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

This unannounced inspection was carried out on 8 June and 11 July 2017.
The inspection was bought forward as we had been made aware that following the identification of risks relating to people's care, the service had been subject to a period of increased monitoring and support by commissioners. The service has been the subject of 11 safeguarding investigations by the local authority and partner agencies. As a result of concerns raised, the provider is currently subject to a police investigation. Our inspection did not examine specific incidents and safeguarding allegations which have formed part of these investigations. However, we used the information of concern raised by partner agencies to plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection. Between May and August 2017, 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 who are living with a learning disability, physical disability or complex health condition. The home also specialises in supporting and treating people living with Huntington's disease. Accommodation is provided in two buildings on the same site, Rapkyns Nursing Home and Sycamore Lodge. Young adults and older people reside at the home.

At the time of the inspection there were 35 people living in the main building (two of whom were in hospital during our inspection) and nine people living in Sycamore Lodge.

We carried out an unannounced comprehensive inspection of this service on 16 May 2016 where it was awarded a rating of 'Good' in all domains and overall. As a result of this inspection, the overall rating of this service has changed from 'Good' to 'Requires Improvement'.

On the first day of our inspection, a registered manager was in post. When we returned for the second day of inspection, the registered manager had resigned their post and interim arrangements had been put in place for the management of the service. A new manager had been recruited, but had not taken up their post at the time of this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Whilst systems were in place to assess, monitor and improve the quality of the service, these were not always effective, as they had not identified the breaches of regulation we found at the time of our inspection. The lack of supervision for some staff meant that staff may not always have understood what was expected of them. Staff did not always keep clear records relating to people's fluid intake where this was needed and there was a lack of guidance for staff on one person's specialised footwear. There was evidence of improvements having been made in accurate record keeping, but further work was still needed.

There were gaps in training for some staff who had not completed all the mandatory training including, moving and handling, safeguarding vulnerable adults and mental capacity. Some staff had not completed all the required training to ensure they carried out their roles effectively. Supervisions had not been held regularly or in line with the provider's guidelines. Some staff had not received supervision at all in 2017 or had an annual appraisal within the last 12 months. This put people at risk of receiving care from staff whose competency had not been assessed recently.

People did not always receive personalised care that was in line with their preferences, although these were recorded in their care plans. Staff had not been deployed in such a way as to ensure, for example, that people were able to get up at the time they wanted because other people with healthcare appointments took priority. Activities had not been organised in line with people's interests. Care plans documented the activities that people enjoyed which had been organised by staff, rather than activities that were tailored to meet people's needs or preferences. There was a lack of mental stimulation for people who had little or no communication. Staff provided care in a task-orientated way; it was not individualised or person-centred.

On the first day of our inspection, the registered manager demonstrated understanding of her responsibilities to protect people from abuse and to provide safe care. They ensured systems were used to monitor and to ensure that appropriate action was taken when incidents and safeguarding situations occurred. Additional training had been provided to staff as a result of safeguarding investigations in relation to personal care. Staff were able to explain the correct procedures that should be followed if they thought someone was being harmed or abused. Senior management shared learning from safeguarding situations that had occurred at other locations operated by the provider to ensure learning and practice improved across the organisation.

Risks to people's health and wellbeing were being managed safely for the majority of people living at the home. Moving and handling risk assessments were reviewed regularly and changes implemented where necessary. These risk assessments described the number of staff needed and what equipment was needed for each movement and we saw that this was being followed. We observed one person was at risk of trapping their fingers in their wheelchair and that this had not been noticed by staff. This was discussed with the acting manager who assured us that a referral for a new wheelchair would be made. For people who had behaviours that posed risk to themselves and others, assessments and care plans detailed how behaviour may present, the warning signs, triggers and how to support the person safely. Staff who supported these people understood how to provide safe care whilst not restricting their freedom.

Except for one observed instance, people with swallowing difficulties were supported to eat safely. Staff were able to explain the support people needed to eat safely and this corresponded with the contents of their care plans and assessments. They were also able to explain signs of choking and what they should do if this occurred including emergency first aid. We did observe one instance when one person was not positioned to eat in line with the recommendations of the speech and language therapist. We fed this back to the registered manager and we received assurance that was acted upon.

People who could not have food and drink orally received safe care. The care plans, monitoring charts and information in people's rooms was accurate and reflected the care we observed people receiving. Staff were knowledgeable about supporting people in this area and had received training.

There were sufficient numbers of staff to keep people safe and the use of staff was generally effective. The registered manager demonstrated understanding of assessing that staffing levels were sufficient to provide safe care. Where possible, regular agency or bank staff were used to cover vacancies. There was a high usage of agency staff at weekends.

In the main, safe medicine procedures were followed. Staff checked the instructions on people's Medication Administration Records (MAR) corresponded with the medicine directions on labels before administering to people and signed the MAR only after people had taken their medicines. Medicines were stored safely. The majority of medicine records were accurate and legible. However, we did note that some MAR would benefit from expansion when codes were used in order that they clearly explained why a medicine had or had not been given.

Registered nurses had completed training in addition to the mandatory training on offer, in areas such as palliative care, enteral pumps, catheter care, PEG management and venepuncture. Staff had also completed training on specific health conditions, such as Huntington's disease. Staff meetings were organised with separate meetings taking place for nurses and care staff.

The service operated within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and put this into practice. Staff had completed training in this area and mental capacity assessments had been completed for people where required. People's capacity to make decisions independently was documented and managed appropriately.

People and a relative were positive about the food on offer. The chef understood people's dietary needs which were documented appropriately. Specialist diets were catered for, including for people who received nutrition through PEG feeding. People told us they had choices within the menu on offer or could select an alternative if they wished.

People had access to a range of healthcare professionals and services. Care plans provided detailed information to staff about how they should support people with their various health and medical conditions. People's healthcare appointments were documented and guidance provided to staff with any actions that needed to be addressed.

People were supported by kind and caring staff who were prompt in helping people when they needed. People's likes and dislikes recorded in their care plans were put into practice, aside from personalised activities which we referenced earlier in this section. For example, one person liked to have a thin sheet or blanket covering them all the time and this was in place. People were supported to stay in touch with their families and their spiritual and cultural beliefs were catered for. They were treated with dignity and respect and had the privacy they needed.

People and/or their relatives were involved in reviewing their care plans and had signed the care plans to show their involvement. Care plans provided detailed information about people from the point of their admission to the home. A range of assessments was in place including people's sleeping, communication, continence, food and nutritional needs. Comprehensive guidance was in place for staff which was followed. Complaints relating to the management of the home were dealt with appropriately.

Staff said that they felt fully supported and that the registered manager was approachable. During their employment, the registered manager involved, consulted and advised staff on the service provided to people in an attempt to drive improvements at the service.

A range of quality assurance processes was in place and had been completed by the registered manager and representatives of the provider. Reports showed progress made to address areas identified as needing improvement in some areas. The provider and senior management met every two months to monitor and discuss progress made in relation to finance, operations, human resources, compliance, quality and information technology. The provider wanted to work collaboratively with other agencies.

