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:
15 December 2020
16 December 2020
17 December 2020

Date of publication:
02 February 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Rapkyns Care Centre is a residential care home providing personal and nursing care for up to 41 people with physical disabilities, autism, and profound multiple learning disabilities. At the time of our inspection there were 24 people living at the service.

Rapkyns Care Centre is located in Rapkyns Care Village, which is a community set behind a locked gate on the outskirts of Broadbridge Heath. The whole Rapkyns Care Village, which contains four care homes, is operated by Sussex Healthcare. Rapkyns Care Centre (also known as The Grange) is comprised of four lodges, each with a dining area, lounge and bedrooms. During our inspection one of the lodges had been temporarily closed.

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
People were not always kept safe at Rapkyns Care Centre. We found concerns with the safe management of risk for areas including behaviour that may challenge others, eating and drinking, feeding tubes, epilepsy care, skin integrity, and physiotherapy.

People were not consistently kept safe from the risk of abuse or neglect. We found issues with people not receiving their medicines when they should or receiving them in an unsafe way.

There were not enough permanent nurses or physiotherapy staff deployed to meet people's needs safely. Infection control concerns were identified in relation to some agency nurses not having correct training to use specialist personal protective equipment (PPE). Lessons were not being consistently learned and similar issues to those highlighted at other inspections and locations managed by the provider were found at this inspection.

Staff training was not effective as some staff did not have a good understanding of some people's conditions and the support they would need, such as autism. People's health needs were not consistently being supported effectively. We found concerns with people's feeding tubes, checking on people and monitoring their changing health needs.

People were not supported to have maximum choice and control of their lives and staff did not consistently support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People had medicines crushed and other restrictions in place without having MCA assessments and best interest meetings.

People were not consistently supported in a way that upheld their dignity. We observed some poor interactions between one staff and some people. Some people had been left for long times in their incontinence pads, for up to 10.5 hours.

There was not a person-centred approach to supporting people at Rapkyns Care Centre. One person with autism was being left for long periods with very little or no staff support or stimulation. Activities were not personalised and were often group craft activities that people passively watched.

There was no evidence of continuous learning. Six regulations had been breached since earlier inspections dating back to September 2018 and February 2019. Urgent conditions CQC imposed on the provider's registration had not resulted in improved standards of care and safety.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Despite our continuing concerns, people's relatives were consistently positive in their praise for the service. One relative told us, "If it was not for Rapkyns [name] would not be with us. To know [name]'s in that environment I am lost for words that it means so much to us that she is safe and happy and is living instead of existing. We've seen what it could be like and nothing compares to Rapkyns." A second relative commented, "Even though we've had [name] home every third weekend, she hasn't been home during Covid and has remained happy. They (Rapkyns) have proceed to be a wonderful family for her." A third relative said, "During summer [name] had to go to hospital for a visit and had to self-isolate on return…We told staff [name] loved sunbathing and next day we video called and [name] was laying with sun cream on and music plying."

People had enough to eat and drink and the chef knew people's needs well. People were able to move into the service or move on to other services. Staff supported an effective exchange of information by sharing care plans. There had been lots of assessments by funding authorities that had been facilitated.

There was a complaints procedure in place and any complaints were logged, responded to and resolved in line with the provider's policy. Nobody at Rapkyns Care Centre was receiving end of life support but plans were available to people and their families who wanted them.

There had been a lot of work done to assess people's needs around physiotherapy and to recruit to vacant physiotherapy posts. There were knowledge checks and safety huddles implemented by the new management team to try and increase staff knowledge and promote best practice, although the management team acknowledged this was a work in progress

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
• Model of care and setting maximises people's choice, control and
Independence
The service was in private grounds in the countryside behind a locked gate. There were limited opportunities for people to access the local community. Staff wore uniforms and name badges to show they were care staff when supporting people.

The service was bigger than most domestic style properties. There were signs on the road before the service's private drive, in the grounds and on the exterior of the service to indicate it was a care home.

Right care:
• Care is person-centred and promotes people's dignity, privacy and human
Rights
People were not always supported safely.
People's support was not always dignified.
Staff did not always respond in a compassionate or appropriate way when people experienced pain or distress.

Right culture:
• Ethos, values, attitudes and behaviours of leaders and care staff ensure people
using services lead confident, inclusive and empowered lives
The culture was not person centred or empowering. Staff tended to do things for people rather than with them.
The management team understood the challenges facing the service but there was significant work to do to raise safety standards and to provide good care.

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 11 September 2020) and there were multiple breaches of regulation. The service had been rated Requires Improvement or Inadequate for the last four inspections. At this inspection not enough improvement had been made we identified seven breaches of regulations.

Why we inspected
This was a planned inspection based on the previous rating.
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.
You can see what action we have asked the provider to take at the end of this full report.

