SHC Rapkyns Group Limited

Rapkyns Care Centre

Inspection report

Guildford Road
Broadbridge Heath
Horsham
West Sussex
RH12 3PQ

Tel: 01403276756
Website: www.sussexhealthcare.co.uk

Date of inspection visit:
14 July 2020
15 July 2020

Date of publication:
11 September 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Rapkyns Care Centre (known as 'The Grange') is a residential nursing home that provides nursing care and support for up to 41 people living with a learning disability, physical disability and other complex needs, including autism. The service is comprised of four lodges, each with their own dining area and nurse's station. At the time of our inspection, there were 30 people living at the service. The service is based in a rural location, outside Horsham, within a locked gated site called The Rapkyns Care Site. The building is purpose built for people with disabilities and is significantly larger than most domestic homes.

Rapkyns Care Centre is owned and operated by the provider Sussex Healthcare. Services operated by the provider had been subject to a period of increased monitoring and support by local authority commissioners. As a result of concerns previously raised, the provider is currently subject to a police investigation. The investigation is on-going, and no conclusions have yet been reached.

The service was registered before the 'Registering the Right Support' guidelines were in place. However, the service was not operating in line with the values that underpin the 'Registering the Right Support' and other best practice guidance. These values include choice, promotion of independence and inclusion. These values were not always seen consistently in practice at the service.

People's experience of using this service and what we found
Risks were not being managed safely at Rapkyns Care Centre. We identified concerns relating to risks around respiratory care, feeding tubes, epilepsy, constipation, monitoring people's health, skin care, choking and unexplained injuries.

People had not been protected from the risk of abuse or neglect as systems to protect them were not effective. Staff had not always reported safeguarding concerns when they had witnessed incidents happen, such as people not receiving the correct care.

Staff were not deployed effectively to ensure people's safety. At the time of our inspection, there was only one permanent daytime nurse employed. Agency nurses relied on care plans that were often inconsistent or on different systems. There was a lack of clinical oversight of nurses from the management.

Medicines were not consistently managed as safely as possible. There had been some improvements with medicines management since the last inspection in September 2019, with regard to the regarding policies concerning medicines management. Other areas required further improvement, such as protocols for 'as and when required' medicines.

Risks around infections were minimised. The service was clean and tidy. There were strict protocols in place to manage the risk of Covid-19 (Coronavirus) and people were safely isolated when necessary, to protect them and others.

Lessons had not been learned consistently. There had been a large number of injuries to people's hands, fingers, feet and toes and these had not been picked up in audits or lessons learned. One person had an injury that was caused by an issue highlighted at our inspection in September 2019, and care plans had not been reviewed. Audits had not been effective in highlighting issues found at this inspection or improving the care and support people received.

As a new manager had started the week of our inspection the culture at the service was being changed during our inspection, but was not positive. Outcomes for people were not good and there were possible indications of a closed culture.

There was currently no registered manager in day to day charge of the service since shortly before our inspection. There was no deputy manager or clinical lead in post at the time of our inspection. Following our inspection, we were informed that a clinical lead had been seconded from the management post of another service. The provider's operations director had taken the role of 'acting manager' one day before our inspection. The provider also had a peripatetic manager based at the service. Management of the service remained ineffective and had not ensured improvements were made.

The provider had not worked effectively with all partner agencies. There had been safeguarding incidents that had not been alerted to the local safeguarding adults' team or notified to the Care Quality Commission (CQC). Local health teams had not always been made aware of people's changing needs or refusal of treatment.

The service had been engaging with people in regular meetings and had made plans for strengthening community links when social distancing measures are relaxed, and it is safe to do so.

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

Rating at last inspection (and update)
The last rating for this service was Inadequate (published 6 December 2019). At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating. The inspection was prompted in part due to concerns received about the effectiveness of improvements made and management of the service. A decision was made for us to inspect and examine those risks. Our last comprehensive inspection was in September 2019 where we found breaches of seven Regulations relating to person centred care, the need for consent, safe care and treatment, safeguarding people from harm, good governance, and staffing.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements. The ratings from the previous comprehensive inspection, for those key questions not looked at on this occasion, were used in calculating the overall rating at this inspection. The overall rating for the service has remained Inadequate. This is based on the findings at this inspection.