Feedback was obtained from people and their relatives by the provider through formal questionnaires and residents' meetings.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are considering our regulatory response to these breaches of legal requirements and will publish our action when this is complete.

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

Some aspects of the service were not safe.

People told us they felt safe. Safeguarding procedures were in place that offered protection to people.

Medicines were managed safely. Some medicine records would benefit from further development.

In the main, risks were assessed and managed safely, with care plans and risk assessments providing information and guidance to staff.

There were enough staff on duty to support people and to meet their needs. Agency staff were often on duty at weekends.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Staff had not always received regular supervisions and some staff had not completed mandatory training on particular topics.

Staff understood the requirements of mental capacity legislation and put this into practice.

Food on offer was nutritious and catered for people's special dietary needs. People had a choice of what they wanted to eat.

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.

Positive, caring relationships had been developed between people and staff.

As much as they were able, people were involved in decisions relating to their care. Their preferences, likes and dislikes were recorded in their care plans and guided staff on how they wished

to be supported.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Staff were not deployed to ensure people received personalised care in line with their preferences. Sometimes people were not able to get up as early as they might wish.
Staff were task orientated in their approach. There was a lack of mental stimulation for people and activities did not take account of people's hobbies or interests.

Care plans provided detailed information about people and guidance for staff. However, this was not always put into practice to ensure people received care that was person-centred.

Complaints were managed and responded to appropriately.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led

Systems were not always effective in identifying areas for improvement or the quality of care people received. Some records had not been completed accurately in relation to people's risks.

Management of the service was inconsistent. The registered manager resigned their post and interim plans were put in place to manage the service on a day-to-day basis. A new manager had been recruited.

People and their relatives were asked for their views about the service. Staff felt well supported.

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.

We undertook this unannounced comprehensive inspection on 8 June and 11 July 2017. Our inspection began as a focussed inspection on two domains but following receipt of further information of concern we returned on 11 July to complete a comprehensive inspection.
The inspection was undertaken by three inspectors, a dietician and a speech and language therapist.
The inspection was prompted, in part, by notification of one death and 10 subsequent safeguarding and quality concerns raised by partner agencies. These incidents and safeguarding concerns are the subject of a police investigation and as a result this inspection did not examine the circumstances of specific incidents.

However, the information of concern shared with the CQC about specific incidents and safeguarding concerns indicated potential concerns about the deployment of suitably qualified and skilled staff, management of people's mobility needs to prevent injury and care of percutaneous endoscopic gastrostomy (PEG) feeding tubes for people who were not able to take food and drink by mouth. Therefore we examined those risks in detail as part of this inspection.

Prior to the inspection we reviewed the information we held about the service. This included information from other agencies and statutory notifications sent to us by the registered 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) since the inspection was planned at short notice. This 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.

During the visit we spoke with nine people who lived at the home, a relative, the activity coordinator, the registered manager, the training manager (who was the acting manager on some days of the week), the area manager, three registered nurses, two care assistants, a team leader, an agency care worker, a

physiotherapist, the nominated individual and the head of quality and therapies. Afterwards we also spoke with a dietician recently employed by the registered provider.

We spent time observing the care and support that people received in the lounges and communal areas of the home during the morning, at lunchtime and during the afternoon on both days of inspection. We also observed medicines being administered.

We reviewed a range of records about people's care and how the home was managed. These included ten people's care records and 14 people's medicine records. We also looked at staff training, support and employment records, audits, minutes of meetings with people and staff, menus, complaints, policies and procedures and accident and incident reports.

Requires Improvement

Is the service safe?

Our findings

People who were able told us that they felt safe. One person said, "I love the staff we all have a good laugh, staff are really good to us, I am definitely safe - no worries at all staff are more than willing to help. This is perfect, I haven't got a problem". A second person said, "I love the staff, they are very dedicated, they make you feel good when you feeling down". A third person said, "The care is wonderful, staff lovely and food very good". A fourth person told us, "I feel safe living here. The staff are fine and can be caring". However we identified some areas of safe care and treatment which required further improvement to ensure safety was consistently assured.

We found examples of risks being managed appropriately. For example, in Sycamore moving and handling risk assessments were reviewed regularly and changes implemented where necessary. These risk assessments described the number of staff needed and what equipment was needed for each movement and we saw that this was being followed. These were clearly written and contained step by step instructions with photographs to aid understanding of precisely how the person needed to be supported. Other assessments for people who lived in Sycamore included risks associated with epilepsy, diabetes, how to support people's behaviours that posed risk to themselves and others and those at risk of malnutrition. One person's risk assessment and care plan detailed how a behaviour may present, the warning signs, triggers and how to support the person safely. For example, warning signs for one person were explicit in detail. We asked a staff member how this person presented when becoming agitated and they were able to explain exactly what we had read in the care plan. The care plan informed staff how to divert the person's attention to an activity they were known to enjoy.

On the second day of our inspection, we looked at how the risk of burns or scalds was managed for one person who had recently been burned when they spilled hot soup on themselves. Their risk assessment and care plan had been updated and informed staff to ensure that cold water was added to hot liquids to reduce the temperature. The nutrition care plan had been updated through a staff member hand-writing the amendments, however, their writing was difficult to decipher and may have also been difficult to read by other care staff. We discussed this with the acting manager who told us the care plan would be typed up the same day, to make it legible. We also observed one person in their wheelchair, where a harness was used to prevent them from unsafe movement or from falling out of the wheelchair. We observed that the person was putting their fingers through the spokes in the wheels, which put them at risk of entrapment, especially if staff moved the person's wheelchair and did not notice the placement of their fingers. This put their safety at risk. We were told that the person had not suffered any injury in the past through placing their fingers in the wheels, however, we did raise the issue with the acting manager. They assured us that a referral would be made to assess the person for a new wheelchair. In the meantime, they would see if there was a spare wheelchair on site which could be used. This was not ideal, as people spending long periods of time in wheelchairs should have a wheelchair that is tailored specifically to meet their postural and care needs.

Staff demonstrated understanding of risk management and keeping people safe whilst not restricting freedom. One staff member told us, "We have people who have epilepsy. We make sure that we follow the risk assessments in place to support the person. This includes administering emergency medication in

response to a certain type of seizure that may have lasted a specific length of time. This is done by a trained staff member. There are always trained staff on shift. We have helmets that some people need to wear when out in the community so they do not injure themselves during a seizure if they fall. We have to go through the risk assessments and care plans. Because you have to know the person before you work with them. Every person is different, with different needs. You can't put them in one box".

We were told about people living with dysphagia in the main building. This is the medical term used for people who have difficulty swallowing. People with dysphagia need support to reduce the risk of choking. The care records for one person confirmed they had this condition and detailed measures needed to reduce risks of choking. For example, that the person needed a pureed diet, that fluids should be thickened, the person needed to be sat in an upright position when eating and their weight checked each month. A referral had been made to the SALT team when changes were identified in the person's needs and the registered manager was awaiting their report at the time of our inspection. We spent time with this person and the member of staff who was supporting them. The member of staff was able to explain the support the person needed to eat safely which corresponded with the contents of the care records. The member of staff was also able to explain signs of choking such as coughing, change of facial colour and general discomfort. They were also aware of what to do if choking occurred. This included giving emergency first aid. We did note that although information about managing this person's dysphagia was recorded in their care records, information about their swallowing difficulties or the need for a pureed diet was not included in their hospital passport. A hospital passport should contain important information about a person that hospital staff can refer to if they were to be admitted to hospital. We fed this back to the registered manager who gave us assurances this would be addressed immediately.