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 breaches in relation to person centred care, dignity, consent, safe care and treatment, safeguarding people from harm, good governance and staffing at this inspection.
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 continue to monitor information we receive about the service until we return to visit. If we receive

any concerning information we may inspect sooner.
The overall rating for this service is 'Inadequate' and the service 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 act 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 effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by three inspectors and a nurse specialist on 15 and 16 December 2020. On 17 December 2020 two inspectors carried out the inspection. During the site visit and afterwards the inspection was supported by a member of 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, but they had left in August 2020 and were not in day to day control of the service. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

This inspection was unannounced.
What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they

plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection-
We spoke with three people who use the service and observed care and support. We spoke with the chief operating officer, the clinical lead and the provider's nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with 11 staff, and the chef. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We reviewed copies of people's care and records, training records, rotas, incident reports and audits. We spoke with the chief operating officer, clinical lead and the provider's nominated individual. We also spoke with three support workers, two registered nurses and four relatives of people using the service via telephone.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- During the last inspection where this key question was rated in July 2020, we found a breach of Regulation 12 relating to the failure to safely manage the risks around constipation, epilepsy, health monitoring, behaviours that may challenge others, respiratory care, and physiotherapy needs. At this inspection insufficient action had been taken and the provider remained in breach of Regulation 12.
- Some people had behaviours that may challenge others and had positive behaviour support plans (PBS) in place. A PBS plan 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.
- Risks associated with the management of these behaviours was not being managed safely or in line with best practice: some staff were unaware of people's plans or how to support people safely and consistently.
- Some people did not have a PBS plan in place despite having behaviours which challenged themselves and others. An absence of a PBS plan and risk reduction strategies meant people were not appropriately supported when they were distressed or supported in consistent ways to ensure their safety
- People living with a learning disability can be prone to bowel problems such as constipation, which if not treated correctly can cause very serious health complications. One person was diagnosed with chronic constipation and had been prescribed a PRN (as needed) medicine to relieve constipation if they had not opened their bowels for 24 hours. The person had not always been given their PRN constipation medicine as directed. On one occasion the medicine was given late and they subsequently needed extra medicines from the GP to help relieve constipation. On many occasions over five months this medicine was either not given or given later than directed. The person had not received the correct care and treatment, and this had exposed them to risk of harm.
- A second person diagnosed with constipation was prescribed two different constipation medicines to be given PRN. These medicines were directed to be given in a specific order but sometimes the person had not received these medicines as directed. They did not receive the second PRN medicine on the third day of not opening their bowels on two occasions, and on another they were given a suppository a day too early. The person had been exposed to a risk of harm by not receiving the correct care and support with their bowels.
- Other risks around constipation were not being managed safely. All continence care plans lacked general information about how to reduce the risk of constipation such as movement, exercise, diet, environmental factors, and fluid intake.
- Some people required support to eat and drink safely, and reduce the risks of choking, but this support was not consistently delivered. One person had a choking episode in December 2020. A speech and language therapist [SaLT] had issued guidance specifically around the person not 'twisting and turning' during meals which added to the risk of them choking.
- Staff did not know about this guidance and the person was seen twisting and turning to speak to others

during lunch. Their eating and drinking care plan referenced the risk of choking if they experienced a seizure during a meal but this risk had not been considered in their choking risk assessment.

● A person had a feeding tube where they received their nutrition directly in to their stomach and was at risk of choking. The person had a choking risk assessment, but this did not cover all areas of known risk for the person. For example, it did not reflect the need to pause the person's feed 30 minutes prior to them moving or to ensure they were at a 45-degree angle in bed if receiving the feed. Given the high number of agency staff working at Rapkyns Care Centre, this left the person at risk of receiving unsafe care from staff who may not know the person's needs well.

● The same person required a type of therapy for a respiratory condition. Staff and records confirmed this person did not consistently receive this treatment as assessed. Current guidelines stated they needed a minimum of four hours daily (ideally six hours) of this treatment. There were two occasions where the person had not received it for the minimum four hours and other times where they had not been receiving this treatment for the recommended 6 hours, without explanation. This left the person at risk of poor health.

● Risks around people's epilepsy were not being managed safely. One person was diagnosed with epilepsy and had a device implanted that was to be activated when they experienced a seizure. There was no care plan for this device until we raised this and not all staff working with the person knew the correct procedure for using this implant. Support staff working with the person told us they would "call the nurse" if the person had a seizure. They said the device had to be activated after five minutes of a seizure. This was incorrect and the device should be activated after one minute of seizure activity. This left the person at risk of not receiving timely treatment with their seizures.

● A second person with epilepsy had contradictory care plans which gave staff different directions on action to take to keep the person safe. The need to give oxygen and monitor vital signs was missing from one plan and discrepancies between care plans put the person at risk of not receiving the care and support they needed to safely manage their seizures. There were similar discrepancies for a third person with epilepsy.

● People were assessed and for funded physiotherapy and hydrotherapy treatments. During our inspection in July 2020 we raised a serious concern about the lack of physiotherapy assessment and provision. At this inspection we found that there were still concerns around physiotherapy provision.

