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

Summary of findings

Overall summary

The inspection took place on 10 July 2018 and was unannounced.

The provider and its associated locations have been subject to a period of increased monitoring and support by commissioners. Investigations are ongoing by the local authority, police and partner agencies at some of the provider's locations. Our inspection did not examine specific incidents and safeguarding allegations which have formed part of these investigations. We have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and will report on what we find.

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

We carried out an unannounced comprehensive inspection at Rapkyns Nursing Home in June/July 2017 and a focused inspection in December 2017, where it was awarded a rating of 'Requires Improvement' in all domains and overall. Whilst much of the evidence resulting in breaches of regulations related to the main building at Rapkyns Nursing Home rather than Sycamore Lodge, the registration covers both locations/buildings, and therefore the rating applies to both. As a result of this inspection, the overall rating for Rapkyns Nursing Home (and the service known as Sycamore Lodge) remains at 'Requires Improvement'.

The last manager at Rapkyns Nursing Home de-registered with the Commission in August 2017. A new manager took over in August 2017 and at our inspection in December 2017, we were informed they had commenced the registration process. However, the manager currently in post at Sycamore Lodge commenced the process of registering with the Commission in May 2018. Therefore, there has been no registered manager since August 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered person'. 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.

Sycamore Lodge, which comes under the registration of Rapkyns Nursing Home, 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.

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 the 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.

At the last inspection, we found people did not receive safe care and treatment. At this inspection, we found that whilst some risks to people were managed safely, this was still an area that requires improvement. Risks to some people had not always been identified and assessed safely and care plans had not provided consistent information in relation to people's risks or guidance for staff. Medicines in the main were managed safely, but we have made a recommendation in relation to the safe administration and management of topical creams.

At the last inspection, we found that staff had not always received appropriate support, training, supervision and appraisal as was needed to carry out their roles. At this inspection we found that insufficient improvements had been made and this regulation was still not met. Staff completed a range of training that was considered by the provider to be mandatory to the role. Not all staff had completed the training as required. Staff received regular supervision from the manager with annual appraisals.

Everyone living at Sycamore Lodge was subject to Deprivation of Liberty Safeguards, although some were awaiting authorisation from the local authority. Capacity assessments had been completed as required. However, when decisions needed to be made in people's best interests, these were not always taken in line with the code of practice under the Mental Capacity Act 2005. Some people were subject to forms of physical restraint for which the process in making this decision had not been followed.

People's nutritional requirements had been assessed, but some people's needs had not been fully documented or assessed. This is an area for improvement. The lunchtime meal for people living at Sycamore Lodge was prepared at another of the provider's locations nearby and transported over to the home in a heated trolley. People enjoyed the lunch provided.

At the last inspection, we found that people did not receive personalised care that met their needs and preferences. This continues to be an area for concern. Some care plans did not document people's personal histories or preferences, so care and support could not be delivered in a person-centred way. Outings into the community were limited. People's communication needs had not been assessed in a way that ensured staff communicated with people in a way that they understood. Information was not presented in an accessible format.

At the last inspection, we found that systems had not been developed to monitor the quality of the care delivered or the service overall, to drive continuous improvement. At this inspection, this is still an area of concern. Some of the provider's audits had identified the same issues we found at inspection, but other concerns had not been addressed. After the inspection, we were sent an action plan which identified what actions the provider said had been, or were to be, taken in response to the concerns we fed back following inspection.

Providers of services registered with the Commission are required to display the rating of the service at the

location and on their website, if they have one. According to the provider's website, Sycamore Lodge was awarded a rating of 'Good' at the last inspection. This was not correct. Sycamore Lodge comes under the registration of Rapkyns Nursing Home, which was awarded a rating of Requires Improvement at the last inspection. The rating for Sycamore Lodge is, therefore, 'Requires Improvement' and not as stated by the provider.

Relatives had mixed views about the management of the home. The manager had plans to involve relatives more with the production of a newsletter and the introduction of coffee mornings.

We observed instances where staff were kind and caring with people and one occasion where the staff member did not know how to respond to one person's needs. Care plans did not always document detailed information about people's preferences, so agency staff would not necessarily have known how to care for people in line with their preferences. People were encouraged to make choices, but work was still to be done to make sure communication systems were implemented that were responsive to people's needs. People were treated with dignity and respect.

Premises were managed safely, with testing and servicing of equipment being completed as required. Staff had an understanding about keeping people safe and the majority of staff had completed training in safeguarding adults at risk. Staffing levels were sufficient to meet people's needs. Safe recruitment systems ensured that potential new staff had all the necessary checks completed before they commenced employment. Staff completed training in infection control; the home was clean and smelled fresh.