Another person in the main building also had dysphagia and their care records instructed that their food must be cut up or softened with a fork. They also advised that the person needed to eat sitting upright in a specialised chair and that staff should ensure extra time was given during mealtimes. Advice had been obtained from the SALT team and was included in their assessment with clear feeding guidelines. We spent time with the person and a member of staff who was supporting them. We observed that food was cut into small pieces as per the SALT report, and the member of staff took their time when supporting the person to eat. We did note that the person was not sat upright as recommended by the SALT but lying semi-upright in their bed. The member of staff told us that the person did not want to sit in their chair in an upright position so they had decided to tilt their bed forward when eating. The person had a mental capacity assessment dated December 2016 which confirmed they had capacity to make this decision. After our inspection, the dietician employed by the provider confirmed to us they had visited the person. This gave us the assurance that people's choices and preferences were balanced against risks to their safety.

We also found that people who could not manage to eat and drink orally and who had feeding tubes (PEG) and (PEJ) (i.e. percutaneous endoscopic gastrostomy and jejunostomy tubes) in place received safe care. These involve placement of a tube through the abdominal wall into the stomach or direct to the intestine through which nutritional liquids and medicines can be infused, when taking in food and drink orally was limited or no longer possible. Staff were knowledgeable about the management of these; nursing staff had been trained in this area. The care plans, monitoring charts and information in people's rooms was accurate and reflected the care we observed them receiving. Information included the type and timings of feeds, positions people needed to be in when receiving food and fluids and bed elevation afterwards to reduce risk of choking, additional fluid requirements, tube sizes, rotation of PEG tube and care of stoma sites. Also there were instructions on the need for availability of suctioning machines and appropriate medicines to manage secretions and we observed these to be in place. For example, people who required regular suctioning had their own machines in their rooms. In addition to this suction machines were located in the dining room, conservatory and the nurse's station in order that equipment was available in sufficient

quantities to meet people's needs. We also noted that records of nutrition given via people's PEG matched the timings and quantities described as required in their care records.

We observed there were sufficient numbers of staff to keep people safe and the use of staff was effective. One staff member in Sycamore told us, "We are adequately staffed, the manager is very helpful. She always comes over to offer support". Another staff member in Sycamore told us, "There are the right amount of staff to meet people's needs". A member of staff in the main building said, "It's very demanding here. People are very complex. Would be better if more staff as it takes time to do all aspects of care, give medicines, feed, everything".

The registered manager demonstrated understanding of assessing staffing and levels were sufficient to provide safe care. We asked the registered manager how safe staffing levels were decided. They explained, "The Northwick Park dependency tool is used for guidance only as it's not specific for nursing care; I take into account one to one needs of people. Also we have to consider the building layout. Staffing is fluid, for example, if activities require we amend". We have, however, raised concerns about the responsiveness and person-centred care provided as a result of the staff deployment in the Responsive domain of the report. We have also elaborated further about the skills, competencies and support of staff deployed.

We discussed staff vacancies with the registered manager and what actions they had taken in order that these did not impact on the safety or quality of care people received. The registered manager informed us that there were two nurse vacancies, one day and one night nurse. One agency nurse was covering the nights on a full time basis to provide consistency of care. Four care assistants had recently been recruited and this left three vacancies. In addition to these, the deputy manager position and a 20 hour per week physiotherapy assistant position were vacant.

The registered manager told us that either bank staff employed by the provider or agency staff from an approved list were used to cover vacant posts or shifts. In order to attempt to minimise the risk of high numbers of agency staff working at the home the registered manager said that they tried to use specific agency or bank staff to cover shifts and records confirmed this. For example, we looked at the rotas for the main building from 15 May 2017 to 11 June 2017. These confirmed two nurses were on shift on every day during the day. During this period of time one bank nurse and five agency nurses were used. The bank nurse and two of the agency nurses covered all vacant shifts apart from four shifts. In addition, eight care staff were allocated during the day. Vacant care shifts were covered by a mixture of permanent staff, nurses awaiting their registration, bank and agency staff. As per the nurse shifts, agency staff in the main were regular. The rotas also detailed for the same period of time a physiotherapist at the home from 9am to 5pm on Tuesdays and Wednesdays for three of the four week period, administration five days per week, activity staff Monday to Friday and the registered manager five days a week. We spoke with two agency staff both of whom confirmed that they had received an induction when first working at the home. They said that they were given sufficient information about people who lived at the home to provide safe care. This included information about moving and handling and eating and drinking. They also said that each time they came on shift they were given updated information about the people they were to care for.

We discussed with the registered manager if there was any impact on physiotherapy that people received as a result of the assistant physiotherapy vacancy. The registered manager said that they felt there was not but that they would conduct an audit to evidence their view. The findings of the audit were sent to us on 12 June 2017. These confirmed that there had been no reduction in the support people received with their physiotherapy support.

Staff demonstrated knowledge of safe medicine procedures. This included cross-referencing information on

individual MAR with the information on the monitored dosage system blister packs. The medicines trolley was locked at all times when unattended. Registered nurses and team leaders administered medicines and their competency was checked. Refrigerators dedicated to medicines storage were in place and the temperatures of these were checked daily to ensure the efficacy of the medicines. We checked a sample of the medicines and stock levels and found these matched the records kept.

In the main building we observed medicines being administered at lunch time. The registered nurse checked the instructions on people's MAR corresponded with the medicine directions on labels before administering to people and signed the MAR only after people had taken their medicines. Protocols were in place for medicines to be taken as and when required (PRN) along with a recorded stock count of PRN medicines. The registered nurse who gave people their lunchtime medicines did so with sensitivity. For example, when giving one person their medicines the registered nurse introduced the inspector to the person and sat down next to them so that eye contact could be obtained. On the second day of our inspection, we observed a registered nurse administering medicines to one person through their PEG and that this was done safely. Between each medicine, the tube was flushed through, ensuring that the medicine was administered effectively and that the tube was clean.

The registered nurse demonstrated knowledge of the people they were giving medicines to without the need to refer to records. For example, with regard to one person the registered nurse explained, "[Named person] has four feeds that have to be staggered else there is a risk of choking. It's in their care plan and on handover sheets". They also demonstrated understanding of safe medicine administration. They explained, "Night staff give morning medicines. This allows me to start lunch medicines at 12 as this is a safe gap between dosages. It can take up to an hour as people have difficulty swallowing. About 17 people have medicines at lunchtime. Some are quicker than others; some take longer so I leave them till last so to give them the time to take safely".