● One person's care plan stated they had physiotherapy to support their use of a standing frame and to maintain and improve their muscle strength and joint condition. This person had not received physiotherapy between January 2020 and 16 December 2020. The physiotherapy sessions had been were designed to encourage movement of joints and staff had reported the person had benefited from this.

● In addition, baths were to be offered as an alternative to physiotherapy. The professional noted to CQC that records showed the person had not had a bath since January 2020. The person's relative also expressed that they not only benefitted from this physically, but they also got a lot of enjoyment from this activity. The person had not had their assessed support to use the standing frame, or to have baths, and risked deteriorating health.

● A second person had received less than 50% of their assessed three sessions a week in December 2020.

● The provider sent us a report showing 102 sessions of physiotherapy and hydrotherapy were provided during December 2020. This would mean only 44% of these sessions had been provided. This left people at risk of poor health outcomes form not receiving their assessed support.

Using medicines safely

● During the last inspection where this key question was rated, we found a breach of Regulation 12 relating to safe medicines management. At this inspection insufficient action had been taken and the provider remained in breach of Regulation 12.

● Medicines were being crushed for two people when they were unwell, so they could be administered via their feeding tube. Some of these medicines were unsafe to be crushed. Both people had slow release epilepsy medicines. Crushing affects the release of the medicines and subsequent absorption rate into

people's bodies. Staff confirmed that these medicines had been crushed and administered to people. This put people at risk of poor health outcomes from receiving medicines unsafely.
● A registered nurse administered medicines to a group of people and then signed all people's medicines administration record [MAR] charts together . Delays in signing the MAR for individuals created the risk of errors, as set out in The National Institute for Health and Clinical Excellence [NICE] guidance document, 'Managing medicines in care home'.
● There was no MAR chart for a person's PRN epilepsy rescue medicine, although a supply of it was held. We were told the PRN charts were in the process of being updated. This put the person at risk of not receiving their medicines in a timely way as there was no record for nurses to record their use.
● The medicines stock control system in one lodge was very complex and was not being followed or used consistently by nurses. There was one incident where a diazepam tablet was missing and not accounted for. The provider's nominated individual acknowledged the stock system was not clear and that a diazepam tablet was missing. These concerns had not been picked up on regular medicine audits. Another person missed three doses of eye drops as the stock ran out. Poor stock control processes put people at risk of not receiving their prescribed medicines.

Learning lessons when things go wrong
● During the last inspection where this key question was rated, we found a breach of Regulation 12 relating to learning lessons when things went wrong. At this inspection insufficient action had been taken and the provider remained in breach of Regulation 12. Lessons had not consistently been learned to ensure people received safe care. There had been some areas of improvement, such as around thickening powder not being left out, and people receiving better hydration as shown in their fluid charts. However, there were areas where lessons had not been learned and people remained at risk of harm.
● At previous inspections in September 2019 and July 2020 we identified concerns around bruises and marks on a person's body that was thought to be caused by a moulded brace to help their posture. We have reported on this issue at this inspection in the Responsive section of this report. However, lessons had not been learned and the person was still experiencing bruises and discomfort up to our inspection in December 2020.
● There remained a high number of injuries to people's feet, hands, fingers and toes as well as bruises, most of which were unexplained. At this inspection we reviewed three months of incident reports showing 28 incidents of bruises, skin tears, abrasions and other injuries [not including pressure injuries]. Some outcomes of these incidents were to follow moving and handling procedures. No effective learning had happened as there was still a high number of injuries being reported as incidents.
The failure to provide consistently safe care and is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● During the last inspection where this key question was rated, we found a breach of Regulation 13 relating to the failure to safely manage the risk around neglect as people had not received medicines and treatments as assessed. There were also concerns about a closed culture and incidents had not been reported to CQC. At this inspection insufficient action had been taken and the provider remained in breach of Regulation 13.
● We continued to find incidents where people had not received their treatments as assessed. Two people had not received their constipation medicine as directed on several occasions. In one of the incidents a person had received an invasive procedure too early when they should have been administered an oral medicine. Two people had received medicines in an unsafe way, and this had not been reported to CQC or the local authority safeguarding team.
● We raised concerns at our last inspection about possible closed cultures. 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. At