The overall rating for the service however has not changed as the provider was still in breach of regulations and not enough improvement had been made since our last inspection.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took

account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified continued breaches in relation to: safe care and treatment, safeguarding people from abuse, good governance and staffing

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider with regular meetings, and the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Rapkyns Care Centre

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 three inspectors and was supported by a pharmacist specialist from CQC's medicines optimisation team.

Service and service type
Rapkyns Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 had a manager registered with the Care Quality Commission. However, they had left the service in the week before our site visit. The provider's Nominated Individual had taken over day to day management of the service. The nominated individual is responsible for supervising the management of the service on behalf of the provider. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short period notice of the inspection due to Covid-19 in order to ensure we could visit the site as safely as possible. We worked with the provider to risk assess the inspection site visit and ensure our presence on site was safe. We requested some documents prior to our site visit to minimise the time we needed to be on site.

What we did before the inspection
Before the inspection, we asked the provider to send copies of care plans and other care and support documents, such as monitoring charts, for inspectors to review. 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 the acting manager, the providers' chief operating officer, registered nurses, and staff members. We reviewed people's care and medicine records, spoke with some people and observed people being supported during lunch service. Due to Covid-19, our time of site was minimised and we therefore sampled records minimised interactions where possible as a safety precaution to ensure the inspection was carried out in a safe manner.

After the inspection –
We continued to seek clarification from the provider to validate evidence found. We asked for assurance to be given around the management of people's physiotherapy and breathing care needs. Due to the level of risk posed to people we undertook urgent enforcement action to keep people safe. This included imposing a condition on the provider's registration. These conditions specifically identified actions to address safety concerns relating to three people's respiratory care; actions to take to manage people's behaviours of concern; action to address safety concerns around choking; the review of people's physiotherapy needs; the management of peoples' feeding tubes, and not receiving new admissions to the service without the prior written consent of CQC.

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 in September 2019 this key question was rated as Inadequate. Risk relating to constipation, epilepsy, health monitoring and behaviours that may challenge others were not managed safely. Medicine management was not consistently safe alongside respiratory care, and the management of people's feeding tubes. At this inspection, this key question has now remained the same. This meant people were not always safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● At our previous inspection in September 2019, we found a continued breach of regulation 12, relating to the safe management of risks around choking, constipation, medicines, and managing behaviours. At this inspection insufficient action had been taken and the provider remained in breach of regulation 12.

● Some risks had not been managed safely. Care and support was provided to some people who required treatments for respiratory conditions. Documentation and staff confirmed that people did not consistently receive this treatment as assessed. Care records for one person identified that they were known to refuse the treatment. Their care plans did not tell staff what action to take when the recommended amount of oxygen was not given or how to mitigate the risks of not getting enough oxygen. Due to the complex health needs of people, the risk of individuals not receiving enough oxygen is critical to their health.

● The same person was assessed by the local health team as needing oral suctioning of secretions to clear their mouth and throat of mucus. The person had an 'upper airway suctioning care plan' that instructed staff to inform nurses if the person had excessive oral secretions. However, from April to July 2020 there were no records of the person having received oral suctioning, despite staff recording excessive secretions. This placed the person at risk from respiratory problems such as aspiration or choking.

● A second person had been assessed by the providers' physiotherapy team who recommended in May 2020 for regular oral suctioning to reduce the risk of aspiration (breathing foreign objects into the lungs). There were no care plans for the person to receive oral suctioning and the person did not have a suctioning machine to administer this treatment. The registered nurse working on the persons' lodge and their key worker were both unaware of the recommendation for regular oral suctioning. The nurse and key worker both confirmed the person was not having this support. This placed the person at risk from respiratory problems such as aspiration. The person was hospitalised in July 2020 for aspiration.

● A third person was assessed as requiring oral suctioning. They had a 'breathing and respiration care plan' which stated they needed their upper airways cleared of secretions. It stressed the importance of ensuring saliva did not build up and cause a choking risk. We spoke to the registered nurse on the person's lodge and were told that nobody received oral suctioning. When we spoke with the registered nurse and showed them the care plan, they told us that staff on the lodge would not perform oral suctioning. The nurse informed us this was a physiotherapist's role. There was no evidence that the person was receiving oral suctioning putting them at risk of choking.