People received support from a range of healthcare professionals and services. Work was in progress to develop strategies in relation to providing a more holistic approach to people's care and support. Complaints were managed in line with the provider's policy.

We found breaches of regulations and areas in need of improvement. We are considering our regulatory response to these breaches of legal requirements and will publish our action when this is complete. As a result of this inspection, the service remains as 'Requires Improvement'.

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

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 safe.

Risks to people had not always been identified or assessed accurately and appropriately.

Medicines, in the main, were managed safely. One area in need of improvement related to the application and management of topical creams and lotions.

Staff understood how to keep people safe and had completed safeguarding training.

Staffing levels were based on people's care and support needs and were within safe limits. Robust recruitment systems were in place.

The home was clean and smelled fresh.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Decisions relating to people's care and treatment were not always obtained lawfully. Deprivation of Liberty Safeguards authorisations for two people had lapsed.

The majority of staff had completed training as needed, however, there were gaps in the training for some staff. Staff received regular supervisions and annual appraisals.

People had sufficient to eat and drink and were supported as needed by staff. People had access to a range of healthcare professionals and services.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

In the main, staff were kind and caring with people. However, people's preferences were not always fully documented within their care plans to enable staff to support them in a person-

centred way.

People were treated with dignity and respect and their privacy was respected.

Systems were being set up to identify ways of communicating with people that met their assessed needs and preferences but these had not been embedded at the time of the inspection.
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Is the service responsive?

Requires Improvement

The service was not responsive.

People did not receive personalised care that met their preferences. Care plans did not always provide detailed information about people's personal histories. People's access to activities outside the home in the community were limited.

Complaints were not always managed satisfactorily.

Is the service well-led?

Requires Improvement

The service was not well led.

A registered manager had not been in post since August 2017.

Systems and processes were not robust enough to drive improvement or to monitor the care and support people needed. Some audits had identified the issues found at this inspection, but not all.

Notifications were sent to the Commission as needed, but the rating on the provider's website was inaccurate. It stated an overall rating of 'Good' for Sycamore Lodge, when the service was rated as 'Requires Improvement' at the last inspection.

The manager said they communicated with relatives and had plans for improving communication.

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 was planned to check 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.

This was an unannounced, comprehensive inspection which took place on 10 July 2018 at Sycamore Lodge, which comes under the registration of Rapkyns Nursing Home. The inspection team consisted of an inspector, an inspection manager and a specialist nurse advisor.

Prior to the inspection we reviewed the information we held about Sycamore Lodge. This included information from other agencies and statutory notifications sent to us by the manager 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 information received and ongoing concerns with the provider, this inspection was brought forward.

Due to the nature of people's complex needs, we were not always able to ask direct questions. However, we did chat with people where possible and observed them as they engaged with their day-to-day tasks and activities. We spoke with the provider's area manager and the autism lead. We also spoke with a senior member of care staff and another member of the care staff. We spent time observing the care and support that people received in the lounges and communal areas of the home. The manager was on annual leave at the time the inspection took place. However, we spoke with them following the inspection when they had returned to work. Following the inspection, we also spoke with two relatives to gain their views of the care provided to their family member.

We reviewed a range of records relating to people's care which included six care plans. We also looked at staff records which included information about their training, support and recruitment. We reviewed

people's Medication Administration Records (MARs). We looked at audits, minutes of meetings with people and staff, policies and procedures, accident and incident reports and other documents relating to the management of Sycamore Lodge. Following the inspection, the area manager sent us additional documents relating to audits that had been completed. We also received records relating to the servicing of equipment and management of the premises which were sent later by the manager.

Requires Improvement

Is the service safe?

Our findings

At the last focused inspection which took place in December 2017, we rated this key question as 'Requires Improvement'. At this inspection, we found the key question remained as 'Requires Improvement'.

At the inspection in December 2017, we found the provider was in breach of a Regulation relating to safe care and treatment. We asked the provider to take action because people living at Rapkyns Nursing Home did not always have their identified risks to their wellbeing and safety managed effectively. These risks related to a number of areas, for example, managing people's mobility needs, risk of malnourishment and the management of medicines. Following the inspection, the manager sent us an action plan which showed what steps would be taken to meet this regulation. At this inspection, we found continuing concerns relating to safe care and treatment for people living at Sycamore Lodge and that this Regulation had not been met.