this inspection we had been made aware by the local authority that a member of staff who had previously suggested to a safeguarding investigating officer that they had not witnessed an alleged assault on a person had subsequently confirmed that they had known about the assault.
● A person made an allegation about a staff member shouting at them and being rude. The provider acted to protect the person. However, there had been other incidents reported in previous inspections 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 when looked at as a whole 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
● During the last inspection where this key question was rated, we found a breach of Regulation 18 relating to the failure to deploy enough staff to meet people's needs safely. At this inspection insufficient action had been taken and the provider remained in breach of Regulation 18.
● The newly recruited physiotherapist said there was no physiotherapy rota for people to receive their treatment. They also confirmed there were not enough physiotherapy hours currently available to complete exercises and active therapies people required, although assessments were being done.
● To provide cover for 50 physiotherapy sessions a week the physiotherapist said they needed one fulltime assistant, and this was not scheduled to be in place until January 2021. The provider reported to CQC that only 44% of sessions had been provided. At the time of our inspection there was one physiotherapy assistant working 'ad hoc' for 10 hours weekly. Exercises and movements were not happening for most people and it was unclear what was planned instead of hydrotherapy. Hydrotherapy pools were closed due to the pandemic, but people should have exercises provided in place of this. Despite recruitment and assessment work being undertaken, a lack of physiotherapy staff had led to people not receiving their care and treatment as assessed.
● The service frequently relied on agency staff, particularly for daytime nursing cover. There was only one daytime nurse substantively employed. Although the temporary closure of one lodge had reduced the impact of this, there remained approximately 80% agency cover of daytime nursing hours. The lack of permanent nurses in the daytime was a concern as care plans were found to be ether lacking detail or were contradictory. This meant agency nurses may not be able to find the correct information they need to care for people safely. We spoke with some agency nurses who were not aware of some people's needs.
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.

Preventing and controlling infection
● We were not assured that the provider was consistently using PPE effectively and safely. Two agency nurses did not have the correct fit test training to safely use FFP3 masks which must be used for certain procedures that were carried out at The Grange. Following our feedback, the provider raised this directly with the agencies who employed the nurses.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. The lack of fit test training for some nurses could cause an infection outbreak such as Covid-19.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service. There was an empty lodge where, e.g., people admitted back from hospital could safely isolate.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the

premises. The premises were clean and tidy, and we saw cleaning staff were regularly and systematically carrying out cleaning of all areas of the service.

● We were assured that the provider's infection prevention and control policy was up to date.

Inadequate

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Inadequate. At this inspection this key question has now remained the same. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to live healthier lives, access healthcare services and support and staff working with other agencies to provide consistent, effective, timely care.

- During the last inspection where this key question was rated in September 2019, we found a continued breach of Regulation 12 relating to the failure to safely manage the risks around epilepsy, feeding tubes, skin breakdown and health monitoring. At this inspection we found not enough improvement had been made and the provider remained in breach of Regulation 12.
- People's health needs were not consistently being met in terms of physical movement. One person had a mobility care plan that referred to a walking frame to help them do walking exercises. Staff said this should happen twice a week, but records showed the person had only received three sessions in three months (with four declined).
- Some people needed to have regular checks on their health and wellbeing. The provider could not be assured that people were receiving them as necessary as electronic care records did not always evidence these happened. The nurse on duty was not able to evidence these checks.
- People who were prone to health deterioration 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. 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.
- One person had a feeding tube to receive their medicines and some of their food and fluid. Their care plan stated an 'extension tube' should be changed every two weeks. A nurse told us they thought this was done on a Sunday. However, staff or managers could not tell when the tube was last changed. This left the person at risk of complications with their feeding tubes and site.
- The NEWS tool was not being used properly or consistently. The NEWS scores for two people had not been repeated even when totals were higher than normal for them. There was a risk people's health could deteriorate further without staff being quickly aware of this.
- A third person became very unwell and nurses completed a NEWS chart and called paramedics. However, they had not scored the chart correctly. The nurse had recorded a score of '5' for the person, but the actual score from the chart totalled '8'. Although emergency medical help was called in this instance there is the risk that the seriousness of people's conditions may not be correctly triaged or passed on to other professionals promptly if scores are inaccurate.
- Until we imposed urgent conditions on the provider's registration in July and September 2020 people were not receiving the physiotherapy they were funded for and assessments for posture and breathing had not been completed. This meant that the physiotherapy team did not know people's needs. Work has been

underway to complete these assessments which had identified that several people were in incorrect wheelchairs and people had not been receiving the support to exercise or maintain their movement. This can have a serious impact on people's health conditions such as respiratory conditions or constipation. The provider had recruited to some posts and assessments are underway, and referrals to wheelchair services were made. However, the work is not complete, and people had not had the correct care and support for an extended period.
The failure to monitor people's health needs is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● During the last inspection where this key question was rated, we found a continued breach of Regulation 18 relating to the failure to provide staff with the training and support they needed to be effective in their roles. At this inspection we found not enough improvement had been made and the provider remained in breach of Regulation 18.
● Not all staff working in the service had received the correct training to carry out their roles effectively. Two agency nurses had not completed training for fit tests for FFP3 masks. This training is essential for anyone supporting people with aerosol generating procedures [AGPs]. There were people living in the lodge in which the nurse was working that had AGP's. One nurse told us, "I am agency have to pay for extra training myself."
● A second agency nurse worked regularly at the service and said they had not received training in oral suctioning; even though people they worked with may require this procedure. The lack of training placed people and staff at risk of contracting and spreading infection, including Covid-19.
●. Another nurse said they had received training about autism but was unable to describe the condition. We asked them about a specific person with autism and what they needed in terms of support, and the nurse failed to highlight important aspects of their support relating to autism (such as high sensitivity to touch that could trigger behaviours).
● We spoke to a care staff about their training and asked if they had safeguarding training. The staff confirmed they had and that they had received PBS training but could not remember anything about it.
● We spoke with a third staff member about their training and they said there were lots of courses. However, the said, "Problem is we have permanent staff and have lots of training, but sometimes work with people who doesn't have moving and handling training or know how to use the hoist." We asked whether the staff thought there was a gap between staff and agency knowledge, and were told, "Yes, but we try and work together and supervise and explain and be sure they understand what we are talking about. Some learn quickly and others been here a while and still don't know."
The failure to provide staff with the training and support they needed to be effective in their roles is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service