● A person's current care needs assessment completed by nursing staff noted that they needed postural draining, which is moving the person in certain positions to allow gravity to clear the lungs. However, the nurse was unable to provide any records that this had happened for one person and told us this was a

physiotherapists role. The nurse told us, "I don't know because its physio, and they have been told to stop lots of things because of Covid-19 so I am not sure what they are doing." The nurse and care worker we spoke with were unable to recall the last time the person saw a physiotherapist and said it was unlikely that the person was receiving postural drainage every day as stated in their care plan. Physiotherapy records showed the last physio session was on 19 June 2020. Between 11 and 19 June 2020 the person had 6 physiotherapy sessions; none of which mentioned postural draining or chest therapy.

● A fourth person had been hospitalised twice in June 2020 for aspiration. Oral suctioning and chest physiotherapy had been recommended in the person's 'NHS Respiratory Risk Assessment', to reduce the risk of aspiration. However, care records showed that they had not received these treatments as assessed. They were receiving oral suctioning only as required, and not twice daily as noted in their care plan. They had not been receiving their assessed chest physiotherapy as confirmed to us by the registered nurse on their lodge due to a lack of physiotherapy staff. This was also confirmed by the providers' physiotherapist. Oral suctioning and chest physiotherapy not happening had put the person at risk of aspiration.

● Some people living at Rapkyns Care Centre had feeding tubes inserted into their stomachs to provide food, liquids or medicines safely. One person was assessed by a speech and language therapist as needing to have their feed paused for 30 minutes before the tubes were flushed and before they were supported to be moved, such as when going to bed or having personal care. This was to reduce the risk of aspiration or choking. There were two sets of records to record the pausing of the feeds, but these had not been completed consistently and there was no evidence that this was happening.

● We spoke with the registered nurse and asked about the pausing of feeds for this person. The nurse confirmed they and other staff did not pause the feed for 30 minutes beforehand when supporting the person with re-positioning or personal care, or before moving the person to their bed. The nurse told us they were unaware that this was necessary. The nurse could not explain why some recording forms were not being completed consistently or why there were two systems in operation, or why no pauses of feed had been recorded on the electronic system. In addition, there was no record of staff elevating the bed or ensuring the person was in the correct position in their wheelchair whilst receiving feed or fluids, or personal care. This placed the person at risk of aspiration or choking.

● Some people required support with turning and re-positioning. Documentation reflected that turning and repositioning charts that had not been completed consistently. There were occasions recorded where staff had left a person on their front or side and they stayed in that position until the morning. We spoke with the local NHS physiotherapist who confirmed that laying on the front or side was unsafe for the person, as this would increase the risk of choking.

● Some people required physiotherapy input to be provided to assist with the movement of their limbs. People were not always receiving this care as assessed. There had been an incident report written on 29 June 2020 that recorded the provider was no longer able to provide physiotherapy support due to a lack of staffing. However, there was no follow up action to ensure people received their assessed care.

● For example, one person was currently assessed as requiring weekly physiotherapy for an ongoing health condition that caused severe pain. They had been prescribed controlled medicines to manage this pain as well as regular physiotherapy. However, the physiotherapy had ceased in mid-June 2020. We found a similar lack of physiotherapy for other people from 18 June 2020. This put people at risk of deteriorating health.

● People who were prone to their health deteriorating were assessed as needing to be monitored with a tool called the National Early Warning System (NEWS). NEWS is a standardised system for recording and assessing baseline observations of people to promote effective clinical care. The NEWS involves taking a baseline for a person's normal temperature, pulse rate and oxygen saturations. It then states what actions should happen if results are recorded outside of the baseline, and a person's health deteriorates further.

● The NEWS tool was not being used consistently at Rapkyns Care Centre. People had care plans and risk assessments that referred to NEWS assessments being completed in certain cases, such as when they had an epileptic seizure or had been administered medicines that could affect their breathing. However, people

had not always received NEWS assessments in accordance with their individual assessed needs. One person had been administered an as required (PRN) medicine on 18 May 2020. Their continence care plan stated they should have a NEWS recorded but this had not happened.

● A second person had a seizure on 19 June 2020 and was administered a rescue medicine that could affect their breathing. Their seizure management protocol stated that if the rescue medicine was administered, staff needed to monitor the person's vital signs via the NEWS charts and monitor their respiration rate. If the respiration rate was depressed staff were to call an ambulance. However, following the medicine being administered on 19 June 2020 a NEWS chart was not completed.