We did note three aspects of medicines management that would benefit from development. The registered nurse told us of one person who they were not going to give a medicine to until 1pm, "As she didn't have morning medicines until 9am." The MAR chart had been signed to say the medicine had been given at 8am. Another person's MAR had not been signed to confirm they had received one of their medicines on 4 June 2017. Staff had recorded 'F' on a third persons MAR on three occasions during May. The MAR defined 'F' as 'other' but no explanation what this was had been recorded. Some signatures on a fifth person's MAR were difficult to decipher despite a list of staff sample signatures being in place at the front of the MAR folder. We discussed this with the registered manager who arranged a nurses' meeting to discuss these issues. After our inspection the registered manager confirmed that all the points raised had been acted upon. However this was a concern as we know a medicines error had been raised about this location previously and a number of quality concerns regarding medicines had been alerted to the provider across their services. Therefore improvements to their safe management of medicines should have been embedded and sustained.

The registered manager demonstrated understanding of their responsibilities to protect people from abuse and to provide safe care. We asked the registered manager about the systems and processes in place to ensure appropriate action was taken when incidents and safeguarding situations occurred to reduce risks to people. The registered manager explained that all individual incident and accident reports were seen by them, that they then compiled a monthly report which was reviewed by the area manager and shared with senior management and a trend analysis completed. The registered manager said that the report collated safeguarding situations, incidents, accidents, pressure wounds, deaths, pressure sores, fractures, hospital admissions, errors, coroners and complaints. This is reported on further in the well led section of this report.

In addition to this, the registered manager maintained a folder entitled 'safeguarding' which detailed potential or actual safeguarding situations, when they occurred, who alerted the local authority, if the case was open or closed and any actions as a result of situations. The registered manager confirmed that this allowed them to monitor all required actions were taken to reduce risks of harm reoccurring. For example, as a result of a safeguarding investigation in January 2016 it was recommended that registered nurses updated their end of life training and this was completed during March 2016. It was also recommended that a MUST (an assessment tool for establishing nutritional risk) was introduced for all people who lived at the home and this was put in place straight away.

During a meeting with the local authority in March 2017 the registered manager said that for every person who had an unwitnessed fall where they may have hit their head, as a minimum, their neurological observations would be completed for up to four hours after the fall. This would assess that, if necessary, appropriate medical or emergency treatment could be provided. At this inspection we found that the registered manager had followed the information they had shared at the meeting with the local authority. For example, one person with a history of falls had been referred to the falls prevention team and was awaiting assessment. Following on from this, a protective helmet had been procured to reduce the risk of injury if the person was to fall again.

A shared learning event was planned for the day after our inspection that had been arranged by the registered manager to support nurses to understand the importance of observations when people sustained a head injury. The registered manager explained, "Tomorrow is on indication, anatomy neurological observations. I'm leading as my background is in this area. I want staff to think rather than someone had a fall I have to do observations, but why and what these mean, for example, dilated pupils, paralysis". The registered manager showed hand-outs they had prepared for the discussion which included CT scans. The registered manager said that they would go through the Glasgow Coma Scale (GCS). This is a neurological scale which aims to give a reliable and objective way of recording the conscious state of a person for initial as well as subsequent assessment. The registered manager also said that the provider had online access to Royal Marsden guidelines and had also printed that off to discuss with registered nurses. These are nationally recognised procedures that relate to essential aspects of care.

The registered manager maintained a report of accidents and incidents in order that they could monitor that appropriate action had been taken and to reduce the risk of incidents occurring again. The May 2017 report for Sycamore detailed no incidents had occurred. The report for the main building dated 28 April to 21 May 2017 detailed seven falls relating to five people (one of which related to the previous month). Information within the report included actions taken at the time of the falls including neurological observations and being seen by a GP or paramedics. Where necessary relevant risk assessments or care plans were updated to reflect changes to the support the person received. For example, as a result of one person falling when being assisted to walk they were given first aid by two registered nurses on duty and taken to hospital due to a large laceration. The person's risk assessment was updated and the frequency of neurological observations discussed and agreed upon resulting in increased monitoring. A registered nurse explained, "If people hit their heads, we do vital signs and neuro-obs straight away. We do these every hour for four hours, then every two hours, then four hourly, for a 24 hour time period". They added that the following day following injury, four observations would be completed and by the third day, once a day.

Staff we spoke with told us they had undertaken adult safeguarding training within the last year. They were able to identify the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local authority Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member told us, "If I suspected abuse I would report this to the manager, if really serious I would call 999 [police]. I would also refer this to safeguarding [local authority]

and the Commission". Another staff member said, "If I saw a staff member doing something inappropriate with a resident, I would remove them and report to the manager. If they did not do something about it quickly, I would let safeguarding and yourselves [the Commission] know. However, this company are really good at responding to concerns raised. For example if there is a concern in another of their homes, they will ensure staff are trained in all of the homes to improve practice. They will also do reflective meetings with staff to see what lessons could be learned from errors or safeguarding. I think that's really good and transparent".

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medication Administration Records (MAR) were clearly printed and each had photo identification of the person and any known allergies; there were also photos of each medicine. This helped to reduce the risk of administration errors.

Sycamore was purpose-built and provided space for people to manoeuvre safely and easily in wheelchairs. Each room where appropriate was equipped with an overhead tracking hoist. There were assisted, height adjustable baths, hydrotherapy pools and a sensory room, each equipped with overhead tracking hoists. Staff supported people to move around in a safe and reassuring way.

In the main building some people lived with Huntington's disease. This is a progressive brain disorder that causes uncontrolled movements and can result in a deterioration in the person's mobility. We found that people's mobility needs were being managed safely. For example, one person's records confirmed that when their mobility needs changed they were seen by the provider's physiotherapist who regularly monitored the person. A care plan and a risk assessment were in place along with bespoke leg support equipment to optimise the position of the person's legs. In addition, the person received physiotherapy that included stretching exercises to improve leg extension and circulation to reduce further contractures. The physiotherapist was able to explain the support provided to this person without referring to records.

Personal emergency evacuation plans were in place in care records to inform staff of people's support needs in the event of an emergency evacuation of the building. Additionally, staff had information available of the action to take if an incident affected the safe running of the service. Moving and handling equipment was tested and certificates of safety were in place. Fire tests took place on a weekly basis and small portable electrical items were tested by the provider's maintenance team. This meant the provider had plans in place to reduce risks to people who used the service in the event of emergency or untoward events.

Requires Improvement

Is the service effective?

Our findings

Records and discussions with staff confirmed that they received training and support, however, they also showed that some staff had not completed their training as needed to ensure that care to people was effective. We sampled the training records of staff on duty on the first day of inspection and these confirmed training had been provided in areas which included safeguarding, infection control, mental capacity and deprivation of liberty safeguards, fire safety, first aid and moving and handling. The overarching training plan however, showed there were gaps in training for at least two care staff who had not completed training in 2017 in moving and handling, safeguarding vulnerable adults or mental capacity, which were considered to be mandatory training by the provider. We discussed this with the acting manager who produced the training timetables which showed the various training sessions that all staff were required to attend on a range of topics. The acting manager told us there was no reason why staff could not easily access the training which was delivered on site at least twice a year. We saw that moving and handling training also needed to be completed by ancillary staff, such as maintenance, domestic and laundry, catering staff, drivers and administrators, at least once per year. According to the training plan we were given, at least four ancillary staff had not completed the mandatory moving and handling training in 2017 as required by the provider. This meant that not all staff had completed the training they needed to enable them to carry out the duties they were employed to perform.

