activities took place either at Sycamore Lodge or at another service operated by the provider with other people who were receiving care by the same provider. People had limited contact with specialist health and social care support in the community due to specialist staff (physiotherapy, speech and language) that were employed by the provider.

There was a manager in post at Rapkyns Nursing Home who had commenced their role at the end of August 2017. At the time of the inspection, they had not yet submitted their application to become the registered manager. Since the inspection, in December 2017, they have submitted their application form. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was a separate unit manager in post at Sycamore Lodge.

At the last inspection we found, risks posed to people were assessed and managed safely. However, at this inspection we found inconsistencies within care records which may increase the potential risk of a person not receiving the correct care and treatment. This included gaps within the guidance for staff who supported people with their continence needs, moving and transferring guidance and those at risk of malnutrition.

At the last inspection medicines were managed safely yet some medicine records would benefit from further development. At this inspection we found inconsistencies and gaps in medicines guidance available for staff in Rapkyns Nursing Home. This included a lack of guidance for staff when applying prescribed topical creams to people with various skin conditions and for people receiving medicines for constipation.

At this inspection there were sufficient staff deployed on each shift, however consideration was needed from the provider regarding how staff were deployed in the upstairs of the nursing home to ensure all people, who received their care in their rooms and beds, had their needs met consistently and safely.

The layout and environment of the Rapkyns Nursing Home did not always lend itself to meet the needs of people with complex physical mobility needs. Due to the narrow layout to some parts of the building we observed on one occasion a staff member manoeuvring a person's wheelchair incorrectly when a person was in it. Staff also referred to the difficulties they had when transferring people when supporting people with their personal care as some of the bedrooms and communal bathrooms were too small for the moving and handling equipment they used.

Accidents and incidents were recorded; however there were inconsistencies within the records regarding the action staff had taken at the time to minimise further risks on behalf of people including informing the West Sussex Adults Safeguarding team to ensure people were consistently protected from harm.

At the last inspection we found systems to assess and monitor the service were in place, but they were not effective. Shortly after the inspection the provider wrote to us to inform us of the action they were taking. At this inspection we continued to find they were not sufficiently robust as they had not ensured a delivery of consistent, high quality care across the service or pro-actively identified all the issues we found during the inspection. This included a lack of analysis and monitoring when people experienced falls to drive improvements to how people were supported by staff to ensure risks of harm to people were reduced.

Environmental risks such as hoist equipment, wheelchairs and legionella checks were managed effectively through prompt and regular servicing. Staff employed by the home underwent a thorough safe recruitment process and told us they were happy with the support they were now receiving from the new manager. People and their relatives were invited to provide their views on the care and treatment received formally through surveys.

At the last comprehensive inspection in June and July 2017 we identified three breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider wrote to us to inform us of the action they were taking. At this focused inspection we found further improvement was needed and we identified new risks to people living at the home. We identified three breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were gaps in available guidance. This meant care staff would not always know how to care for people safely and mitigate any risks. There were inconsistencies in available guidance for the application of prescribed topical creams and people at risk of constipation.

Further consideration was needed regarding how staff were deployed upstairs in the nursing home.

Accident and incident records were not consistently and accurately completed and people were not always protected from harm.

People were protected from infection due to safe control measures within the home.

Staff underwent a safe recruitment process.

Is the service well-led?

Requires Improvement

The service was not well led.

There was a lack of effective and robust auditing systems to identify and measure the quality of the service delivered to people.

People and their relatives were routinely asked their views on the care and support they received both informally and formally. They spoke positively about the support they received.

The new manager was aware of their role and responsibilities and promoted an open and inclusive environment.

The provider had been working with other agencies with the aim of improving service delivery. The staff team were aware of their role and responsibilities when caring and supporting people.

Rapkyns Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We carried out this inspection to check what improvements the provider had made following our last inspection in July 2017 where we identified breaches of legal requirements and potential risk to people living at Rapkyns Nursing Home.

People who live at Rapkyns Nursing Home may have a learning disability, physical disabilities and other complex health needs.

This inspection took place on 7 and 8 December 2017. The first day was unannounced. The inspection team consisted of one inspector, one inspection manager, a specialist nurse advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise included learning disabilities and people with complex health needs.