Risks to some people had not always been identified and assessed appropriately and, as a consequence, were not managed safely. Care plans included assessments of people's risks in a range of areas, such as nourishment using the Malnutrition Universal Screening Tool (MUST) and Waterlow, a tool to assess people's risks in relation to skin integrity. One person's care plan included information and guidance for staff in relation to their epilepsy. Information was provided about the person's review from a hospital specialist and their anti-epileptic medication. The person was monitored with the assistance of an audio alarm in their bedroom and the epilepsy protocol in place advised staff to ring 999 if the person sustained a seizure. However, there was no associated risk assessment for epilepsy which should have been included in this person's care plan. This meant that staff were not fully informed on how to support this person in relation to their epilepsy, because a risk assessment had not been completed.

In another care plan, some assessments had been completed in relation to the person's dependency, skin integrity and a MUST. Some care plans were clear and detailed, but others lacked solid information on how staff should support this person. For example, a Waterlow assessment and skin integrity assessment showed different scores that could affect the correct management of this person's skin integrity; this put the person at risk of unsafe care and treatment. This person had a history of weight loss and had previously been seen by a dietician. In October 2017, a dietary plan was drawn up and food supplements were prescribed. There was a steady weight increase over the next few months, until the person gained their target weight. The future plan was for the person to be continued to be weighed monthly and that a dietician should be informed if their weight fell below a certain level. We saw that in July 2018, the person's weight had dropped to below this level; this indicated there had been a significant weight loss of four kilograms over two months. A referral was not made to the dietician at this time. A nutrition care plan written in January 2018 made no mention of the dietician's recommendations or input, other than the need for a healthy diet and to consult a GP if there were any concerns. We spoke with a member of staff about this person and the staff member told us the person was not receiving any food supplements nor had the GP been informed of their weight loss. Within the person's care plan we saw that a team leader had requested the person be weighed weekly, but this document was undated and we found no evidence to suggest the person's weekly weight had been taken. This meant that the person was at significant risk of

malnourishment because no advice or action had been taken to address their loss of weight.

In a third care plan, a risk assessment identified a 'medium' risk in relation to the person's mobility, but there was no action plan for staff on how to support this person safely and mitigate the risk. In addition, this person's mobility plan referred to a handling belt, but staff told us this was no longer used. This meant that the mobility plan did not provide staff with up-to-date, accurate information. This person's Waterlow assessment provided a score of 10, which identified a risk, but in the care plan it recorded that no action was needed. An assessment of the risk of a person of choking included actions for staff to follow, but these actions were not incorporated into the nutrition care plan. This meant that this person was at risk of receiving unsafe care and treatment because their care plans contained insufficient information and were not accurate or current .

Accidents and incidents were reported and recorded by staff as needed, however, in some cases, staff who completed these reports were not the staff who actually witnessed the events which resulted in the accident or incident. This could mean the information recorded might not be completely accurate.

Whilst lack of information and/or gaps within people's care plans was largely a recording issue, the risk was elevated due to the high use of agency staff in caring for people. Care plans and related risk assessments need to provide accurate and detailed information about people's needs to ensure they receive safe care and treatment from all staff.

The above evidence demonstrates that the provider had failed to provide safe care and treatment. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the main, medicines were managed safely and were stored in a locked room that was clean and tidy. Each person had prescribed medicines and for those who received medicines on an 'as required' (PRN) basis, clear protocols were in place. Many people had prescribed topical creams and lotions, with body maps for the majority of people, indicating to staff where creams should be applied on the body. However, some people did not have body maps indicating where creams should be applied. Creams and locations stored in people's bathrooms did not show when these had been opened; this could affect the efficacy or safety of the product.

We recommend that the provider refers to guidelines on the safe administration and management of topical medicines.

At the inspection in December 2017, we found the provider was in breach of a Regulation related to safeguarding people from abuse and harm at Rapkyns Nursing Home. We asked the provider to take action because people were not always protected from abuse and improper treatment. Systems and processes had not been established and operated effectively to prevent abuse or to investigate allegations of abuse. Following the inspection, the registered manager sent us an action plan which showed what steps would be taken to meet this regulation. At this inspection, we found that this Regulation had been met.

We asked staff about their understanding of keeping people safe and what they would do if they had concerns about people or suspected incidents of potential abuse. One staff member said they would report any unexplained bruising or aggressive acts and raise a safeguarding concern; however, they did not understand that any medicines errors were also possible safeguarding issues. Eight out of ten permanent staff had completed training in safeguarding adults at risk. The other two were in the process of studying for the Care Certificate, a universally recognised qualification, which included a safeguarding element.