Supervision sessions were not regularly available to staff in line with the provider's guidelines. We asked a member of the management team how often staff should receive supervision with their line managers. We were told that staff should have at least three supervisions per year, one of which would be an annual appraisal of their work performance. For example, records showed that a member of the nursing staff had supervision in January 2017, with others held in May 2016 and December 2015. Another member of the nursing team had one supervision and an appraisal in July 2016, but none since that time. They told us, "Even my manager was aware I've not had staff supervision this year. She scheduled one for me on 28 June 2017", but this supervision meeting had not taken place as planned. Therefore this member of staff had not received supervision at all within the last 12 months. According to records we saw, another member of care staff had only completed one supervision this year, in March 2017. Three care staff had not received supervision at all in 2017. We saw minutes relating to a staff meeting held in March 2017 which referred to supervisions and appraisals and stated, 'These must be done and kept up to date and done every three months'. Staff did not always receive regular supervisions to ensure their competency was maintained. This put people at risk of receiving care from staff who had not been assessed as competent to carry out their roles.

The above evidence shows that staff did not always receive appropriate support, training, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In addition to the mandatory training that staff were required to complete, records confirmed that nursing staff had completed training in areas such as palliative care, enteral nutrition pumps, venepuncture and a respiratory case study day. One registered nurse told us, "We are asked what courses we need" and said

they were happy with the training on offer. Another registered nurse said, "I was invited to Huntington's training, plus you have to take responsibility yourself as a nurse to maintain your own knowledge. For example, after my first shift here I went home and researched Huntington's as I had not worked with this client group before. I was given instructions when I first came but still wanted to know more". With regard to Huntington's disease the registered manager said, "I can also confirm that staff working here receive specialist HD training. Those who have not attended yet are booked on the next scheduled session at the end of the month". Discussions with the registered manager and nurses confirmed they had also recently received training in catheter care and PEG management.

Staff meetings were held and we looked at the notes relating to meetings held in March 2017 and for four meetings held in 2016. Nurses attended separate staff meetings and a member of the nursing team told us these were held every three months or as required. Records confirmed that meetings with nurses on 6 March 2017 and a general staff meeting was held on 26 March 2017 with the registered manager, the area manager, physiotherapist, nurses and care staff. During these meetings the audit findings were discussed and staff instructed about the areas that needed to improve which included accurate and complete records. Nurses were also reminded of their NMC responsibilities.

Consent to care and treatment was sought in line with legislation 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where people had been assessed as lacking capacity, then applications for DoLS had been completed as needed.

We checked whether the service was working within the principles of the MCA. Staff confirmed they had received training on the MCA and explained that mental capacity assessments were completed for people by their GP. A registered nurse explained their understanding of mental capacity and said, "That is really applicable to people with cognition. We have to base mental capacity on the GP's assessment. If the person has no mental capacity, we have to support them. If there's an issue, we raise it to the area manager and do something straight away. It's always the GP who makes the assessment on admission or on their next round". They went on to talk about the need for capacity to be assessed according to the decision to be made and referred to a best interests decision made on behalf of someone who lacked capacity, but who wanted to go home. The registered nurse described the meeting had involved the person, their family, social worker and the registered manager. They said, "We explain to the person, they may not understand, but we involve them. The decision is made they need to stay here".

Care records showed that mental capacity assessments had been completed for people as needed. For example, an assessment for one person demonstrated they had capacity relating to decisions about their health, medicines and care and this was also recorded in their hospital passport. A hospital passport is a document which provides hospital staff with important information about them and their health when they are admitted to hospital. In another care record, we read about a best interests meeting that had taken place for one person due to them not eating or drinking. Following an assessment by a speech and language therapist and a GP, the decision was taken for a PEG insertion.

People were supported to have sufficient to eat and drink and were encouraged to maintain a balanced

diet. A relative said, "The food is always good and I think it tastes good, especially the pureed food". People were generally positive about the food on offer. One person said, "It depends which chef is on" and said they had been offered a choice of lamb or vegetarian curry, which they liked. Another person told us, "If you don't like what's on the menu, there's an alternative. I can have egg and chips if I don't like what's on offer". They explained that egg and chips was one of their favourite meals. We observed that people were asked where they wanted to eat their lunch and two people chose to remain in the lounge area.

We spoke with the chef who showed us a spreadsheet which recorded the special diets that people needed in relation to their specific health conditions. These included diabetic diets, soft or pureed diets and people who received nutrition through PEG feeding. The chef said, "We have a four week menu. Residents are met with and their choices are reflected in the menus". We saw that alternative menu choices were available to people if they did not like the main menu choices. On the second day of our inspection, one person chose a jacket potato with baked beans; others chose to have sausages and mashed potato. After lunch, we observed a member of care staff went round to each person to ask them what they would like for supper.

People were supported to maintain good health and had access to a range of healthcare professionals and services. A GP was visiting on the second day of our inspection and a registered nurse explained that GPs visited once a week on a regular basis. They added, "However, if we have a problem, we would contact them. We can refer anyone". They told us about one person who had sustained a fall and that the GP visited promptly. The registered nurse explained that if people suffered a severe injury or became extremely unwell, "We will call the ambulance if a person sustained an injury or loss of consciousness, vomiting, pupil dilation or were talking in a slurred way". They also told us they would write a report when a person sustained an injury and that a body map would also be completed. The acting manager told us of plans that were underway to introduce a clinic via Skype where a Huntington's disease specialist could speak with people and staff on-line about their health condition. This was not intended to replace people's healthcare appointments with consultants, but the acting manager explained that travelling to see specialists in London could be extremely tiring or unrealistic for people who were very unwell.

Care plans we looked at described in detail how care staff should support people with various health and medical conditions. For example, for one person living with diabetes, we read how their blood sugar should be monitored and recorded and that they attended annual retinal eye checks and had diabetic reviews. They also saw a chiropodist to maintain healthy feet. Guidance was provided to staff on what action to take if their blood levels fell below a certain point and to ensure this person did not wear tight fitting shoes.

Requires Improvement

Is the service caring?

Our findings

From our observations, people were supported by kind and caring staff. A relative said, "Staff are definitely caring and they always dress [named family member] nicely". We observed a staff member chatting with people as they finished making butterflies during an arts and crafts session and that people enjoyed this interaction. People we spoke with were positive about staff and we observed several occasions where care staff demonstrated a compassionate attitude with people. Staff were friendly and warm and attended to people's needs in a sensitive way, for example, making sure they were warm enough. We overheard one conversation with a member of staff who was chatting with a person about their outing planned that day when they were visiting a local supermarket. Care staff were continually checking on people's wellbeing and asked if they needed anything.