● Although NEWS had been used to monitor people who were isolating after positive Covid-19 tests, it was not being used consistently to monitor other health needs, despite care plans and risk assessments setting out the need for it. We spoke with registered nurses during the inspection who told us that the NEWS system was no longer used as people's vital signs were recorded on the electronic care planning system. One nurse told us, "There are no NEWS charts being used anymore." A second nurse told us they were not filling in NEWS forms for people except two people they identified. However, for one of the people the nurse identified, they had not had a NEWS assessment since 1 April 2020. When questioned on this the nurse told us that baseline observations were recorded on the electronic plan.

● We checked the electronic system and the recording of any vital signs for this person following a seizure were inconsistent. Furthermore, they had not had their respiration rate recorded. This person was living with a respiratory condition and was at risk of breathing difficulties. The failure to monitor people's changing health needs put people at risk of not receiving the clinical care they needed when their condition deteriorated.

● Some people were diagnosed with epilepsy and risks around this condition were not always being managed safely. One person had been recently hospitalised following an epileptic seizure that caused them to have breathing difficulties. However, their epilepsy care plan did not reflect that the person was prone to breathing difficulties following a seizure, and there was no epilepsy risk assessment for the person. The person was also prescribed oxygen to help them recover from their seizures but the instructions for its' use were not clear. The epilepsy care plan directed staff to administer it when needed; it did not state what the persons oxygen saturations should be before giving the oxygen.

● A third person with a respiratory condition was prescribed a rescue medicine that could affect their breathing. They had an epilepsy care plan, but this did not explain what their baseline respiration rate was, or what depression of the respiratory system looked like for them. It also failed to state how staff should keep the person safe until an ambulance arrives, for example, by administering oxygen.

● The same person had three seizures between April 2020 and July 2020 where they were recorded as breathing heavily. There was no record of oxygen being administered to the person following these seizures or during the person's recovery, and no record of their respiratory observations being taken. The failure to manage the risks around epilepsy put people at risk of prolonged seizures, not receiving the care they require or breathing difficulties.

● Some people living at Rapkyns Care Centre had behaviours that may challenge others. Risks associated with the management of these behaviours was not being managed safely or in line with best practice. One person was identified at our last two inspections as requiring a Positive Behaviour Support Plan (PBSP), or similar plan in line with the principles of positive behaviour support. At this inspection they still did not have guidance for staff on how to support he persons behaviour in a positive way. A PBSP is a document that explains how a person needs to be supported when they are experiencing high anxiety and could be challenging, and how to reduce the chances of this happening in the future. We asked the registered nurse on the lodge if there was a PBSP, or other similar guidance on how to support the person with their behaviours, and were told there was not.

● The same person had a sensory screening completed in 2019 and it identified important interventions, such as staff giving the person deep pressure, that helped manage their anxiety. However, this was not

reflected in their ABC charts. ABC charts record what happens before, during and after an incident of behaviour that may challenge. The persons' support, as recorded in their ABC charts, did not reference any of the sensory activities, such as deep pressure or messy play, that were outlined in their sensory screening. Staff support when the person was anxious tended to be offering pain relief or a change of environment. These actions were not in line with the person's sensory screening assessment.

● Another person bit themselves on the arm in June 2020. The reason recorded for this was 'distress'. However, the person had no PBSP, there were no ABC charts completed, and no risk assessment around this. The persons 'mental health behaviours' care plan was updated in July 2020 after the incident, but it stated, 'I have no behaviours that may challenge'. The lack of guidance for staff on how to support this person with their behaviours put them at risk of injury, restraint or experiencing more behaviours in the future.

● We spoke to the providers Autism and positive behaviour lead who feedback to us that the service was not recording ABC charts correctly and that staff understand of and recognition of behaviour support needed improvement. The failure to manage people's behaviours put people at risk from injury or distress.

● Some risks around choking were not being managed safely. An NHS England Patient safety alert on 6th February 2015 set out the risk of death from asphyxiation by accidental ingestion of thickening powder. However, during our inspection, we found cupboards in the dining rooms containing thickening powder that should be locked, that were left open. In one Lodge one person could reach up to the cupboard. This posed a risk to people from choking. We requested immediate action was taken to put this right.

● Some people had specific eating and drinking instructions to reduce the risk of choking. We observed two people being supported to eat by staff. On three occasions we observed that people's spoons were loaded with food, where their eating and drinking guidelines advised level spoonful's or smaller amounts to reduce the risk of choking.