Staffing levels were sufficient to meet people's needs and were flexible according to people's dependency levels on any particular day. Five people received 1:1 support from staff during the day and there were six staff on duty at the home, including three agency staff, on the day we inspected. Three care staff were on duty at night. When Rapkyns Nursing Home was operational, staff might be asked to swap shifts between sites. A staff member said this occurred, "If we were understaffed, but we try and use permanent staff". The service was reliant on agency staff to ensure safe staffing levels. We observed the area manager checked the staffing rotas for the week to ensure there were enough staff and which staff members were allocated to specific duties. The area manager identified that an additional member of staff was needed for one particular day and arrangements were made to ensure that people received the support they needed from sufficient numbers of staff. The area manager told us there were three permanent staff vacancies, two for day care staff and one night care staff; he added that a permanent recruitment drive was underway. There were plans to make care roles more flexible in the future, with split shifts and longer holidays, in an attempt to attract more new staff. Staff records showed that new staff were recruited safely, with the relevant Disclosure and Barring checks completed, references obtained from previous employers and their employment histories checked.

Records, such as servicing and testing relating to the management of premises, including the safety of equipment, had been completed and were up to date. Staff were observed to use personal protective equipment as needed and had completed training in infection control. The home was clean and smelled fresh.

According to a senior manager's audit, when things went wrong or accidents and incidents occurred, a thorough investigation took place. This was demonstrated in relation to one incident we were informed of in relation to a person who managed to leave the home for a short period of time.

Requires Improvement

Is the service effective?

Our findings

At the last comprehensive inspection which took place in June/July 2017, we rated this key question as 'Requires Improvement'. At this inspection, we found the key question remained as 'Requires Improvement'.

At the inspection in June/July 2017, we found the provider was in breach of a Regulation related to staffing at Rapkyns Nursing Home. We asked the provider to take action because staff did not always receive appropriate support, training, supervision and appraisal as was necessary to carry out the duties they were employed to perform. Following the inspection, the manager at Rapkyns Nursing Home sent us an action plan which showed what steps would be taken to meet this regulation. At this inspection at Sycamore Lodge, we found some improvements had been made but this Regulation was still not fully met. Additional work was needed to ensure all staff completed relevant training.

We were shown a copy of an induction sheet for agency staff which provided information that agency staff had been given or were shown, when they came to work at Sycamore Lodge. The induction of agency staff was satisfactory. We looked at the records for three agency staff who were on duty at the time of our inspection. These showed that one staff member had not completed learning disability training and none had completed training in relation to the Mental Capacity Act 2005.

Staff were required to complete a range of training considered by the provider to be essential to carry out their roles and responsibilities. The staff training plan showed that mandatory topics for training that staff had to complete included safeguarding, mental capacity, infection control, chemicals hazardous to health, food hygiene, moving and handling, fire safety and information governance. The training plan showed that the majority of staff had completed all their mandatory training, apart from two staff who were studying for the Care Certificate. We were later informed that one staff member had almost completed the Certificate; the other member of staff was still in the process of completing it, although they had commenced employment with the provider in March 2017. This same staff member, according to the training plan, had not completed training in safeguarding, mental capacity, infection control, chemicals hazardous to health or fire safety training. Additional training was available to staff in first aid, autism awareness, management of challenging behaviour/incidents and health and safety. The plan in relation to this training showed that half the staff had completed the management of challenging behaviour training/use of restraint, four staff had completed autism awareness training and four people had been trained in first aid. Training was also available electronically to staff, such as autism, challenging behaviour, epilepsy awareness and learning disability. Eight staff had completed various topics of training online.

After the inspection, we were sent an email which showed that eight members of staff had also completed epilepsy awareness training. Training scheduled for July and August included diabetes, food safety and training related to the de-escalation of challenging behaviour and use of restraint. The majority of staff had completed the training required, however, some staff still had gaps in their training. Some agency staff had not completed training in learning disability and/or mental capacity. No training was offered in relation to staff learning Makaton or how to provide information in an accessible format, in line with the requirements

of the Accessible Information Standard.

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

Staff received regular supervision from the manager and annual appraisals.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We were told that everyone living at Sycamore Lodge had their freedom restricted and that applications for DoLS had been completed. The staff member we spoke with was unsure how many DoLS had been authorised and how many required attention from the local authority. One DoLS had expired in September 2017 and another in January 2018. We were told the manager was re-applying for these with the local authority.