Prior to the inspection we reviewed the information we held about the service. This included information from other agencies and statutory notifications sent to us by the provider about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection. On this occasion we did not ask the provider to complete a Provider Information Return (PIR) as the inspection took place within six months of the publication of the previous inspection report. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Due to the nature of people's complex needs, we were not always able to ask direct questions. However, we did chat with four people and observed them as they engaged with their day-to-day tasks and activities. We spoke with two registered nurses who were employed by the provider, one agency registered nurse and the clinical nurse lead. We spoke with one agency care assistant and two care assistants employed by the provider. We also spoke with the two manager's from Rapkyns Nursing Home and Sycamore Lodge. The

clinical nurse lead and area manager were also available to answer our questions throughout the inspection. The quality assurance manager, lead clinical tutor and recently recruited clinical auditor introduced themselves during the inspection. The nominated individual who represents the provider introduced themselves to the inspection team and was present at the inspection feedback session on day two of the inspection. We also spoke with one relative face to face to gain their views of the care provided to their family member. We spent time observing the care and support that people received in the lounges and communal areas of the home during the morning, at lunchtime and during the afternoon. We also observed medicines being administered to people.

We reviewed a range of records about people's care which included six people's care plans. We also looked at three care staff records which included information about their training, support and recruitment record. We also reviewed people's Medication Administration Records (MARs). We read audits, minutes of meetings with people and staff, policies and procedures and accident and incident reports and other documents relating the management of the home.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us the home provided a safe service. Sycamore had a separate staff team led by a different unit manager which ran independently to the nursing home. At this inspection we were unable to observe interactions between people and staff who lived at Sycamore Lodge as most people were out at day services at the time of our inspection. The records and discussions we had with staff demonstrated how they aimed to provide safe care and support to young people with a learning disability. However, we found shortfalls within the Rapkyns Nursing Home which held potential risks for people living there.

Risk assessments provide information, advice and guidance to staff on how to manage and mitigate people's risks. At the last inspection we found risks posed to people were assessed and managed safely. At this inspection risk assessments we read at Sycamore Lodge identified a risk and provided sufficient guidance to enable staff to support people safely in areas such as epilepsy and asthma. We also checked to see how risks were being managed in the Rapkyns Nursing Home unit. People living in this section of the home had a diagnosis of Huntington's Disease. Huntington's Disease is an inherited condition that damages certain nerve cells in the brain. The brain damage gets progressively worse over time and can affect movement, cognition and behaviour. People were receiving various levels of support from the staff team depending on how the condition had progressed for them individually. We found inconsistencies within the care records we read which meant there was an increased risk of people not receiving the correct level of care and treatment. This included gaps within the guidance for staff who supported people with their mobility, continence needs and those at risk of malnutrition.

Where people were at risk of malnutrition, the staff team completed a Malnutrition Universal Screening Tool (MUST). MUST is a five step screening tool to identify adults who are malnourished, at risk of malnutrition or obese. One person was identified as at risk of malnutrition and prescribed a food supplement. Their care records provided conflicting information as to the exact support they required. Due to the person's weight loss, a dietician had recommended an increase from one food supplement to two daily. However, the person's risk assessment guidance and Medication Administration Record (MAR) had not been changed to reflect this increase since the appointment in October 2017 and remained at one supplement. Therefore the dietician's recommendation had not been followed up with the person's GP or influenced a change in the person's care plan. The person's weight had decreased by 4kg by November. However, this had not triggered staff to follow up the dieticians recommendation with the person's GP, placing them at an increased risk of further weight loss. We spoke with the clinical lead and manager. They informed us the increase should have been referred by the dietician with the person's GP at the time of the appointment. Shortly, after the inspection the manager wrote to us and provided assurances this had been increased and the person now received the correct amount of nutritional supplement.

Some people's mobility needs had deteriorated meaning they needed to use a wheelchair. At the last inspection we described how we had observed one person at risk of getting their fingers trapped in the spokes of their wheelchair. The acting manager at the time referred the person for an assessment of their wheelchair to minimise any further risks to the person and to ensure it specifically met their postural needs. At this inspection we identified the layout and environment of the building did not always lend itself to meet

the needs of people with complex physical mobility needs. Due to the narrow layout in some parts of the building we observed on one occasion a staff member manoeuvring a person's wheelchair around a corner incorrectly by lifting it. This was not safe practice as it meant there was an increased risk the person could be harmed as they were not remaining in the correct postural position at the time. In addition, the staff member could be injured due to this unsafe manoeuvre. When speaking with staff they also referred to the difficulties they had when transferring people when supporting them with their personal care needs. They told us this was because some of the bedrooms and communal bathrooms were too small for the moving and handling equipment they used.