was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● At the last inspection where this key question was rated, we found a continued breach of Regulation 11 relating to the failure to obtain and document people's consent for care and support. At this inspection we found not enough improvement had been made and the provider remained in breach of Regulation 11.
● Two people had been receiving crushed medicines via their feeding tubes when they were unwell. We have reported on the safety issues around this in the Safe part of this report. However, there had been no assessment of either person's capacity to consent to this. We reviewed their care plans and saw that for one person there were some MCA assessments on file, but these did not cover the crushing of medicines.
● For another person they had bed rails in place to help them stay safe at night time. However, there was no MCA assessment or best interest decision on file for this restriction.
The lack of consistent practice with regard to obtaining and documenting consent for care and support is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Not all people's needs had been effectively assessed to ensure risks around indirect discrimination were mitigated. Some people were in relationships or were aware of their sexuality. One person had an 'expressing sexuality' care plan that stated an aim was for staff to know how the person expressed their sexuality. However, there was no information on how the person wanted to be supported with meeting their sexual needs or how to support them with relationships.
● Two people were in a relationship and saw each other as boyfriend and girlfriend. However, there was very limited guidance on how staff should support the two people to have a relationship; for example, to understand boundaries or consent.

Supporting people to eat and drink enough to maintain a balanced diet
● During the last inspection where this key question was rated, we found a continued breach of Regulation 12 relating to the failure to safely manage the risks around people receiving enough fluids. At this inspection we found improvement had been made and this part of the breach was met.
● People had their fluid intake recorded on daily fluid charts. We checked the fluid charts for two people who were at risk of dehydration and saw that they had met or exceeded their recommended daily allowance of fluid.
● People were receiving enough food to maintain good health. We spoke with the chef who knew people's special dietary needs. People and their relatives told us the food was very good at Rapkyns Care Centre. One relative told us, "We worked closely with chef to put together menu for her they give her special food she likes and needs because of her condition. She needs high fibre diet with fruit and veg and she gets it."

Adapting service, design, decoration to meet people's needs
● The building was designed specifically for physically disabled people with wide corridors and overhead hoists. People had en-suite bathrooms in their rooms.
● There were extensive grounds for people to access, and some people told us they enjoyed going for walks in the grounds.

Requires Improvement

Is the service caring?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

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

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

- We observed some poor support that was not kind or caring. During one lunch service we observed a staff member talking in a way that was not inclusive, empathetic or person centred. There was no attempt to engage the person or offer them a way of being involved in the task. The poor communication from the staff member reinforced the power imbalance in the caring relationship. The lack of intervention from other staff indicated the culture was not positive.
- Another staff member asked if the person was OK after the incident but did not challenge the first staff. They told the person they were going to move them and wheeled the person near the TV; however, the person could not see the TV and was facing out of the window. The person was displaying signs of distress and staff left them. The person continued to display distress behaviours and vocalisations, but no staff intervened to support. The person's care plan said staff should talk to the person, offer reassurance or distract them with an activity.
- The first staff member was later talking loudly to another staff member in the dining room in front of other people and speaking about people rather than involving them in conversations about themselves. The staff member went in to a person's room and talked to another staff loudly about supporting someone else while the first person was having personal care support. Later this staff member was talking loudly to all people as if they were children. This was not kind or dignified for people.
- We observed people being supported with their lunch. One person became distressed on being moved from the table after their lunch, grabbing their wrists, biting fingers and scrunching their face: no staff support was offered. This person's care plan stated there were no behavioural concerns but did state scrunching face can mean they are in pain or need a pad change. An agency staff was unable to tell us what the person's actions might mean and said, " It's just [name]". Staff took no action to check what support the person might need.
- Some people required support to manage their pain but did not consistently receive this support. One person had a communication care plan that described a distress behaviour and that staff should reassure them or provide the person with alternative choices. The same person also had very similar indicators for pain. Staff were directed to complete a pain scale assessment and administer pain relief in line with their PRN protocol. However, we observed this person on several occasions displaying this indicator of pain or distress and staff did not engage with them. There were no pain checks completed or PRN pain relief offered, and no other support provided.

