SHC Rapkyns Group Limited

Rapkyns Care Centre

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

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 28 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.

People's experience of using this service and what we found
We received information raising concerns about the support people received with their feeding tubes and positioning, particularly when lying in bed. We inspected the service, without giving any notice, at 07:15. We found people were at the correct angle whilst lying in bed. However, we also found that people were not having the care and support they needed with their physiotherapy.

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

Rating at last inspection
The last rating for this service was Inadequate (published 11 September 2020).

Why we inspected
The inspection was prompted in part due to concerns received about people's postural care and support with their breathing and physiotherapy needs. A decision was made for us to inspect and examine those risks.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. We do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Please see the Safe section of this full report.

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

Follow up

We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question Inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Is the service well-led?

Inspected but not rated

At our last inspection we rated this key question Inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Rapkyns Care Centre

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check on a specific concern we had about postural and respiratory care, and physiotherapy support.

Inspection team
The inspection was undertaken on both days by two inspectors.

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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection. We had requested information from the provider prior to the inspection and this information was used as part of the inspection plan.

During the inspection-
We spoke with four people who used the service about their experience of the care provided. We spoke with seven members of staff including the provider, manager, clinical lead, senior care workers, nurses and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included six people's care records and a variety of records relating to the management of the service, including physiotherapy records and positioning charts.

After the inspection –
We continued to seek clarification from the provider to validate evidence found. We looked at care plans and documents sent to us by the provider. 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 people's physiotherapy needs and the management and review of people's physiotherapy support.

Inspected but not rated

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question, we had specific concerns about.

The purpose of this inspection was to explore the specific concerns we had about Rapkyns Care Centre.

Assessing risk, safety monitoring and management

● People were not receiving their assessed physiotherapy support. One person had a care plan that stated the need for daily chest physiotherapy or postural drainage care. This person had been identified on the service's physiotherapy roster for five sessions of this physiotherapy provision a week. Their physiotherapy notes show that for July 2020, August 2020 and September 2020 they received a total of 22 physiotherapy sessions whereas the physiotherapy roster shows the person should have received 66 physiotherapy sessions.

● The person was assessed as 'high risk' on the provider's 'Respiratory Decision Tool'. The Respiratory Decision Tool was used by the provider to determine a priority of need and risk level. However, the physiotherapy assistant was unable to state why the person was not receiving 5 sessions a week or whether their assessed needs had changed to account for the reduction in therapy. The person had no risk assessment for missing these sessions, and there was no documented decision to stop chest physiotherapy. There was no care plan to manage any reduction in physiotherapy sessions, despite two thirds of planned sessions failing to be delivered in the period 1 July to 30 September 2020. Without the physiotherapy and postural drainage sessions the person could be at risk of secretions building up in their airways.

● Another person had been identified on the physiotherapy roster for two sessions of physiotherapy per week. Care records for this person for September 2020 showed they had not received these treatments as assessed. The physiotherapy notes for September 2020 showed only five of the person's nine sessions were delivered. This person had also been assessed as 'high risk' on the provider's Respiratory Decision Tool. There was no risk assessment or care plan to account for the reduced physiotherapy service provided to the person. This person would also be at risk of secretions building up in their airway without the correct physiotherapy support.

● A third person was identified on the physiotherapy roster for two sessions of physiotherapy each week. Care records for September 2020 showed that they had not received these treatments as assessed. The physiotherapy notes for September 2020 showed three of their nine physiotherapy sessions had not been delivered. This person had been assessed as a 'medium risk' on the provider's 'Respiratory decision tool'. The 'Physiotherapy spreadsheet' showed there had been no postural or respiratory physiotherapy assessment completed for this person. The person had been recorded on their care plan as being at risk of chest infections.

● Prior to our inspection we were told by two visiting health professionals in a safeguarding alert that a person had been lying flat whilst in bed despite this being a known risk. We raised this with the provider in a formal meeting and were told that this categorically was not the case. However, during our inspection we found evidence that indicated that this person had in fact been laid flat as described in the safeguarding

incident by the visiting health professionals. This put the person at risk of choking or aspiration (taking particles such as saliva or food or fluid into the lungs).

● One person had a type of ventilation which they needed for set times in the day and evening to help manage a health condition. The mask used for this ventilation had broken and they had not been supported to receive the treatment consistently as required for a period of five days. The person had been given the ventilation with a broken mask during this five-day period, or it had not been given at all. Staff had failed to recognise this issue or assessed the possible risks until the fourth day as no action was taken to seek advice or put alternative arrangements in place to keep the person safe until the fourth day of the mask breaking.

● A second person had a type of ventilator to treat a medical condition. Their breathing and respiration care plan stated for staff to follow the guidelines in the person's room, but we checked their room and there was no guideline for staff to follow on how to use the ventilator. The person's medications support plan also contained no clear guidance about the ventilator and referred to guidance in their bedroom and care plan, for how to correctly place the mask. Staff were not able to produce this guidance.