We also found gaps in guidance for staff on how they should support people with their individual mobility needs. For example, one person who was a wheelchair user required staff to support them with all transfers from one piece of furniture to another. Their physical management and mobility plan indicated the need for a sling to be used when transferring the person with the use of a hoist. Slings come in various colours and types depending on the needs of a person; however the type and loop colour was not mentioned within their records. The care record referred staff to the person's transfer guidance however this could not be located during the inspection. The staff we spoke with demonstrated their knowledge of people's moving and handling needs including the equipment they used. However, the gaps within the guidance increased the risk people would be moved incorrectly potentially placing them at risk from harm. This was particularly relevant as Rapkyns Nursing Home frequently used agency staff who may be less familiar with people's needs and would rely upon this guidance in order to provide safe care.

People's care records identified and assessed if a person was at risk of constipation. People who are at risk of constipation can experience a loss of appetite and become dehydrated therefore require specific care, support and treatment. Care plans referred the reader to The Bristol stool chart (BSC). This is a diagnostic tool designed to classify the form of the human faeces into categories. People at risk of constipation had an associated bowel monitoring chart which was designed for staff to record the appropriate category in a box when supporting a person with this need. We read a number of bowel monitoring charts which had been completed incorrectly by staff members. The entries made were not in relation to the BSC categories. Due to the lack of accurate records in place we queried how the nursing staff would be able to decide if a person needed 'when required' PRN medicines for constipation. Whilst we found no evidence of actual harm and staff we spoke with demonstrated that they knew people and their bowel care needs well, the lack of clear guidance and care records placed people at increased potential risk of not having their health needs met consistently. This was particularly relevant as Rapkyns Nursing Home regularly deployed agency staff who may not have been as familiar with people's needs and associated risks. We discussed this with the clinical nurse lead and manager for their review who agreed the monitoring charts had been completed by staff incorrectly.

One person who was at risk of constipation was prescribed four different medicines to support this diagnosis. However, there was no assessment of the severity of the risk this posed to the person and guidance in place to inform the staff team how to manage and support the person safely with this. This included guidance to state when and how their prescribed medicines should be administered by staff placing the person at risk from harm or prolonged periods of discomfort.

Prior to the inspection we were made aware of a specific concern regarding how medicines were administered to a person. Whilst we were not investigating the specifics of this incident we used the information to inform how we focused on how medicines were managed. Nurses told us prescribed topical creams were given to care staff to apply whilst supporting people with their personal care. Topical creams can be prescribed to people for a number of skin related issues. However, we found inconsistencies regarding the guidance for care staff to enable them to do this consistently and safely. At Rapkyns Nursing

Home nine out of 14 people had no body maps or protocols in place for their prescribed creams which provided guidance for staff so they knew where and how it should be applied. Whilst people, their relatives or staff did not raise any concerns regarding this aspect of care, due to the lack of guidance there was an increased potential risk prescribed topical creams would be applied incorrectly for people with skin conditions.

On one occasion after dinnertime, we were alerted to one person in their bedroom upstairs by hearing them coughing. They had an empty meal plate next to them on a tray. We informed the registered nurse on duty who was also upstairs. They told us they had not heard the coughing and attended to them. We spoke with the manager about the person. We established the person was on soft diet and at risk of aspiration therefore may require additional supervision surrounding and after meal times. The manager told us the person had chosen to eat their meal in their room and were checked every hour in accordance with their agreed care plan. The manager told us as we had highlighted this they would review how staff were deployed upstairs to ensure the safety of the person was protected at all times. Shortly after the inspection, the manager confirmed they had increased the person's supervision around mealtimes and after to ensure they were protected from harm however, this was not necessarily the case prior to this inspection.

The above evidence demonstrates that not all was reasonably done to mitigate risks to service users. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had been trained in safeguarding adult procedures. However, the training received was not always implemented in practice. Accidents and incidents were recorded however there were inconsistencies within the records we read regarding the action staff had taken at the time to minimise further risks on behalf of people. This included whether they had been reported to the local safeguarding team for their review. For example, one accident record we read dated 13 October 2017 described how one person had fallen and banged their head. The description provided by the staff member completing the accident form held conflicting information. It stated, 'no injury sustained' however also stated, 'noted swelling-back of head'. It had also answered 'no' to the question of whether the GP was contacted. Shortly after the inspection, the manager sent us a neurological observation document which provided details of the action the registered nurse had taken at the time to monitor the person for signs of a head injury. They also sent confirmation the GP had been contacted. We have discussed the lack of analysis surrounding falls people had experienced further in the Well-Led section of this report.