A care plan relating to one person showed that they wore clothing that had been adapted to prevent them from accessing their continence pad at night, as there was a risk they might eat it. The risk assessment was completed appropriately, however, there was no associated capacity assessment to establish if the person had the mental capacity to consent to this. There was no record that a best interests decision had been reached on the person's behalf, following that assessment. In another care plan, we read that the person wore an all-in-one body suit to prevent them from removing their clothes to protect their dignity. Restricting freedom in this way is a form of physical restraint and should be managed according to the MCA code of practice. There was no evidence to demonstrate how best interest decisions had been taken for either of these restrictive practices.

The above evidence demonstrates that the provider had failed to obtain consent in line with the requirements of the Mental Capacity Act 2005. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other capacity assessments we looked at had been completed appropriately, for example in the use of a lap belt.

Food for the lunchtime meal was prepared at another of the provider's locations then transported to Sycamore Lodge in a heated trolley at 12.30pm. Staff assisted people to eat their meal in the dining room at lunchtime and people enjoyed the food on offer. Care plans included information about people's nutritional needs. One person's care plan highlighted the need to ensure they drank in sufficient quantity, but not how much the person should drink or how fluid intake should be monitored. This person did not have an assessment of their nutritional needs in their care plan. This is an area in need of improvement since this person's nutritional needs had not been fully documented to ensure they were monitored effectively. However, the care plan provided guidance for staff on how to promote the person's

independence, by cutting up their food so they could eat without support. The plan also noted that if staff filled up the person's cup, they were likely to drink more. Another care plan stated the person had a particular health condition which meant that certain foods needed to be excluded from their diet, but we could not find a dietetic report to support this.

Sycamore Lodge provides accommodation for people on one level. Corridors and communal areas are spacious, enabling people who use wheelchairs to navigate easily. Rooms were personalised and tailored to meet people's needs. In one person's bedroom, there were two damaged chests of drawers with protruding edges that could cause injury and both the wardrobes were padlocked. We were told that this was because the person had a history of behaviour resulting in them damaging furniture and that the damaged furniture was due to be replaced.

Work was in progress to support registered managers of the provider to develop strategies in relation to providing a more holistic approach to people's care and support. The autism lead told us they were introducing 'behaviour boards' and 'choice boards' to support people with rewards for positive behaviour and in making choices about their lives. The autism lead was identifying training for staff to help them have a greater understanding of learning disability and autism, including positive behaviour techniques.

Care records documented that people were supported from a range of healthcare professionals, such as GPs, physiotherapists and specialists for specific health conditions. People had access to annual health checks with their GP. Hospital passports had been completed which provided information that healthcare professionals needed to know about people should they be admitted into hospital.

Requires Improvement

Is the service caring?

Our findings

At the last comprehensive inspection which took place in June/July 2017, we rated this key question as 'Requires Improvement'. At this inspection, we found the key question remained as 'Requires Improvement'.

We observed instances where staff were kind and caring with people and would crouch down to people's level to gain eye contact. Relatives commented on the kindness of staff and one relative told us, "Generally I'm very happy and staff look after him very well". However, we also observed an occasion when an agency staff member did not demonstrate such a caring approach. One person was sitting by the patio doors and banging the door. When we asked the staff member why the person was doing this, they said it was because they wanted to go out into the garden. The agency staff member had not recognised they should meet this need. Another member of staff asked the agency staff member to take the person out into the garden and got a beanbag for them to sit on. In the person's communication plan, it stated that when they banged the door, this meant they wanted to go out. Guidance for staff advised them to offer the person a distraction or take them for a walk. The agency staff member had not understood this or taken the appropriate action in line with this person's care plan.

Care records did not always contain information in relation to people's likes, dislikes or preferences. This meant that agency staff would have been unable to know people's preferences as they did not have access to accurate information about how to meet people's needs and preferences. For example, in one person's care plan, a document entitled, 'All about me' had not been completed. Care was not always provided in line with people's preferences and care records contained gaps in information about people. We have written about this further in the Responsive domain of this report.

Care plans documented people's personal care needs and how staff should support people in a way that preserved their dignity. For example, we read that when assisting one person to use the toilet, a towel should be placed over their lap.

As much as they were able, people were encouraged to make choices about their day to day care and what they would like to do. We observed one person being asked by staff whether they wanted to go out on the day we inspected and then organised this. Work was in progress to set up systems that aligned to people's communication needs to ensure these were taken account of. The autism lead was looking into this and planned to introduce choice boards, Picture Exchange Communication Systems (PECS) and identify ways of communicating that met people's needs and preferences.

Requires Improvement

Is the service responsive?

Our findings

At the last comprehensive inspection which took place in June/July 2017, we rated this key question as 'Requires Improvement'. At this inspection, we found the key question remained as 'Requires Improvement'.

