SHC Clemsfold Group Limited

Beechcroft Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service:
Beechcroft Care Centre is a residential care home that provides nursing care and support for up to 30 people with a learning disability and other complex needs, including autism and physical disabilities. Beechcroft Care Centre is in close proximity to East Grinstead and the local amenities. The service comprises of three 'lodges', one lodge is known as the main building or referred to as Beechcroft Lodge. This is where the registered manager and deputy manager's office is based. The other two lodges are Chestnut Lodge and Hazel Lodge. Together the three lodges make up Beechcroft Care Centre. Each lodge has a separate living room, dining room and kitchenette. Rooms were single occupancy and had en-suite facilities. The service offered the use of specialist baths, a spa pool and physiotherapy. At the time of our inspection there were 20 people living at the service. Some people stayed at the service for short breaks.

Beechcroft 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 raised, the provider is currently subject to a police investigation. The investigation is on-going, and no conclusions have yet been reached.

The service was registered before the 'Registering the Right Support' guidelines were in place. However, the service was not operating in line with the values that underpin the 'Registering the Right Support' and other best practice guidance. These values include choice, promotion of independence and inclusion. These values were not seen consistently in practice at the service. For example, some people were not being supported to be as independent as they could be, and other peoples' experiences of activities was not person centred.
The service did not always apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

Care outcomes for people did not fully reflect the principles and values of Registering the Right Support because of a lack of choice and control, limited independence, and limited inclusion.

People's experience of using this service and what we found
Several aspects of the service remained unsafe. Some risks were not being managed safely such as risks around people's behaviours. Not all safeguarding alerts had been sent to the local authority, or statutory notifications submitted to CQC. There were some concerns around staff having the time to provide both activities and direct care. We have made a recommendation about this in our report.
There were concerns found with medicines, such as 'as required' medicines not having protocols for their use and some controlled drugs not being managed safely. Risks around infection control were being managed safely and the building was clean and free of any malodours.

Some people who required their fluid intake to be monitored did not have this monitored effectively. Some

people took their food, drink and medicines through feeding tubes and we found inconsistencies in care plans. Some people were at risk of not receiving the care and support they needed with their feeding tubes. The building was accessible to people's needs and people received consistent care when they moved to or from the service.

People were not supported to have maximum choice and control of their lives and staff did not 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. There had been a lot of work to complete MCA assessments and hold best interest decision meetings, but some assessments of people's capacity were inconsistent. We have made a recommendation about this in our report.

Some support we saw was not person centred or dignified. Some people were supported during a lunch service in a way that did not maintain their dignity or promote their independence. Other support we saw was kind and staff used language when speaking to people that was appropriate and kind, but this was not consistent. Staff respected people's privacy and relatives told us they could visit people freely.

People did not receive personalised support with activities. Staff and relatives told us that since some activities staff had left the service, support staff were struggling to provide activities people required. Complaints were being managed as per the provider's policy and end of live care plans were in the process of being implemented and updated with personalised information.

Audits had not been effective in highlighting or putting right shortfalls identified at this inspection or previous inspections. Leadership at the service was not effective. The previous inspection rated the well led domain as 'Inadequate' and the same rating remained at this inspection. Only two breaches of regulation identified at the last two inspections was met at this inspection with 5 continued breaches.
The registered manager had worked with staff to improve the culture in the service and this was evident form the way staff spoke with people.

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

Rating at last inspection
The last rating for this service was Inadequate (published 1 July 2019).
The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected

This was a planned inspection based on the previous rating.

Enforcement

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

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
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 take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always 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?

Requires Improvement

The service was not always 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.

Beechcroft Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
On 11 December 2019 the inspection was carried out by three inspectors, a nurse with a specialism in learning disabilities and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience had knowledge about care of adults with learning disabilities and autism. On 12 December 2019 the inspection was carried out by three inspectors and a nurse with a specialism in learning disabilities. On 13 December 2019 the inspection was carried out by two inspectors.

Service and service type
Beechcroft 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. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We sought feedback from the local authority including the safeguarding team and from local health teams.

During the inspection-
We spoke with four people who used the service and three relatives about their experience of the care provided. We spoke with nine members of staff including the registered manager, deputy manager, senior nurse, and care workers. We also spoke with six visiting health professionals. 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.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at four staff files in relation to recruitment safety and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection -
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with two professionals involved with peoples care.