● The person's daily notes stated when the ventilator treatment was started but there was no clear record for how long they had it. We spoke with a physiotherapist appointed by the provider to oversee improvements in the physiotherapy provision following our inspection in July 2020. The physiotherapist confirmed to us that they had seen guidance for the ventilator but was not able to see corresponding records in care notes about what had happened. This left the person at risk of not having the care and support they needed with this treatment.

● We spoke with the manager who identified people with a risk of reflux. Reflux could put a person at risk of choking or aspirating if they are laid flat. We checked the care plans for three people who were identified as a risk of reflux. All three people had a respiration care plan that stated there were no respiratory problems, and a low risk of developing chest infections. This left people at risk of developing respiratory issues related to reflux.

● One person had oral tasters. Tasters are small amounts of food given under specific conditions to people who usually do not get their nutrition orally. The person was presenting as 'chesty' and the GP was called. However, the person's tasters were not suspended, and staff continued to give amounts of food orally to the person. A visiting health professional raised this concern as a safeguarding alert. During our inspection we found the care plan did not outline any risks around tasters and the risk of aspiration, chestiness or choking. The person's care plan had not been updated despite the safeguarding being raised. This left the person at risk of not receiving safe care.

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.

Inspected but not rated

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question, we have specific concerns about.

The purpose of this inspection was to check concerns raised around the management of postural support, respiratory care and physiotherapy provision.

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

- Managers had not taken sufficient action from our previous inspection in July 2020 when we raised serious concerns about people's physiotherapy provision. A physiotherapy audit was sent to the Commission by the provider on 24 August 2020. This was followed by an updated physiotherapy audit sent to the Commission on 17 September 2020 and was for the week ending 11 September 2020. In the three weeks between the two audits only two respiratory assessments were marked as 'in progress' and only one postural assessment had been marked as 'in progress'. No assessments had been completed.
- Of the 26 people assessed in the audit as requiring physiotherapy and hydrotherapy sessions per week, two people, had been assessed for both their respiratory and postural needs. Since an urgent condition was imposed upon the registration of Rapkyns Care Centre on 24 July 2020 to complete an audit of each service user's physiotherapy needs, only three assessments had been completed. This left 49 assessments still to complete in respect of physiotherapy and hydrotherapy needs. The failure to carry out these assessments left people at risk of their respiratory and postural care needs not being met, and of exposing them to risks to their health and well-being.
- The management team did not have oversight of physiotherapy provision at Rapkyns Care Centre. We spoke to the manager about how physiotherapy and hydrotherapy was managed, and the manager explained to inspectors there was a standard 'physio roster' in use. The manager confirmed there was no central record of what physiotherapy support had been provided, and all that was in place was people's individual physiotherapy notes that the physiotherapy assistant completed after each session.
- However, the physiotherapy assistant, who was providing daily physiotherapy support, confirmed they wrote individual physiotherapy notes after delivering each session, but there was no central spreadsheet or tracker in use to review how many physiotherapy sessions had been provided. The physiotherapy assistant told us, "No one is checking that people are having the right amount of support with me. If they checked, they would see how much people are missing the session. I am worried about some people."
- Assessments of service users' physiotherapy needs had not been carried out to enable the risks to individuals to be understood and reduced appropriately. At our last inspection in July 2020 we imposed an urgent condition on the provider's registration to complete an audit by 31 July 2020 of all people's assessed physiotherapy needs detailing what physiotherapy input each person required, what action will be taken if it cannot be provided and how these needs will be monitored. This was not completed, and we were told by a manager that the assessments did not start until 14 September 2020. Failing to act in a timely way put

people at risk of not receiving their correct physiotherapy and hydrotherapy support. The condition also highlighted the need for the provider to send a report detailing any missed physiotherapy and what actions were taken when physiotherapy was missed. This report was not received by the Commission.

● The provider had failed to deploy enough physiotherapy staff to deliver the physiotherapy and hydrotherapy the 'physio roster' showed was required. Managers had not carried out sufficient or robust auditing to have adequate oversight of physiotherapy provision at Rapkyns Care Centre, and timely action had not been taken to address shortfalls in that provision which has failed to meet people's needs. This potentially placed people at risk to their health and well-being.

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.

● Following our inspection, we imposed an urgent condition on Rapkyns Care Centre that set out that the registered person must appoint sufficient numbers of qualified and experienced physiotherapists, with the correct skills and knowledge to carry out detailed assessments of all peoples' physiotherapy needs. The provider must also send to the Commission a report detailing the physiotherapy care and treatment delivered to each person identified as having physiotherapy needs.

● We have held meetings with commissioners who are responsible for people's care at Rapkyns Care Centre and are working with partner agencies to ensure people's needs are assessed and met. We will continue to monitor the care and support people receive at Rapkyns Care Services.