At the inspection in June/July 2017, we found the provider was in breach of a Regulation related to person-centred care at Rapkyns Nursing Home. We asked the provider to take action because people did not receive personalised care that met their needs and preferences. Following the inspection, the manager at Rapkyns Nursing Home sent us an action plan which showed what steps would be taken to meet this regulation. At this inspection at Sycamore Lodge, we found insufficient improvements had been made and that this Regulation was not met.

We were told of a meeting that took place the day before our inspection with the local authority, when one person's care plan was reviewed. The autism lead, who had recently commenced employment, told us that some recommendations that had previously been made had not been adopted, that she was concerned about this and was investigating further. We were also informed that the person under review had a particular health condition and epilepsy, but neither was documented in their care plan or were known to staff. We looked at the care plan and saw a GP's note which made reference to this person's health conditions, but contained no guidance for staff on meeting the person's health needs. We asked a staff member if they were aware of this person's diagnosis for the health condition, but they were not. This meant that the person could not receive personalised care that met their specific needs. We looked at the behaviour strategy plan for this person which identified they had 'attention seeking behaviour'. The response to this included a 'planned ignoring strategy', for staff to ignore what they perceived to be attention seeking behaviour by the person. The plan described the person in a derogatory way and included reference to 'tantrums'. We showed the plan to the autism lead and asked for their views. They felt the behaviour strategy plan was completely inappropriate and removed it from the person's care record; they then began work on a positive behaviour support plan for the person. We looked at the continence plan which stated this person used incontinence pads, but there was no information to tell staff how to support the person to maintain independence with their continence. Local authority staff had reported to us that this person was continent and felt they had lost this skill due to lack of support.

In some care plans, people's preferences and interests had been recorded, but they did not receive personalised care that ensured these needs were met. For example, in one person's care records, there was a lack of information about their past history, including where they had been educated, that would have provided a useful foundation for a person-centred approach. There was no information about plans for social activities or events outside the home. We observed this person during the day of inspection. They spent all morning sitting in the dining room, listening to the radio and mostly alone. The only interaction was when a member of staff offered them a drink and a choice of biscuits. Later in the afternoon we saw the person spent time sitting in the garden, but with little interaction from staff.

We looked at another person's communication plan which made reference to the use of Makaton and

Picture Exchange Communication System (PECS). During the morning we observed interactions between the person and staff members, and neither used these aids. We spoke with one member of staff who stated they did not use Makaton and did not know of any pictorial aids that should be used. Another member of staff told us that staff had not completed training in Makaton. This demonstrated that the person was not cared for in a person-centred way in line with the advice contained within their care plan.

From August 2016, all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so they can communicate effectively. We saw information which indicated which staff were on duty that day, but this would not easily have been understood by people. In the dining room there was a menu board, but this was completed with small writing and no pictures. The information was not presented in a way that would have made it easy for people to understand. Care plans were not written in a way that met people's preferred methods of communication, therefore, people could not be involved in reviewing their care plans. Keyworkers were allocated to people and helped to review people's care plans. We were told that keyworkers looked at the plans, including risk assessments, to see whether any information needed changing or amending. There was no evidence to show how, or if, people were involved in reviewing their care plans. One care plan showed that a review had taken place, but did not record the date this took place, only the month. No actions had been identified or recorded and there were no goals or targets set for people.

Keyworkers also helped to ensure activities were organised for people. People had daily and weekly planners which showed how their time was structured and the activities that had been arranged for them. In one person's social care plan, we read they liked to visit cafes and go to the park; they also went home to visit their parents. The plan stated they enjoyed going out in the community. However, daily records we looked at showed that this person had not been out for a week. Many people living at Sycamore Lodge visited a day facility, Redwood House, which was close by on site and run by the provider. However, this day facility was closed and we were told that it always shut for one week during the summer and another at Christmas. This meant that people who were reliant on attending this day facility needed other activities planned for the week. On the day we inspected, we were told that a trip was planned to a local park, but not everyone was able to join in on this outing. One person spent their day, either sitting with us in the office or walking aimlessly around the home. When we brought this to the attention of staff, they immediately made arrangements for the person to go out in the minibus later in the day. Outings were planned from the provider's other locations on site, so if staff were aware of them, people could be involved in these activities. One staff member said, "We are a community here and we need to share facilities".