● One of the people who had heaped spoonsful of food, had several different guidance documents about how to support them to eat and drink safely. The person had speech and language guidelines and care plans around how to eat and drink safely. Information within these plans was not consistent. We asked a registered nurse how they were assured that staff would know the correct and safe way to support the person to eat and drink. The nurse said staff would refer to the eating and drinking guidelines. However, these did not match the person's care plans. The latest guidance from 2019 described support that we did not observe during the inspection.

● Another person had an eating and drinking plan, but this did not state that they required their food to be prepared in a safe way. Their risk assessment for choking stated that staff should ensure the person had a soft, moist and mashed diet, with normal fluids. However, if the person was unwell then they may require level 1 (slightly thickened) fluids. None of this was in the person's eating and drinking plan. Failure to keep people safe from choking put people at risk or death or severely ill health. We requested the provider took immediate and ongoing action to put this right.

● We identified some concerns around the management of people's bowel conditions. One person was prone to constipation and had a constipation care plan. There was no mitigation of the risks around constipation within the care plan, and no constipation risk assessment. This left the person at risk of experiencing further episodes of constipation or of not receiving the correct support with their bowel care.

● Another person was diagnosed with constipation and was prescribed a PRN medicine to help them open their bowels. The medicine should be administered after 48 hours of no bowel movement. However, there were two occasions in May and June 2020 where the person did not open their bowels for three days and were not administered their medicine. We asked a registered nurse working on the person's lodge about this and they agreed the medicine should have been administered on both occasions.

● Some people were at risk of dehydration and needed their fluids monitored by staff. The recording of fluids was not consistent, meaning people may not be getting enough to drink to maintain good health. For example, one person's care plan stated that they should be offered a drink of their choice every two hours.

However, their care records showed this was not happening. There were days when the person was recorded as drinking very large amounts in a short timeframe and other days when the person was recorded as drinking very small amounts over the course of the whole day .

● Another person had a recommendation made in an NHS assessment in January 2020 that their fluid intake should be reviewed to ensure they are adequately hydrated. In subsequent physiotherapy reports, written by the provider's physiotherapists, there was no evidence that this had been carried out. We reviewed their fluid balance charts for April to July 2020 and these had not been completed consistently. From the records we reviewed, the person was consistently not receiving the recommended amount of fluid (2200ml) every day. Failure to consistently monitor people's fluid intake placed them at risk of dehydration, respiratory risks and health complications.

● Following our site visit, we raised serious concerns about people's safety to the provider in a letter of intent. We also imposed urgent conditions on the location to ensure people's safety.

Learning lessons when things go wrong

● During our inspection, we became aware of a pattern of injuries to people's fingers, hands, toes and feet, including two unexplained fractured bones, one of which was for a person without independent movement of their limbs. There were a very high number of bruises, cuts, marks, abrasions and injuries to toes and fingers that we highlighted when reviewing care plans and incident reports prior to the site visit. We discussed with the provider whether this could be due to poor moving and handling and requested an audit and report. The pattern of injuries had not been identified by the provider and lessons had not been learned from injuries to people.

● One person had a bruise on their body that was thought to be caused by a moulded brace to help their posture. The same issue was noted for this person during our inspection in September 2019. The same guidelines were in place at this inspection, on a different format. A risk assessment had been completed on 29 June 2020 but had not been updated to reflect the lessons learned from this previous incident or to advise of a planned new brace.

● Following our site visit we asked the provider to take action to ensure peoples safety. We requested a full review of people's care plans for feeding tubes, respiration plans, suctioning plans and monitoring forms or documents that relate to how people are supported with breathing, reflux, or aspiration risk. The provider sent care plans to us that had not addressed our concerns and in some cases had not been reviewed. For example, one person assessed by the providers own physiotherapist as needing oral suctioning still did not have this information in their reviewed breathing and respiration care plan.

● We sent a letter of intent to the provider setting out our serious concerns and asking for action to be taken. The providers' response did not address the concerns, was high level and set timescales for action that were not sufficiently urgent. As a result of this we imposed urgent conditions on the providers' registration for Rapkyns Care Centre setting out the actions required to keep people safe.

The failure to ensure effective risk management, to monitor and analyse incidents and to ensure that suitable actions were taken to make improvements and prevent further occurrences was 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

● At our previous inspection in September 2019, there was a continued breach of regulation 13, relating to keeping people safe from the risk of abuse. The provider had not been analysing incidents to identify potential abuse, such as neglect, when delivering care. At this inspection, we found insufficient action had been taken and the provider remained in breach of regulation 13.