Despite some positive and warm interactions observed between people and staff, we have reported in other areas where care was not always person-centred or delivered in line with people's choices and wishes. There were aspects of the 'Caring' approach of staff which required improvement to ensure people's dignity and choices were consistently respected.

We observed one person in their wheelchair and saw that the harness was dirty, with what looked like several days' worth of food and fluid spills which did not reflect due attention to the person's dignity.

People were not always treated with dignity and respect. On our second day of inspection, we observed that people who were still in bed had their bedroom doors left open. We asked a member of care staff whether this was people's choice and they said it was. However, another member of staff said, "If people are in their rooms, they have hourly checks at night. We try and put people downstairs, so we can check easily. The doors are always open, so we can see and check on people easily". There was no evidence in the care plans that we read to show that it was people's preference to have their bedroom doors left open.

Care plans recorded people's likes and dislikes and information was provided to staff on people's preferences. For example, we read in a care plan that the person preferred to have a thin sheet or blanket covering them all the time and have a towel to cover their chest. This person also liked to be clean shaven and preferred a wet shave. Advice to staff included, 'Shave him every day or whenever he asks'. The care plan also recorded that the person should be offered a towel or blanket and have a sheet covering them whilst they received personal care, in order to ensure their dignity and privacy were maintained.

Care plans also included information about people's families and social histories, their spiritual and cultural beliefs. One care plan explained the person had regular contact with a family member and that if this family member telephoned, 'Staff should hold the phone close to his ear until he has finished the conversation'.

People were supported to express their views and to be involved in decisions relating to their care. We observed one person being discreetly asked by care staff if they needed the toilet, to which the person agreed. Later we heard another person calling out and staff intervened, without delay, reassuring the person in a sensitive way and offering to take the person to the dining room for lunch, which was what the

person had wanted.

When people were receiving personal care from staff, notices were displayed on their bedroom doors to indicate they needed privacy. We asked one person whether they felt staff treated them with dignity and respect. They replied, "Most staff do, but honestly I just 'switch off' when I have personal care" meaning they did not take any notice of what was happening to them. We asked care staff about dignity and respect and one member of staff explained, "We just automatically do this by closing people's windows and doors. If you want to assess, we do this in private". We observed that some people were wearing hospital gowns and we asked the care staff about this. They explained that people living with Huntington's disease would often become very stiff and have muscle contractures, making it difficult for them to move flexibly, especially in relation to getting dressed in clothing that could be restrictive. This issue had been discussed with a GP who advised care staff to use hospital gowns which would make it easier for them to dress people and be less distressing and painful for people in having their joints manipulated unnecessarily.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive personalised care that was responsive to their needs, wishes or preferences. People and a relative had mixed views about the deployment of staff. A relative referred to agency staff and said, "That is my main bone of contention at weekends. Permanent staff are brilliant, they know the residents and residents know them. I'm not impressed with agency care staff. At weekends, they seem content to do as little as possible". They provided an example of a particular Sunday recently when they observed an agency care staff was nearly asleep whilst on duty. A registered nurse said, "It's okay with staffing. Sometimes people's conditions are difficult to manage, which could delay people getting out". They went on to say, "We try to have the same staff. At weekends, they may be new and we have to supervise them closely. The agency try and send the same people, but there are more agency staff on at weekends". A person told us, "I'm not seen as important, I seem to get left behind everyone else. I didn't get up until 12.30pm today and they knew I was going out this afternoon". They added they would like to get up at 10am each day and had asked for this, but was told there were not always enough staff. A second registered nurse explained, "If people want to get up early, the night staff will do this. People with hospital appointments take priority. Sometimes people will have to wait longer. At times, it can be midday before people are got up". We observed that a catheter was used for one person to empty their bladder of urine into a bag. The care plan for this person stated that the bag should be emptied twice daily. On the second day of our inspection, at 11.10am, we observed the bag was extremely full and needed to be changed. We alerted staff to this and they took immediate action, so that the bag was emptied. Delay in emptying overly full urine bags over time could elevate the risk of the person contracting a urinary tract infection and put their health at risk. At busy times of the day staff were not deployed in such a way as to provide people with the support they needed in a timely fashion. Staff were under pressure during the early part of the day and people did not always get the support they would like or needed.

Care plans were written in a personalised way, but, from our observations, staff did not always provide care or support in a person-centred manner in line with people's care plans. Food and drinks were freely offered by staff. When people were upset they were responded to, but interactions, in the main, were task-orientated. From our observations, people did have their care needs met by staff, but there was a lack of mental stimulation on offer. A programme of activities was provided on a daily basis, but these were not structured in a way that meant everyone could be included. We observed ten people sitting in the conservatory area on the second day of our inspection. One person was looking at their mobile, three people were making butterflies and one person was watching television. We saw one person was asked if they would like to do some colouring, but they chose not to. The majority of people were sat in their chairs, staring aimlessly. A relative said, "[Named person] can't go out unless I'm with her. She did have 1:1, but that doesn't happen now. I have asked staff to take her out as she used to love walking. There's new furniture and chairs, but like a lot care homes, staff just whack people in front of the television to keep them occupied". One person told us they would be taken out into the community by staff every couple of months. They said that they enjoyed some of the musical entertainment commenting, "Most of the music is good. We have music for health, but I'm not happy about bashing a tambourine on my head".

A whiteboard in the lounge area recorded some of the activities on offer. These included games and

television on a daily basis, jigsaws, art, colouring, music and occasional visits by external entertainers. A registered nurse told us it was important to provide mental stimulation to people through conversation or activities, but we did not observe this was put into practice in any kind of meaningful way. Throughout the second day of our inspection, some people were sitting in front of a television in the conservatory, watching the same television channel. They were disengaged and had no choice in selecting a particular television channel as no remote control was available to them. Staff did not ask what people might be interested in watching or whether they wanted to be sat in front of the television. In a staff meeting held in March 2017, minutes recorded, 'Care staff to be advised of activities so service users are given the opportunity to partake in these activities if they want to'. A relative told us about external entertainers who visited adding that, "People don't go out so much. An outing was planned for today, but the weather put a stop to that".

We asked whether there were staff dedicated to organising personalised activities for people. In the past, an activities co-ordinator helped structure activities for people, including 1:1 activities for people in their rooms. However, some activities staff had left, or were due to leave, so that activities now available were repetitive and impersonal. We looked at care records which showed the kind of activities that people enjoyed, such as television, films, music, walks around the garden and animal therapy. Two care records showed people were interested in almost the same activities. However, these activities were those which staff had organised and which were on offer, rather than based on things that were of particular interest to people, for example, in line with their past hobbies or what they were interested in. We asked the acting manager about activities available for people who stayed in their rooms. They said, "For those service users, we should have activity staff or care staff engaging with them. It's very easy to become disengaged". People who stayed in their rooms were totally reliant on staff, family or friends visiting them for any kind of social engagement and were at risk of becoming disengaged and isolated. One person said, "I get bored. I chose to be in bed today. Sometimes staff will chat with me. I would prefer them to talk to me more. There is not much to do. I like the food". Another person told us, "I hate living here, but the staff keep me in check", adding that staff were kind to them. A registered nurse said, "People with Huntington's disease – they cannot really communicate or express their needs. All that we have to do".