Another accident record described how a person had displayed self-injurious behaviour and had caused a minor injury to their foot. There was no information available within the document to state what action was taken to support the person with their well-being and mental health immediately after the incident. It made no reference to external professionals being contacted; however it did make reference to the first aid applied. Shortly after the inspection, the manager informed us the person had involvement from the appropriate health professionals for additional support and the West Sussex safeguarding team had been informed at the time. Despite the Rapkyns Nursing Home and other locations operated by the provider being subject to safeguarding investigations and police investigations improvements were needed to ensure people were always protected from harm in line with legislation and best practice safeguarding people guidance. Shortly after the inspection, the West Sussex Safeguarding team informed us they had visited the Rapkyns Nursing Home in January 2018 and found not all incidents and accidents had been reported to them in line with safeguarding people policies and procedures. This included falls people had experienced.

The above evidence showed that people were not always protected from potential abuse and improper treatment. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with registered nurses who were based at the Rapkyns Nursing Home. They confidently discussed how they administered medicines to people. Registered nurses were knowledgeable as to the reasons why people had medicines prescribed to them, any known side effects and what to do in the event of any concerns. The recording system included a photograph of the person and information that was pertinent to them, this included any known allergies. Tablets were dispensed from blister packs and medicines administered from bottles or boxes were stored and labelled correctly. We observed that the Medication Administration Record (MAR) was completed on behalf of each person by the registered nurse on duty each time someone was supported to take their oral medicines. Oral medicines were administered by nurses only.

We observed other occasions where staff were able to respond to people's requests and support them within and outside of the building in a timely manner. One person told us, "I feel safe, Staff always know where I am and they remind me of things I need to do". We discussed staffing levels further with the manager at Rapkyns Nursing Home. They told us, "They have enough staff to keep people safe". One person told us, "There are always enough staff around to keep you safe, at night as well". There were 30 people living in this section of the home. They told us, and staff and rotas confirmed there was between 11-12 care staff there daily, depending on people's needs and what activities were happening. In addition there were two registered nurses permanent or agency on during the day time and at night time, separate domestic staff, an activity co-ordinator and a chef. The manager, who was also a registered nurse, was present throughout the week to offer their support regarding clinical decisions. One person had recently been provided with one to one support due to the falls they had experienced. The home had to use agency staff however the manager and staff explained most agency carers and registered nurses had been working at the home for over six months. One staff member told us, "We have enough staff since she has been here, she has made improvements". Another staff member told us they used to be short staffed but, "Now it is much better" and added, "I know these people since they were walking and talking. We manage to keep them safe".

People and their relatives told us they received a safe service and one which met their needs. One person told us, "I definitely feel safe, that's why I am here". Another person told us, "I have no doubts this was the right move for me. Staff have a good understanding of Huntington's Disease, they realise it has emotional aspects as well as physical needs". A staff member told us about the external agencies they would go to if they were concerned about people. They told us they would go to, "The police, CQC and/or safeguarding (West Sussex local authority)".

Due to concerns raised prior to this inspection the nursing home was receiving support from West Sussex County Council moving and handling advisors and other professionals from the West Sussex Clinical Commissioning Groups. They were assessing people and ensuring they were in receipt of the correct moving and handling equipment and care records were completed with the detail required to guide staff accordingly. We spoke with the manger about the impact this had on people and the staff team and if there were any lessons learned and shared from the investigations to minimise potential risks to people's safety. They told us when they had started their role, "Paperwork had been a problem" and they had already made some changes to care records to bring all the relevant information about a person together in one place to make it easier for staff to navigate around. They told us they valued any support they were given and they were trying to resolve any issues and concerns as they had been raised. They had also ensured if person had an active, 'Do Not Attempt Cardiopulmonary Resuscitation' (DNCPR) status this was clearly labelled in the daily handover file as this had been highlighted as a concern in another location under the same provider. The records we checked included guidance for all staff in the event of an emergency to ensure the correct action was taken. The manager confirmed all people who had difficulties with swallowing and were at risk of choking, had been referred to the Speech and Language Therapist to ensure they were doing all they could

to maintain safety at mealtimes. Staff had received training in 'mealtime management' and our observations confirmed staff applied safe mealtime principles in practice. The manager had been attending the recent safeguarding adult meetings and was able to comment on what investigations had concluded and what remained as on-going.