● People were not being kept safe from the risk of neglect. During our inspection, we raised a safeguarding alert to the local safeguarding adults' team, for one person who had not received their prescribed medicines

to relieve constipation on two different occasions.
● We were also made aware of concerns raised by the local health team. These were raised as a safeguarding alert for a person not receiving the treatment, they needed with their ventilation machine. We had not been notified by the provider of this safeguarding alert.
● We also became aware of several other safeguarding alerts that we had not been made aware of. There had been three safeguarding alerts raised by the local health team since December 2019 relating to respiratory concerns that we had not been notified of. Another safeguarding alert had been raised by a hospital that we had not been notified of. When we discussed this with the providers' peripatetic manager, we were told they did not think they needed to send the statutory notifications to CQC until the alleged abuse was corroborated. This was incorrect and it is an offence to fail to notify CQC without delay of any alleged abuse.
● Following our inspection, we requested the provider conduct an audit and report to us about the number of injuries to people's feet, toes, hands and fingers, including fractures. During this audit process the provider found two incidents that had not been reported by the management of the service to safeguarding or notified to CQC. We requested that these Notifications were sent to us without further delay.
● There had been incidents that could indicate a closed culture. "A closed culture is a poor culture in a health or care service that increases the risk of harm. This includes abuse and human rights breaches. For example, one person had been witnessed to be drag lifted. A drag lift is a dangerous moving and handling technique that involves moving a person from underneath their armpits. It is not taught in moving and handling training and can result in broken bones. There were three staff who witnessed the drag lift, but it was only reported to the local safeguarding adults' team by a visiting health professional.
● There had been incidents reported where staff had allegedly been verbally and physically abusive to people. The provider had been quick to act when made aware of these alleged incidents. However, these alleged incidents could also indicate the provider was unaware of a possible closed culture.

The failure to implement systems that effectively prevent abuse was a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Staffing and recruitment
● At our previous inspection in September 2019 there was a continued breach of regulation 18, relating to a failure to deploy enough nurses to meet people's needs. At this inspection, there was insufficient action had been taken and the provider remained in breach of regulation 18.
● There were not sufficient resources deployed to meet people's needs safely. At the time of our inspection there was only one full time permanent nurse employed in the daytime. This meant that agency nurses were covering at least 82% of daytime nursing hours, before annual leave or sickness. The lack of permanent nurses in the daytime was a concern as care plans were found to be lacking or contradictory meaning agency nurses may not be able to find the correct infomration they need to care for people. The provider assured us, and staff rotas confirmed, that all nursing shifts were covered with registered nurses. The registered manager who was also a registered nurse, was no longer employed at the service having retired before our inspection. This meant that there were even fewer qualified nurses to cover shifts or provide clinical leadership.
● The service had no registered manager, deputy manager, or clinical lead at the time of our inspection. Following our inspection, the provider informed us that another manager, who was a registered nurse, had been seconded to act as clinical lead and the operations director was applying for registration with CQC to become the registered manager for Rapkyns Care Centre.
● Deployment of staff had been a concern reported in relation to the pattern of injuries to people's hands, fingers, feet and toes. Following our inspection, we had requested the provider complete an audit and report into the cause of these injuries. One of the conclusions drawn in their report was for staff to be

supported to continue to mix agency staff with permanent staff and to regularly book the same competent agency staff to assure continuity of care.
● There were further issues identified around the deployment of physiotherapy staff. An incident report was written by the providers' physiotherapy team stating that due to a lack of staffing, they were unable to provide physiotherapy support to people. This meant that people's assessed needs were not met due to a lack of staffing. We spoke with the providers' physiotherapist, who was the only physiotherapist available to support all people at Rapkyns Care Centre. The physiotherapist told us that it would be impossible for them to meet people's needs until at least three or four more physiotherapy staff were recruited. This put people at risk of not receiving their assessed care and support.

The failure to deploy enough staff with relevant skills, competence and experience to care for people safely is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had been recruited safely and had the correct employment, identity and criminal records checks on file. Registered nurses had PIN numbers to verify they were registered with the Nursing and Midwifery Council.
● The service had managed to safety staff the service throughout the Covid-19 pandemic. A staffing tracker, with each staff's skills was used when staff had to self-isolate. The tracker was kept up to date by the management team.