Activities in the community were extremely limited and opportunities had been missed to provide stimulation for people outside the home. For example, in one person's activity plan it stated they went for a walk on Tuesday mornings and an outing on Wednesdays and Saturdays. According to the records we looked at, this had not always happened. During May, this person went for two local walks and one trip out; they visited the day facility weekly. In June, this person went for one local walk, had 12 trips out and went to the day facility weekly. During July, until the date of inspection, they had been on one trip out and no walks. The person's plan recorded they enjoyed swimming, walking to the spa and having their hair and nails done; they also enjoyed sensory activities. The plan also stated that the person enjoyed trips out in the car and that staff should offer regular trips and walks. Swimming was not included in this person's activity plan. There was a sensory room on site, but the light projector was not working, so activities in this room were limited. We were later told the sensory room was not used by people at Sycamore Lodge as, "It needs an overhaul". There was a computer in the dining room, but staff told us that people did not use this. After the inspection, we spoke with the manager at Sycamore Lodge and asked for her comments on a person-

centred culture, to which she responded, "You saw their rooms", referring to the fact that people's rooms were personalised. The manager added that they were in the process of introducing new systems, including tablets and downloading apps for people, to provide a range of activities. The manager told us they had spoken to some parents to ask if they would buy their family members tablets or iPads.

We spoke with a couple of relatives about the activities organised from Sycamore Lodge. One relative said, "They could do more with activities", but seemed to think that a lack of funding prevented more activities from taking place. This relative told us their family member enjoyed the day facility at Redwood House, but were unaware of its closure for the week. They commented, "It's not satisfactory for people to sit around when Redwood House is closed". Sycamore Lodge offers residential care and support to young adults, both male and female. There was little evidence of social and community integration and activities outside the home were limited, especially after 8pm and at weekends.

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

After the inspection, we were informed that the issue in relation to Redwood House was being addressed, to ensure the day facility stayed open for people all year round. We were also informed by members of the management team that there were plans to change the way that drivers worked so that a pool of drivers could be set up who could then take people out into the community for longer periods during the day and into the evening.

People who had elements of nursing care had these met by a registered nurse who visited daily to offer support and advice. We could not find any information with regard to how these nursing needs were recorded or how people's needs were met. We asked the manager how people's diverse needs, including different backgrounds and cultures, were addressed. She said, "Everyone's the same and you treat them as individuals, meeting their individual needs". In one person's care plan we read that their faith was based on Christianity and that they had the option to go to church if they wished.

We looked at the complaints that had been received and at the provider's complaints policy which was reviewed in April 2017. Complaints were not always managed appropriately. One relative felt that, "Communication was terrible", when their complaint was being investigated and added, "They need to have more external activities, including swimming". Another relative said they had, "Complained gently", to the manager about various issues, but had not felt they had been listened to. They told us of a significant recent event, which we cannot document in this report because of the risk of identifying the person. However, the relative said they had not been informed of the event in a timely way nor had they received an apology from the manager. This is an area in need of improvement. The provider's area manager conducted monthly visits to the home and complaints were looked at as part of this visit. The record logged each complaint and how they had been dealt with.

Requires Improvement

Is the service well-led?

Our findings

At the last focused inspection which took place in December 2017, we rated this key question as 'Requires Improvement'. At this inspection, we found the key question remained as 'Requires Improvement'.

At the inspection in December 2017, we found the provider was in breach of a Regulation associated with quality assurance and monitoring the service at Rapkyns Nursing Home. We asked the provider to take action because the provider was unable to demonstrate the systems or processes in place operated effectively to ensure compliance with requirements. Following the inspection, the manager at Rapkyns Nursing Home sent us an action plan which showed what steps would be taken to meet this regulation. At this inspection at Sycamore Lodge, we found insufficient improvements had been made and that this Regulation was not met.

The last manager at Rapkyns Nursing Home de-registered with the Commission in August 2017. A new manager took over in August 2017 and at our inspection in December 2017, we were informed they had commenced the registration process. However, the manager currently in post at Sycamore Lodge commenced the process of registering with the Commission in May 2018. Therefore, there has been no registered manager since August 2017.

Since the last focused inspection took place at Rapkyns Nursing Home, the facility that provided nursing care to people with a range of health needs, including Huntington's disease, has closed for refurbishment. Sycamore Lodge comes under the registration of Rapkyns Nursing Home and accommodates up to 10 people with a learning disability and/or autism, in a separate unit on the same site. According to the area manager's monthly provider report in June 2018, there were plans that Sycamore Lodge would have its own separate registration with the Commission by the end of the month. We asked the manager what the plans were in relation to Rapkyns Nursing Home and when this might be re-opened, however, they told us they did not know what the future plans were.

Systems were not effective to ensure compliance with requirements and were not always effective in assessing, monitoring and improving the service. At the end of our inspection, we gave feedback to members of the provider's senior management team. We discussed the issues we found in relation to the safe management of people's risks, best interests decisions, the deficiency of staff training in specific areas, the limited opportunities for people and access to the community and lack of person-centred care.