Staff recruitment practices were thorough. Staff were only able to commence employment upon the completion of a satisfactory application form, attending an interview and the provider obtaining suitable recruitment checks which included, two satisfactory reference checks with previous employers and a current Disclosure and Barring Service (DBS) check. Staff record checks showed validation pin number for all qualified nursing staff. The pin number is a requirement which verifies a nurse's registration with the Nursing and Midwifery Council (NMC). Recruitment checks helped to ensure that suitable staff were employed.

The manager and clinical lead ensured they used agency nurses who had attended the relevant training to promote people's safety. This included access to Huntington's Disease training. Four people living at the home required enteral feeding and had a percutaneous endoscopic gastrostomy (PEG) feeding tubes. A PEG allows nutrition, fluids and medicines to be put directly into the stomach, bypassing the mouth and oesophagus. Registered nurses we spoke with had attended training on the subject, were knowledgeable about the management of supporting the person using their PEG and the person's care records reflected the level of support they required from the staff team.

Due to the concerns we received prior to this inspection about the quality and safety of care provided to people living at Rapkyns Nursing Home we used this to inform what we checked during the inspection. However, we also spent time at Sycamore Lodge. People at Sycamore Lodge did not require 24hour nursing care therefore the risks to people's physical health needs were not as great as those who were living at Rapkyns Nursing Home. We were limited regarding what observations we could make regarding staff interactions with people as most people who lived in Sycamore Lodge were out accessing day services at different locations owned by the same provider. However, the care records we read supported safe quality practices. This included risk assessments which contained guidance for staff to enable them to support people safely and mitigate any further potential risks in areas such as accessing the community and epilepsy. We checked to see if people's medicines were being managed safely at Sycamore Lodge. MARs contained information pertinent to the individual they were relating to and were completed accurately this meant people were getting their medicines as prescribed.

Infection control promoted a safe and clean environment within the home. Sycamore Lodge was a purpose built spacious home which was well maintained, decorated and furnished in a style appropriate for the young people who used the service. The Rapkyns Nursing Home was an older style building which was free from offensive odours and infection control equipment was accessible for staff in the form of gloves, anti-bacterial spray and aprons. Regular cleaning took place.

Requires Improvement

Is the service well-led?

Our findings

As a result of our previous inspection in July 2017 we identified a breach of Regulation 17 of the Health and Social Care Act Regulations 2014. Inspectors had identified that systems to monitor and improve the quality of the care provided were not always effective. The provider sent us an action plan which detailed the steps that would be taken to achieve compliance. The action plan stated what had already been achieved including, 'Reviewing of risk assessments is on-going and extensive risk assessments have been put in place where needed'. The previous inspection report had been published in November 2017 therefore the provider required more time to embed and implement the improvements. However, at this inspection we found gaps in people's care records including risk assessment guidance which increased the risk of harm for some people living at the home. The action plan also stated, 'Extensive audits continue with an external consultant and Regulation 17 reports are being monitored by the quality team'. Yet external audits had failed to highlight what we had found during this inspection such as the inaccurate completion of bowel monitoring charts on behalf of people who were diagnosed with constipation and inconsistencies in other records relating to people. We read three 'Regulation 17 Good Governance' monitoring checks carried out by the provider's area manager. The last one was completed in October 2017 and given to the manager on 27 November 2017. It stated, 'MAR charts were viewed' and added, 'These were fully completed and the protocols in place for administering medication were detailed and signed by the GP'. However, these were not consistently in place at the time of this inspection.

Some people living at the Rapkyns Nursing Home were at a high risk of falls. Falls were documented and recorded on accident forms as discussed in the Safe section of this report. The provider had an extensive falls procedure which included an array of forms for staff to complete at the time. However, during the inspection these had not consistently been completed. Shortly after the inspection, the manager sent us an example of a post assessment monitoring form completed after a person fell in October 2017 which we discussed at the inspection. However, this was not held with the accident record and it was on a different format to what was within the provider's policy and procedure file and provided to us at the time of the inspection. We asked the manager about the steps and measures that were in place to audit and check information about falls, they told us they had not done this yet. The lack of overarching falls analysis and reflective practice on behalf of this person or other people when they fell meant there was a missed opportunity to ensure all actions taken by staff at the time of the accident were appropriate, responsive and carried out in a timely manner. It also meant there was no available data to identify any patterns to how, when and where falls were taking place. This information is important to help inform understanding of a people, influence improvements in guidance within care records, risk assessments and potentially aid changes to equipment and people's immediate environment. Therefore the provider had failed regarding their responsibilities to continuously review the care they provide. Considering the home aims to the meet the needs of a people with complex mobility needs this was an area which required improvement. Feedback about the quality and consistency of monitoring and care documentation at Rapkyns Nursing Home had been consistently given by external professionals and agencies in the months prior to this inspection in relation to specific safeguarding concerns. However, despite this, improvements had not been consistently made or sustained as a result.