Respecting and promoting people's privacy, dignity and independence

● Some people had long gaps between continence pad changes without any recorded reason. One person had been left for 10 and a half hours in their pad in the daytime during October 2020. A second person had been left for 10 and a half hours in a pad in the daytime on one occasion in November and several times was recorded as left in a pad for seven and eight hours. This is not dignified for people and is a risk to their skin integrity.
● A third person had an incident recorded in September 2020 where staff found the person sat on the floor in a hallway 'soaking wet' at 11:00. The staff recorded the person had not had a pad changed 'at least since handover' . It is not clear how long this person had been left but action was for this to be handed over to the night staff, indicating the person had not received enough personal care in the previous night shift. This was not dignified support for this person.
● People's privacy was not always respected. We observed one person was visited by the provider's PBS champion, who spoke with them for half hour in the dining room with other people present. The person was talking about private matters and their feelings. This was in a communal area and no attempt was made to have this conversation in private.
The failure to protect people's dignity was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care
● Some people were able to use Makaton, but we did not see staff supporting people to make day to day choices or conversations with Makaton. Makaton is a spoken and signed language system designed for people with learning disabilities or communication difficulties. We saw one person sitting with a book of Makaton signs and staff repeated some back to the person. Although this was well intentioned it was essentially repeating random words such as 'yoghurt'; out of context.
● We looked at the person's care plan and the communication section did not contain much information. It did not state the person had a hearing impediment as we were told by a professional, it just said they used a hearing aid for an hour a day. It also failed to state which Makaton signs the person knew, and just referenced some common ones like please and thank you.
● Some care plans and documents were available to people in easy read format. There were community meetings and families and carers were invited to be involved. Advocacy services independent to Rapkyns Care Centre were available to people. The clinical lead told us, "It is a constant involvement: it's their home so whether it's a minor or major change it's discussed with them."

● We saw some kind and caring support, for example, between one person and their one to one carer. We saw examples where some staff were very positive towards people. For example, one staff intervened with an agency staff who they saw supporting a person to drink. The staff said, "[Name] is very clever and can do it herself when drinking to take medicines." The staff helped the person grip the cup themselves to give some independence, and spoke very kindly with the person. People we spoke with told us they liked their staff. One person said, "They [staff] are A1 absolutely brilliant."
● We spoke with people's relatives and they were very positive about the care their loved ones received. One relative said, "[Name's] key worker loves them and really cares for them, and you don't just follow the procedure you have to love them; it goes for everyone not just those in charge."
● A second relative told us, "They [staff] talk to [name], not as a baby, as an adult and allowing to have some control. They pay attention to detail and ask 'are you comfortable, let me see your hands'… Every family birthday and celebration there is a card and some of them are hand made in craft centre."
● A third relative told us, "[Name] is non-verbal but [key worker] reads her bodily expression and can understand non-verbal cues."

Inadequate

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

● During the last inspection where this key question was rated in September 2019, we found a breach of regulation 9, relating to providing people with person centred care, personalised activities and person-centred care plans. At this inspection we found insufficient action had been taken and the service was still in breach of regulation

● Some people's experiences of care were not person centred or positive. One person's care plan stated they needed to have a routine and not to be unoccupied. This person was observed to spend most of their time during the inspection in bed in their room, without staff support, or any structure . They were recorded as going out for a walk in the morning for 10 minutes and 10 minutes after lunch. Other than for personal care and lunch the person was alone. There was very little stimulation for this person.

● The person had a PBS plan that said they had a worry box [where they could deposit concerns] and should have 'talk time' for an hour, and staff should work on understanding and reflecting on a new emotion each week. We spoke with an agency carer and asked where the worry box was, but the agency carer didn't know what it was. We spoke to a permanent carer who said the worry box should be in the person's room. However, they confirmed they had never used a worry box with the person.

● There was a lack of structured engagement and long periods of little to no sensory stimulation for this person. For example, on the first day of our inspection we reviewed the person's interactions from 10.50. Staff had offered a drink at 11.30 but by 11.55 the person had no other interaction and was rocking, shouting and banging with their door open. No staff went to their room and nothing was recorded in their care notes.

● The person was alone in their room with very little to no stimulation, wrapped in their duvet, or rocking on their bed. Over two days of observing the person for periods between approximately 10.30 and 16.00 we only saw one staff go in to 'play balls' for less than 5 minutes other than providing direct care needs, and the care records did not record other activities for these times. We asked the nurse what one to one support the person received and were told, "Feeding and personal care; staff speak to her during that time." The person's care plans referred to the importance of a sensory based approach to supporting them, but the person was sometimes alone for. two hours or more, without stimulation.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Although people's relatives were positive about the provision of activities at Rapkyns Care Centre, our inspection identified significant concerns: People were not receiving personalised activities. We spoke to one staff about this and asked if they thought activities were person centred. The staff told us, "No, like for example [name] if you put paint and decoration in front of him, he wouldn't even look at it and everybody is

different in their own ways. But if the whole table is set up for painting not everyone would do that. [Person] likes to write and [name] likes to listen to music." A second staff member told us, "It's difficult to have one activity for one, like cooking or sensory activity; but it's fun to stay together and maybe next time they do something specific to the other person."