Using medicines safely
● At our previous inspection in September 2019 we found a breach of regulation 12, relating to the safe management of risks around choking, constipation, medicines, and managing behaviours. During this inspection the provider had made some improvements, but further improvements were necessary to meet the breach of regulations and manage medicines safely.
● One person had a 'mobility care plan' that stated the person had a drug allergy to aspirin and ibuprofen. This was not in their medicines care plan. They were prescribed a controlled medicine for pain relief, but this was also not in their medicines care plan. This put the person at risk of not receiving the correct medicine or being given unsafe medicines.
● The same person had no separate PRN protocol for oxygen. The persons seizure management protocol only stated to administer oxygen at 2-3 litres but not at what point. This left the person at risk of not receiving oxygen following a seizure, when they could experience breathing difficulties.
● Another person had a PRN medicine to manage their constipation. The instructions for use were to administer this medicine if the person had not opened their bowel for three days. However, they were administered it after opening their bowel the day before. The nurse we spoke with was unable to state why this medicine had been administered. This meant the person had received an overdose of medicine.
● The medicines administration records (MAR), care plans and personal emergency evacuation plans (PEEP) we reviewed were not always consistent.
● We reviewed care plans and MARs for people living with epilepsy. Whilst they contained sufficient information to support people, the information was located across three separate documents. This meant if a person had a seizure there was a risk the staff may not be able to access the necessary information on how to manage the seizure safely in a timely manner. This placed people at risk of not receiving the correct care to recover from seizures.
● We reviewed care plans and MARs for people who were prescribed medicines to relieve their constipation and found that two people's allergy information was not recorded consistently in their MARs. This placed people at risk of receiving unsafe medicines.
● We reviewed the care plans and PEEPs for people. A 'PEEP' is a bespoke "escape plan" for individuals who may have difficulties evacuating a building to a place of safety without support or assistance from others.

PRN oxygen and flammable barrier and dry skin creams were not documented as risks within the PEEPs.

The failure to manage medicines safely was a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Preventing and controlling infection

- The provider had been implementing strict procedures to keep people safe from the risk of Covid-19. There were separate entrances and exit from different areas of the building. Staff were asked to change clothes on entering the building, had their temperature taken, and their shoes disinfected.
- There were procedures for staff to comply with PPE requirements, and where people had returned from hospitals, they were isolated to ensure they and other people were safe.
- The service was clean, and the risk of infections had been reduced through regular cleaning.

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 in September 2019 this key question was rated as Inadequate. At this inspection this key question has remained the same. 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.

Continuous learning and improving care

● At our previous inspection we identified six breaches of regulation. This was a focused inspection covering the Safe and Well led domains, so we did not look at all of these areas; however, the breaches we looked at that were identified in the key questions Safe and Well-led remained unmet. These were breaches relating to safe care and treatment, safeguarding people from abuse, good governance, and staffing. The breach relating to good governance was identified at our inspection in September 2018 and this is now the fourth consecutive inspection in which this regulation has remained in breach. In addition, we identified a new breach of CQC's Registration Regulations relating to failing to notify CQC of significant events.

● CQC imposed provider wide conditions on the provider requiring a monthly report to be sent to CQC. From the monthly report in June 2020, the provider referred to a safeguarding alert around one person's ventilation treatment and recorded that actions had been taken. However, the actions were not found to be in place at this inspection and the person remained at risk. This demonstrated a failure by the provider to act on safeguarding concerns.

● At this inspection, that people were still not always safe from a range of risks to their health and safety, including risks related to respiration, epilepsy, behaviours that may challenge others, positioning, feeding tubes, unexplained injuries, choking, monitoring people's health needs, and constipation. Staff were not being deployed to ensure people's safety, and people were not being protected from neglect or abuse, as systems and processes to protect them from abuse were not effective.

● The provider's quality audits had not been effective in identifying areas of concern, or in responding to our concerns. Prior to our site visit, we were sent a service improvement plan, but actions recorded as complete were found to be lacking at this inspection. For example, Waterlow charts should be completed monthly for people who were at risk, but this was not happening, despite being marked as complete on the service improvement plan. We checked the care records for one person with a 'very high' risk rating and their Waterlow chart had only been completed in May 2020. Another person at risk of skin breakdown had only had their Waterlow assessment completed in April 2020. The plan also marked as complete the action for notifying CQC of every safeguarding incident. This was not found to be the case and we had not been notified of several safeguarding alerts.

● Following our inspection, the acting manager had sent a copy of an audit plan that would aim to ensure the service and the provider learned lessons and improved the quality of support offered.