The above evidence shows that people did not receive personalised care that met their needs and preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff told us that people and/or their relatives were involved in reviewing their care plans. A registered nurse explained, "Through people and their families, we can assess people's needs well". We saw that people and relatives had signed care plans to show their involvement. We were told that care plans were reviewed monthly by nursing staff, or as required. A relative confirmed they were involved in reviewing their family member's care plan and said, "Yes, I'm always involved. I haven't seen her care plan recently, but I know what her care plan consists of. I see the doctor regularly". They added they were always consulted if their family member's care needs changed. They said, "Staff are constantly filling in notes about people. They do a very good job here under sometimes difficult circumstances. I'd give it eight out of ten". A registered nurse explained their involvement in drawing up people's care plans. They said, "The staff are very supportive and I respect them. We help each other. Care staff will notify us of any changes they notice with people".

We looked at care plans and these provided detailed information about people and guidance to staff. Each care plan included admission details, religion, family contacts, medical conditions, medicines and any equipment required. We looked at assessments relating to people's sleeping, communication, continence, food and nutrition. For example, in one person's care plan we read about the support they required when they went to sleep, about their mobility, that they liked to wear loose clothing and consented to have bed

rails in place which made them feel safe. There was detailed guidance for staff on how to achieve this person's needs in relation to their sleeping arrangements. The care plan also showed a review that had taken place in July, to which their family had been invited.

We asked people how they might make a complaint if they had any concerns. One person said, "I'm not sure who I would talk to". However, a relative told us that they would have no concerns in raising complaint if they needed to and that any issues they raised would be responded to appropriately. We asked a member of the senior management team whether any complaints had been received in 2017. After the inspection, we were sent a copy of the complaints log which showed that three complaints had been received and that actions had been taken to address these, to the satisfaction of the complainant.

Requires Improvement

Is the service well-led?

Our findings

A relative confirmed that they received a questionnaire annually from the provider to ask for their views about the service offered at Rapkyns Nursing Home. Comments we read from the feedback included, 'Magic – thank you all' and 'My relative is really looked after'. At the time of our inspection, questionnaires had been completed by residents during June 2017, but the results had not yet been analysed. Of the five questionnaires returned at the time of our inspection, feedback was positive, with people commenting on various areas of the home, such as accommodation, staff and cleanliness. Ratings were between 'Satisfactory' and 'Excellent'. Residents' meetings were organised, with the latest held in April 2017. Minutes showed that topics under discussion included food, activities, entertainment, outings and event.

The registered manager completed her registration with CQC on 29 December 2016 and was present on the first day of our inspection. When we returned for our second day of inspection, we learned that the registered manager had resigned and the home was being managed by other managers of the provider on a day-to-day basis. It is a condition of the provider's registration that a registered manager is in post. We were told that the vacancy had been recruited to, although the new manager had not yet started in post. In the interim, the management of the home was covered by the training manager and an area manager. We asked a relative for their views on the management of the home. They felt the previous registered manager had not been very 'hands-on' and had not seemed particularly accessible. We asked staff about the management and leadership of the home and they told us they were happy with the management arrangements. Other managers involved in the running of the home following the resignation of the registered manager were not always knowledgeable about things that had happened within the home and were unaware of the issues we found at inspection, until these were discussed at the end of the second day of inspection, when we provided feedback.

The registered manager informed us that the week prior to our inspection a deputy manager had been recruited who was very experienced clinically and in neurological issues. We viewed the CV of the new deputy manager and this confirmed that they had extensive experience as described by the registered manager. At the time of inspection the registered manager did not have a date when the deputy would commence employment. By the second day of our inspection, over a month later, the new deputy manager had still not taken up their post and the acting manager was unclear when the new staff member would commence employment.

At this inspection we identified concerns related to the skills, competencies and support of staff, deployment of staff to ensure responsive and person-centred care, consistency of providing care with dignity and respect, accuracy of care records and ensuring that safe care and treatment was delivered to keep people safe. Some of the matters in relation to safe medicines, clear and accurate care records, risk management in relation to mobility and staff skills had been raised with the provider in previous months with regards to Rapkyns Nursing Home and other Sussex Health Care locations. Despite this, the provider had not taken sufficient action to proactively monitor and respond to known risk and quality concerns.

On the second day of our inspection, we asked the acting manager how they would ensure that agency

nursing staff were trained in the use of PEG and suction training. They expressed uncertainty about whether agency nursing staff had been specifically trained in these areas. A registered nurse, who was permanently employed at the home, told us that agency nurses would be supervised by them when carrying out these invasive procedures, to ensure their competency.

We asked staff about the vision and values of the service. One staff member said, "To provide a safe service that is personalised and meets the people's needs in an individual way. To ensure we offer people the best quality of life we can, balancing risk with promotion of independence". However, in our view, it was clear that a lack of recent guidance and support from management had resulted in missed opportunities for the staff team to be developed to drive improvement. Many staff had not received supervision in line with the provider's guidelines, so did not have the chance to discuss their working practices or discuss work challenges in a consistent way. This meant that staff may not always have known and understood what was expected of them or for staff to share ideas about the running of the home outside of staff meetings. Whilst gaps in staff receiving regular supervisions had been alluded to in the minutes of a staff meeting, no plans were in place, or action taken, to address this shortfall at the time of our inspection. Some staff made efforts to provide activities for people on a daily basis, but these activities were not well-thought out and were not tailored to meet people's interests. Some staff were unsure how to relate to people, especially people who had difficulty in communicating or no communication, resulting in little mental stimulation for many people. In our view, the culture of the home had suffered from a lack of consistent leadership and guidance for staff, the end result of which had impacted on people receiving person-centred care.

Staff did not always keep clear records about the care and support people received. People had plans to show how much fluid they needed in 24 hours to reduce their risk of dehydration. However, fluid balance charts did not detail the total of fluid a person was assessed as needing to have and were not always checked to ensure that enough fluid had been given. For example over a seven day period there were four occasions when the amounts of fluid entered had not been tallied to ensure a person had drank enough. A member of staff told us for this person they needed 2000mls per day. This was not recorded on the charts. Over a seven day period there were two entries that indicated the person had drank 1200mls. The member of staff indicated the person could have been out on these occasions, however, this could not be evidenced. There were no entries written in the staff daily notes about the person that indicated they were unwell or showing signs of dehydration. Therefore, we concluded this to be a record issue rather than a safety issue.

Another person had a mobility risk assessment and care plan detailing the person required specialist footwear made by the orthopaedics. However, the documentation failed to inform staff as to why and what specialised footwear was recommended. A member of staff told us the person wore specialised boots to support the person's ankles. The care plan was vague about what footwear the person should have based on different occasions or weather. The member of staff explained, "When [named person] goes for a walk or where the ground may be uneven, [named person] should wear their boots. When at the gym, [named person] has trainers and they have sandals for summer". This information was lacking in guidance for staff. The member of staff demonstrated clear understanding of the person's needs and therefore we were satisfied the person was safely being supported, and this was a documentation issue. However a lack of clear guidance may make it difficult for a new care worker or agency care worker to ensure the person had the right footwear to keep them safe.
The provider had failed to maintain accurate and contemporaneous records to evidence the care delivered to people, despite this matter being raised as a concern at Rapkyns Nursing Home and other Sussex Health Care services previously.