● Some people had personalised activity planners, but these were not being followed and the majority of activities were group activities, where people were passive. For example, one person should have been having a communication session one day and a games activity the next but instead was supported as part of a group activity around a pantomime.

● We reviewed the activity records for one person who had two care plans related to activities that were meaningful for them. However, the plans did not give much detail about how the person's needs around their loss of vision had been accounted for when helping them to plan activities. It also failed to state the support they might need to carry out the activities as independently as possible. There was also a lack of detail about how activities helped the person to learn new skills and further their interests and life goals.

● For the week ending 29 November this person had a cooking activity on one occasion as suggested, but otherwise the only activity recorded was listening to music whilst in bed in the afternoons or having personal care support. Activities such as sensory/audio books, or alternative activities as suggested in care plans, had not been recorded as offered.

● In a months' worth of records there was no instance where the person was supported for a trip out on a Sunday as suggested, or on any other day in the month. Some activities had been offered that were not part of the person's suggested plan. For example, they were recorded as participating in group activities such as making a leaving card, choosing Christmas decorations as part of a group, and playing games as part of a group. However, it was not clear how staff supported the person to do these activities in a personalised way given their limited sight. It was also noted the person spent much of the time during the game's activity asleep.

● We observed several group activities and saw people were disengaged or asleep. Staff were well meaning but lacked the skills and training to engage people in a personalised way. For one afternoon we saw six people in wheelchairs around a table in a dining room. There was a TV on with subtitles that people may not have been able to read. We saw people sat with staff as they completed daily notes on the electronic system for one hour and 15 minutes. About 30 minutes in to this we saw one person had a phone to watch videos on. Five other people were sat with very little to no interaction. One person was making vocalisations and another person was repeating a phrase but neither person was responded to by staff.

● During another observed activity staff were making Christmas cards. There were five people at a table. Staff spent only 30 seconds to a minute with each person showing them cards. One person was asked to put glue on a card. There was very little communication. Different people, at different activities seen across this inspection, fell asleep during the activity. One person told us, "…when you are doing nothing time can drag."

Meeting people's communication needs

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

● People's communication needs were not being fully met. There was a lack of assistive technology to support non-verbal people to communicate. One relative told us, "There used to be an IT department and there were various switches and so on that were used to help [name] to communicate, and I haven't seen evidence they're doing that now."

● We did not see staff using communication aids, such as augmented sign language systems, 'now and next' boards or objects of reference. Staff we spoke with were unable to give examples of how they would support

non-verbal people to communicate other than giving a choice and following their eye movements.
● One relative told us, "[Name] likes changing their clothes several times some days, and they offer it and she will burst our smiling like I got my message across." However, this was not in any of the person's care plans and we did not see this being offered during the inspection, including during times when the person was displaying distress indicators.

The failure to provide centred care was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● Complaints were being recorded so they were tracked and audited through to conclusion. The majority were around a poor WIFI connection during lockdown and had been resolved.
● The provider's complaints policy was up to date and reviewed; an easy ready version of the complaints policy available for people. However, it was not clear how people would be supported to make complaints or to who to contact. No recent complaint on file were from people living at the service.

End of life care and support
● Nobody at Rapkyns Care Centre was receiving palliative or end of live care.
● Most people did not have a care plan completed for the end of their lives, though many people were young. One person's relatives had completed a future care plan, which needed to be confirmed via a best interest process.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as 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

● During the last inspection where this key question was rated in July 2020, we found a breach of Regulation 17 relating to the failure to assess, monitor and improve the quality and safety of services, to mitigate risks, and to maintain accurate records. At this inspection not enough action had been taken, and the provider remained in breach of Regulation 17.

● At the last inspection where we rated all five key questions, in September 2019, we identified six breaches of regulations relating to person centred care, consent, safe care and treatment, safeguarding people from harm, good governance and staffing. At this inspection we again found breaches of the same six regulations plus an additional breach of Regulation 10 relating to Dignity and respect.

● The breach of Regulation 12 for safe care and treatment was first identified during an inspection in September 2018. This breach has remained in place over five subsequent inspections including this one. Breaches of Regulations relating to person centred care, consent, safeguarding, good governance and staffing were all identified in our inspection in February 2019. The provider had not been able to evidence enough improvement to meet these breaches.

● The provider had a service improvement plan [SIP] which was reviewed regularly to ensure improvements were driven in the service. Some actions were out of date and referred to staff who had left the service. Other actions were marked as complete, such as, 'choking risk assessments to be reviewed and updated to reflect needs of people'. However, we found after the latest choking incident the assessment had not been updated and staff did not know one of the key recommendations made to keep the person safe.