● The provider had introduced a new electronic care planning system in the weeks before our inspection. There had been some positives noted, such as some improvement around recording bowel movements or some people's fluid charts. However, there were cases where two separate recording forms were in use: in paper form and electronically. This made it difficult to audit people's care. There was also the risk that

people's health needs would be not monitored correctly as staff were recording incidents, such as epileptic seizures, on paper copies as well as electronic formats.
● There had not always been effective oversight of the provider's physiotherapy team. We spoke with the providers' physiotherapist who told us they had worked in the providers' 'east' team, and had been seconded to Rapkyns Care Centre as part of the provider's 'west' team to cover for the physiotherapy staff who had left. The physiotherapist did not know what had happened about the oral suctioning requirements, chest physiotherapy treatment or not following recommendations for nebulisation for one person. This demonstrated the provider had not implemented effective systems to maintain and improve people's care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● The leadership of the service remained ineffective. The provider and management team had failed to ensure that people's needs were effectively met. This continued to have an impact on people's safety, and the quality of care they received.
● There was a registered manager in post, but they had left shortly before our inspection. This meant they were not in day to day charge of the service. There was no deputy manager or clinical lead in post at the time of our inspection. Following our inspection, the provider informed us that a clinical lead had been appointed. There was also a lack of daytime permanent nurses, as agency nurses were working more than 80 percent of the daytime nursing shifts. Clinical oversight of nurses from the management team had been reduced with the retirement of the registered manager who was a registered nurse.
● Concerns about risks associated with: respiratory care, constipation, choking, epilepsy management, feeding tubes, staff deployment and auditing had all been highlighted to the provider on many occasions at Rapkyns Care Centre and other of their services. This information had not been properly shared or used to improve safety and care at Rapkyns Care Centre.
● Following our inspection site visit, we spoke with the NHS physiotherapy team who highlighted several safeguarding alerts and ongoing risks around one person's respiration care, ventilation treatment and aspiration risks dating back to August 2018. The most recent safeguarding alert for this person had been raised in May 2020 after a routine 'check in' call discovered that the person was not receiving their ventilation treatment as directed, since the ventilator was issued in February 2020. There had been no action taken by management at the service to address this or report the concerns.
● Following our inspection, we raised our concerns about people's safety with local commissioners and also with commissioners that were funding placements at Rapkyns Care Centre out of placing local authority area or borough.
● We found during the inspection process that at least four safeguarding incidents had not been notified to CQC. Two of these were raised by the local health team, one by a hospital and a further incident involving an injury was not notified at the time of the injury. All registered providers must notify CQC of all incidents that affect the health, safety and welfare of people who use services. The failure to Notify CQC of incidents without delay is an offence.

The failure to notify CQC of significant incidents is a breach of Care Quality Commission (Registration) Regulations 2009: Regulation 18

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● A culture change had started to be enacted by the new management team. However, the overall culture in the service was not always positive. The service was not safe for people, people's needs were not being met, outcomes were not good for people's health and people were not protected from abuse.
● There were indications of a possible closed culture, such as staff not reporting safeguarding incidents

when they occurred, and external professionals having to raise several safeguarding alerts.
● Health outcomes for some people had not been consistently good. For example, one person had been hospitalised twice in June 2020 with aspiration pneumonia. When we checked their care records, we found they had not received the care and support they needed for their respiratory needs. There had been a high number of injuries to people's hands, fingers, feet and toes, including two unexplained fractures.

Working in partnership with others
● The provider had not been working effectively with all partner agencies. Some safeguarding alerts had not been sent to the local safeguarding adults' team.
● The local NHS physiotherapy team had not been made aware of one person not receiving their ventilation treatment as assessed.

The failure to assess, monitor and improve the quality and safety of services, to mitigate risks, and to maintain accurate records, was a continued Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had recently conducted a 'people we support' survey for the whole company. There were weekly attendance meetings, to discuss activities; what people wanted to do. Prior to social distancing measures related to Covid-19 there were regular family's meetings.
● The acting manager told us that people from other of the provider's services visit and met up with people at Rapkyns Care Centre. There were local links to pubs where people go to visit. The acting manager had attended a Skills for Care 'well led training' which had led to an idea to use some of the spaces at Rapkyns Care Centre for community groups such as the local Lions Club or Women's Institute groups to use and foster reciprocal relationships.