We were provided with a health and safety audit report from May 2018 and an audit completed by a member of the senior management team in June 2018, as well as monthly audits. These showed where actions were required in order for the home to be compliant. However, there was no date to show when identified actions should be completed or by whom. Some of the areas of concern we found at this inspection had also been highlighted in June 2018, but not all. For example, in relation to person-centred care and identifying people's preferred methods of communication, to enable them to be involved in all aspects of their care. Improvements have not always been sustained when actions were identified as needed such as in relation to a person who had lost weight. Lessons have not always been learned to drive improvement.

In October 2015, national guidelines were published in relation to supporting people living with a learning disability and/or autism who display behaviour that challenges, under 'Building the Right Support'. The guidelines talk about the support people need to enable them to live the lives they choose and that services should be more person-centred. Part of the guidance refers to people having an interesting life that they enjoy, well planned care and support and their right to have choice and control about their care and support. The Commission published a policy in June 2017 regarding the new registration of services supporting people with these defined needs. Rapkyns Nursing Home, including services provided at Sycamore Lodge, was registered prior to this guidance being published. Nevertheless, we would expect providers of existing services to develop plans and strategies on how they will provide, improve and enhance the lives of people they support, to enable them to live meaningful and fulfilling lives. We spoke with the manager about their understanding of 'Registering the Right Support', the Commission's policy, but they were not aware of this guidance. The findings of our inspection reflect that people did not always receive the consistent care and support they needed and were entitled to, so as to ensure they received high quality, compassionate care.

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

The Commission's rating of the home, which was awarded at the last inspection, was not displayed accurately by the provider on their website. According to the provider's website, Sycamore Lodge had received a rating of 'Good'. This is not the case. Sycamore Lodge comes under the registration of Rapkyns Nursing Home and therefore has a rating of 'Requires Improvement'. It is a requirement that ratings are displayed accurately following inspection.

The above evidence demonstrates that the provider had failed to display an accurate rating following the last inspection. This is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notifications that the provider was required to send to us by law had been completed and sent to the Commission as needed.

Since the last inspection, the provider has made significant changes to the senior management team. After the inspection, and as a result of the feedback discussed with members of the senior management team, we received a 'service improvement plan', which stated how they will address the issues we found and the actions to be taken. It stated the majority of the actions taken had either been completed, or were due to be completed, by the end of July 2018. A member of the senior manager team told us, "What keeps me here are the people, not the company. They will change because they have absolutely no choice. I want more robust planning and schedules. We're absolutely committed to that. I expect a high standard and quality of life for these people". This staff member also talked about making links with individuals and agencies who could support the service to improve, for example, speech and language therapists and professionals from the local authority's learning disability support team.

We asked a member of the senior management team for their views on the vision and values of the service. They felt that historically, registered managers, deputy managers and area managers have received, "directive and non-supportive management", but that things were changing. The manager of the home felt supported by the management team and told us about the culture. They explained, "It's about good outcomes, giving people the skills they need to have a good quality of life, getting them into the community and supporting them". The manager enjoyed working at the home and said, "It's like one big family,

everyone looks after everyone". When asked about areas for improvement, the manager commented, "I'm sure everywhere needs improvement somewhere along the line". The interim area manager met with the manager fortnightly to discuss areas they had identified for improvement, with target dates for actions. The interim area manager told us they worked with several managers on the same site to ensure they all worked together in a constructive way. They said, "There are a lot of the same issues from [named another service] here, so we can build on the work done". They added, "Staff meetings are now a forum. Staff have been afraid to do things in the past, now we welcome new ideas and staff working together".

The manager told us that meetings took place for people who lived at Sycamore Lodge and that their feedback contributed to developing the service. Meetings with relatives were not formally organised, but the manager said, "I do meet with the relatives. We're just starting a newsletter and hope to do coffee mornings". We asked relatives for their views about Sycamore Lodge. One relative said, "I'm never going to get perfection, I realise that. Communication is much better now. We contact them by email and we receive prompt responses. Overall we are very happy".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to obtain consent in line with the requirements of the Mental Capacity Act 2005

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to provide safe care and treatment as they were not adequately managing risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish systems or processes that operated effectively to improve the quality and safety of the service

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 20A HSCA RA Regulations 2014

personal care Treatment of disease, disorder or injury	Requirement as to display of performance assessments The provider had failed to accurately display the rating awarded at the last inspection. Regulation 20A (a) (2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff had received the necessary training and support