During the course of our inspection we were informed of various mechanisms that the registered manager and provider operated to monitor and address quality and safety across their registered location, including

Rapkyns Nursing Home. However in some instances we found that these mechanisms were not implemented effectively to ensure quality as they did not prevent the issues and breaches of Regulation identified during this inspection.

An audit to review compliance with CQC standards and regulations was completed in February 2016, February 2017 and May 2017 by an external auditor commissioned by the provider. This was carried out as part of the home's internal quality monitoring programme. Although this did result in some improvements made as a result of recommendations, there were a number of areas which continued to arise at these reviews that were not actioned or sustained over the course of the three reviews. This included recommendations made about staff supervision, accuracy of care records. These issues still remained at the time of this inspection. Therefore the external auditing had not been fully effective in implementing and sustaining improvements required.
There were a number of mechanisms of support for managers to share information and learning including regular managers' meetings attended by the nominated individual for the provider, the quality lead for the provider, area managers, registered managers and other heads of department across the provider. We saw evidence of senior leadership meetings, quality assurance meetings and policy group meetings undertaken regularly to review areas of quality and improvement required across Sussex Health Care services.

However, in some instances we found that these mechanisms were not entirely effective in driving sustained change. In many cases the topics of these meetings were driven by quality and safety concerns that had been raised by other external professionals or agencies rather than proactively identified by the provider. For example in one managers' meeting held in February 2017 we saw that manual handling was reinforced as a priority due to safeguarding concerns raised at other locations about this area of care. Additional training had been arranged for staff between March and June in response to gaps in staff skills and competencies identified by external agencies and professionals. In response to a meeting held with WSCC on 20 March 2017 the head of quality emailed all senior managers and registered managers on the same day and advised them to ensure that as part of the monitoring with each home, various areas should be addressed. These included audits, handovers and staff supervisions to ensure all prescriptions are signed by the GP or other relevant professional prescribing, nurses countersign all care plans, ensure care plans for people who use respite services are robust and reviewed accordingly and dedicated, detailed care plans are produced for all people who require suctioning. These issues were also discussed at a managers' meeting on 21 April 2017. However, despite this, quality issues and safety issues have persisted at Rapkyns Nursing Home and other services particularly around staff skills and competencies, accuracy of care records and robust quality monitoring systems.

Systems were in place to assess, monitor and improve the service, but these were not being operated effectively as they had not prevented the breaches of regulation we identified from occurring.

The above evidence shows that systems were not always effective in assessing, monitoring and improving the quality of the service. Records relating to people's care were not always completed accurately. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Commission has received feedback from partner agencies about improvements made following recommendations across a number of Sussex Health Care services but this has not always been consistent or sustained and further work is needed to ensure change is fully embedded.

On the first day of our inspection, staff said that they felt fully supported and that the registered manager was approachable. One member of staff said, "[Named registered manager] is very nice, helpful and approachable. She's knowledgeable, it helps she's a nurse. She explains things for example policies". A

second member of staff said, "A very good leader and has time for everyone". One agency member of staff said, "I have been really looked after. I was given a comprehensive induction so that I knew essential information before starting my shift, for example what to do if there was a fire, or who to talk to if I was not sure about something. I have been based here full time and I like it so much that I am transferring from the agency to be a contracted full time member of staff here. I like it very much". Staff confirmed that the registered manager operated an 'open door' policy and they felt able to share any concerns they might have in confidence.

We asked the registered manager about the quality monitoring systems in place at the home. She explained that a range of audits took place. These included audits of medicines, accidents, incidents, safeguarding, pressure wounds, deaths, fractures, hospital admissions, coroners, complaints and health and safety. In addition to these, monthly audits by the area manager were completed and audits by an external auditor commissioned by the provider.
Records confirmed that accidents, incidents, falls, manual handling incidents, drug errors, safeguarding, violence and aggression and choking incidents were audited on a monthly basis. The form allowed for details in relation to date, name, details, action taken, explained or unexplained, if safeguarding or CQC notification raised and details, outcome i.e. closed, on-going, no further action. The form also included a section for recording any details of any trends developing and noted actions taken. In addition, the form also had a section for the area manager's analysis of the report. The May 2017 audit for Sycamore stated that no events had occurred. The audit for the main building from 28 April to 21 May 2017 detailed seven falls. Records included details of action taken in response and of action in order to attempt to reduce further risks where a trend was identified. For example, it was identified that one person's mobility had deteriorated. As well as receiving first aid and having neurological observations completed arrangements were made for their medicines to be reviewed and they were seen by the provider's physiotherapist who reviewed their mobility needs.

The registered manager demonstrated understanding of prioritising areas for improvement that were identified within the quality monitoring systems at the home. She explained, "Sometimes action plans are done for you. I delegate some tasks to relevant people, for example, the physiotherapist. It's important to plan properly, give realistic timeframes and most relevant people to meet the need. When prioritising consider the volume of work involved, danger is a priority, number one is safety. As registered manager I'm still responsible overall for ensuring safe care".

The registered manager said that she was fully supported by the provider to fulfil her role and responsibilities. The registered manager gave examples of senior management sharing learning from safeguarding situations that had occurred at other locations operated by the provider to ensure learning and practice improved across the organisation. She explained, "It was actioned immediately for all services that if a person is nil by mouth (NBM) a sign must be put on the back of wheelchair stating NBM. This was a direct result of a safeguarding situation at a different service". We observed that the signage described by the registered manager was in place for people who lived at the home. In addition, this information was also on display in people's bedrooms and documented within their care records.

The registered provider had employed a new data analyst who was introduced to managers within the organisation during the February meeting. Part of the person's role was to review information sent by registered managers within the organisation in order to monitor trends at service and provider level.

Prior to our inspection the provider informed us that they had recruited a dietician who would commence employment on 30 May 2017. At the inspection the registered manager confirmed the dietician had commenced employment and was currently completing their induction. We spoke with the dietician about their role and the support she would give to the home to ensure people received a quality service. They explained, "Even at interview I was told about service users in the organisation so I have been doing mapping of homes and service users with dietetic needs to help me understand who needs to be seen. NICE (National Institute for Clinical Excellence) guidelines state we must review enteral feeds three to six months so we need to prioritise these". The dietician confirmed that she had made contact with registered managers who were making referrals for her input based on risks that included significant weight loss, changes in health, hospital admissions, and problems with feeding or new swallowing difficulties. The dietician also told us how she had made contact with other professionals such as WSCC speech and language therapists in order that people received a "cohesive service." As part of her role the dietician would be producing a weekly report that would be discussed at senior managers' meetings and used to drive improvements throughout the organisation.

Examples of clear records we observed were repositioning records, bowel charts and epilepsy charts for those known to have seizures. These were completed in full and had been used to monitor people's health and seek further guidance and support when required.