● We were not assured that ABC charts [for monitoring behaviours that may challenge other] were being monitored effectively. The clinical lead said a PBS champion was having some oversight of the ABC charts. However, there was no systematic review of incidents that would lead to a change in how a person was supported. This left people with behaviours that may challenge others, at risk of not receiving safe support when they were distressed

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

● The provider's quality audits had not been effective in identifying areas of concern, or in responding to our concerns. We had identified issues, for example, with medicines, constipation and dignity that the provider was not aware of through their own auditing systems. In addition, areas in which we had previously identified serious concerns, such as with safely managing people's behaviours with a positive behaviour

approach, had not been addressed. Some of these concerns were first highlighted in February 2019.

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

● During our inspection in July 2020 we raised a number of serious concerns about the lack of physiotherapy assessment and provision, the safe management of people's feeding tubes, the lack of a positive behaviour support approach, a person's respiratory condition, oral suctioning and the safe storage of thickening powder. We imposed urgent conditions on the provider's registration, setting out what they must do and report every month to the CQC. This included information about any missed physiotherapy sessions, positive behaviour support and the pausing of feeding tubes.

● Following concerns raised by visiting health professionals we conducted a targeted inspection in September 2020 and found that our concerns remained around the lack of physiotherapy provision. We imposed another urgent condition setting out that assessments of people's needs around physiotherapy must happen and that the provider must report to CQC on the progress of these assessments.

● Despite urgent conditions being imposed in July in relation to providing monthly reports for positive behaviour support we only received audit reports in October and November. Reports for December and January were not forthcoming. The reports we did receive did not demonstrate change was underway and our findings on inspection confirmed this.

● The physiotherapy audit report in to missed sessions was not sent until November 2020. We acknowledge that there was a large number of assessments and physiotherapy hours to recruit to and that work is underway. However, less than 50% of funded hours were being provided in December 2020 and of those hours being provided, some of these hours were used carrying out assessments.

● There was no registered manager in day to day charge of the service as the previous registered manager had left and had not yet deregistered with CQC. There was a clinical lead who was a registered nurse but the acting manager who had been in post during our last two inspections had left the service prior to our inspection. During our inspection we were told that a registered manager from another of the provider's services was going to be overseeing the service. The provider's nominated individual and some of the quality team had been based at the service, and the provider's chief operating officer told us they were applying to be registered as manager of the service. Although this was positive, there had been a high turnover of managers in the service, over this and the previous two inspections, dating back to July 2020.

● Concerns about risks associated with: constipation, dignity, 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The culture at the service was not person centred or positive. One person was being left for two or more hours with very little interaction. Activities were mainly in groups and staff told us these were not personalised. Staff did not support people to communicate in a range of ways to maximise their independence.

● There were indications of a closed culture. For example, a staff not being transparent in a safeguarding investigation about an assault on a person. Staff wore uniforms and many staff lived on site, so there were not as many external visitors to the site, as there otherwise would have been. People were removed from the community through the structure of the service. There were a high number of injuries to people including cuts and bruises, and people were not being supported to safely manage any behaviours that may challenge others.

● Health outcomes for some people were not always positive. People were not receiving their assessed

physiotherapy sessions and some people had not been supported to walk or stand as assessed.
● The provider had recently commissioned a nationally recognised and independent specialist learning disability organisation to review learning disability service provision across their registered services, including Rapkyns Care Centre. This review had highlighted significant and multiple shortfalls in the provider's model and approach to delivering care to people with a learning disability.
● The review concluded significant changes and improvements were needed to be able to deliver, person-centred, open, inclusive and empowering support that achieved good outcomes for people.

Working in partnership with others
● We received feedback from the local health team that referrals had not been sent to the correct teams but recently this had improved. However, Referrals made to health professionals were not made in an organised way which sometimes led to delays in people receiving support. This meant there could be delays in people receiving care and support.
● When people had been moved to temporarily close one lodge we received feedback that partner agencies were not aware of or involved in the move. Some information may not have been handed over accurately as a result of this.

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

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● When incidents happened, these were shared with people's families. One relative told us, "They call if there is an issue or if [name] has any seizures and they always let us know he's had one." A second relative told us, "[Clinical lead] is lovely and seems extremely conscientious and determined to get home on track." A third relative described the management as, "…switched on and doing right thing in trying times. I have had not a concern and they are contactable and approachable: if we have request it is listened to."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● We spoke with the provider's nominated individual, clinical lead and their chief operating officer. They described how they took account of people's protected characteristics, such as disability. We were told, "We had clear face masks delivered and are trialling these to allow people to see facial expressions to communicate effectively."
● There were meetings where people could discuss activities, menu's or other areas that affect their home. Minutes from these meetings were produced in easy read format. Managers described how they had used social stories to explain Covid-19 to some people so they could understand why some activities were no longer viable.
● The management team were supporting staff to be more involved with the running of the service. Staff had taken the lead on arranging a pantomime performance in house as theatres were closed and had led on a Christmas card designing competition.
● Staff meetings were held formally and also via 'huddles' when infomration was needed to be passed form management to staff. The provider's quality team had worked on an individual basis with staff to look if there were any barriers to how they wanted to work. The head of quality told us, "We took their lead and asked what was helpful and what wasn't."