The above evidence shows that the provider was unable to demonstrate the systems or processes in place operated effectively to ensure compliance with requirements. There was a failure to assess, monitor and mitigate the risks relating to health, safety and welfare of service users. The provider failed to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager at Rapkyns Nursing Home, who was also a registered nurse, started their role in August 2017. Therefore this was a different manager in post since the last inspection. At the time of the inspection they had yet to complete their application to become the registered manager with the Care Quality Commission. Shortly after the inspection the manager from Rapkyns Nursing Home submitted their application to become the registered manager including Sycamore Lodge.

The manager told us they were in the process of discussing with the provider separating Rapkyns Nursing Home with Sycamore Lodge as they were currently under the same registration. The ten bedded home, or unit as the provider describes it was run completely separately. It has its own manager, deputy manager and staff team and supported the needs of young adults with a learning disability. Previously managers at Rapkyns Nursing Home had maintained management oversight of Sycamore Lodge. However, the new manager at Rapkyns Nursing Home did not feel she could offer support to both sections given the very different needs required of service users in both parts of home. We discussed this with the area manager and nominated individual and wrote to them after the inspection as this was a condition on the home's registration for a registered manager to cover both units as they were under the same location registration.

Managers were approachable and made themselves available to the inspection team and were supported by a clinical lead nurse who, we were told, deputised in their absence. The provider's area manager and quality assurance manager were also present throughout the inspection.

People and their relatives spoke positively about the contributions the manager had made since joining the team. They operated an open door policy which helped promote an inclusive atmosphere. The new manager at Rapkyns Nursing Home was hands on in her approach and people appreciated how she made time for them. One person said, "[Named manager] is a good manager. She comes around every day, shows genuine interest, asks how things are going". Another person said, "We've formed a good relationship and she is about a lot we see her everyday". We checked how the provider gained people's and relative's views of the quality of care provided. Surveys were sent out monthly from the providers head office. The four we read were all positive. People also spoke about opportunities they had been given to attend resident meetings. One person told us, "We have resident meetings and we get listened to".

The manager told us they were supported by a clinical Huntington's Disease nurse specialist who was employed by the provider. They told us the specialist had been a valuable source of expertise and provided all the Huntington's Disease training to all the staff team, including the manager and agency staff. The manager said, "Throughout September [named specialist] was here every day" and added, "They are very supportive". The nurse specialist contacted us after the inspection and provided confirmation of their own qualifications and a wealth of information of the training they had undertaken with the staff team on the subject.

Staff understood their role and responsibilities when supporting people. They were provided with supervision, training and staff meeting opportunities to enable them to be involved with developing the service they offered to people. We spoke with care staff who had been working at the nursing home for five

years or more about their views about the care provided. They all presented as caring and compassionate about supporting people with Huntington's Disease. One member of staff told us, "We have had training about Huntington's Disease. The condition changes day by day, we have to adapt to the situation. I would like to carry on working here it is a good place to work" and added, "I think now (the home) is well managed. I feel the home is better now".

The manager told us they understood the responsibilities in becoming the registered manager as they had previously been registered with the Commission when working for another provider. They shared knowledge about when they formally had to send the Commission notifications. A notification is information about important events which the provider is required to tell us about by law. On the 1 November 2017 amendments to the Key Lines of Enquiry (KLOE) came into effect with five new KLOE and amendments to others that all regulated services are inspected against. We explored these with the new manager. They were aware of changes that the provider was introducing as a result of the amended KLOE and shared with us communication by the provider about how the amended KLOE would impact on location inspections such as the introduction of a 'Lessons learnt' folder to show what action was taken when things went wrong to drive improvements regarding the quality of care provided to people living at the home. The manager also explained they were introducing the National Early Warning Score (NEWS). This is a standardised system for recording and assessing baseline observations of people to promote effective clinical care. For example, it will include a baseline for what a person's temperature, pulse rate and oxygen saturations should be and what actions nurses should take if physiological checks they take are outside of the baseline and a person's health deteriorates further. The manager demonstrated they understood the areas which required improvement within the home and told us they were, "Never afraid of challenge".