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. We found concerns around how risks were being managed in relation to managing people's behaviours, keeping people safe from abuse and the failure to provide enough staff in one lodge. 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, and learning lessons when things go wrong

- At the last inspection in July 2019 we found a breach of regulation 12 relating to the safe management of risks around epilepsy, medicines, moving and handling, behaviours that may challenge others and monitoring peoples' health needs. At this inspection we found insufficient action had been taken and the breach had not been met.
- Some people living at Beechcroft Care Centre had behaviours that may challenge others. We found risks associated with these behaviours were not being managed safely. One person displayed behaviours indicating distress. There was a mental wellbeing care plan in place which stated the persons' feelings should be respected but there was no indication how staff should do that and did not mention the signs of the person being distressed. There was no other care plan or positive behaviour support plan to direct staff on how best to support the person. A positive behaviour support plan [PBSP] is a document that explains how a person needs to be supported when they are experiencing high anxiety, and how to reduce the chances of this happening in the future.
- We spoke with staff about how they managed this person's behaviours. A registered nurse told us, "There's no care plan how to respond to [name]." Staff confirmed that there was no strategic approach to managing the persons distress. Staff told us they sometimes sat and watched TV with the person and spent one to one time, which could help. We asked whether the times the person was distressed were recorded on ABC forms and were told, "No not for [name] because it's not like a bad behaviour." ABC forms are 'antecedent, behaviour, consequence' forms that are used to gather evidence about what happens before, during and after episodes of behaviour that may challenge. ABC forms are a way of gathering information about people's behaviours and using that information to reduce future instances of behaviours that challenge. Without a PBSP or ABC forms there was a likelihood the persons behaviours would continue, and staff would not know how to support the person to reduce their distress.
- Another person had behaviours that may challenge including slapping themselves, but there was no PBSP or ABC charts to effectively manage and monitor this to reduce the likelihood of repeat occurrence. Staff we spoke with during the inspection did not identify this behaviour as challenging and we observed this behaviour in practice. As a result of a lack of proactive management of this person's needs, they were at risk of continued self-inflicted injury which may be preventable.
- A third person had behaviours that may challenge others including self-injurious behaviours. This person had a behavioural plan which stated they could reach out to grab people if they were unhappy. However, there was no information about how to support the person when this occurred. One staff member told us there was no risk to other people and the person would not display physically challenging behaviours towards other people or staff when this did not match with what their care plan stated.

● The behaviour plan did not mention the person could display self-injurious behaviours. The behaviour plan failed to mention the person was prescribed 'as required' [PRN] medicine for distress and did not give a timescale for how long to isolate the person when they were distressed. Other measures to keep the person safe such as giving another PRN medicine at night time, and supervising the person at night were not included. This meant the behavioural plan was not effective and left the person at risk of not receiving the care and support they needed when distressed.

● We reviewed some ABC charts for this person and found that staff had not followed the stated protocol of reviewing the PBSP following an incident, and no record of a 'de-brief' within 72 hours as directed by the PBSP. There had been occasions where the person had been distressed and had been given a PRN medicine but there had not been an ABC chart completed to better understand why the incident had occurred and how to reduce the likelihood of the person becoming distressed in the future.

● We spoke with the registered manager and deputy manager about the lack of ABC charts on specific occasions and was told there was a checklist for a daily audit of paperwork in each lodge, which included checking ABC charts. The registered manager confirmed that if an ABC chart had been completed, they would review it with the staff member and discuss the reasons for the behaviour. We were told the registered manager would expect an ABC chart to be completed if the person was given PRN paracetamol to help manage the person's behaviours from increasing. We asked why staff might not be completing ABC charts and were told there had been lots of changes going on and staff had been forgetting what they need to do.

● A fourth person had some behaviours that may challenge others identified in their care plans and there were agreed strategies to manage these including regular trips out to a fast food restaurant and other places. These trips were included on a weekly activity's planner. However, we reviewed activities records for the person and they were not being supported to access the activities as set out in their PBSP. We spoke to the provider's behaviour support lead and they agreed that the person was not having the activities as set out in their plan. This left people at risk of not receiving the care and support they need around their behaviours. After the inspection a new seven day planner was put in place for the person.

● Other risks were not being managed safely. On the first day of our inspection we observed a person who fell when they were being supported. The actual incident was managed safely by the staff at the time of the incident. However, there had been no recording of the incident in the person's care plans and risk assessments had not been updated, despite inspectors speaking to the senior nurse on two occasions about this. This left the person at risk of further falls as learning from the incident had not been assessed and shared with staff. We spoke to the registered manager about the risk assessment not being updated at the end of the second day of inspection and this was completed.

● One person had recently experienced a serious choking incident after they were given food that was not prepared correctly. Another person who required their food to be chopped up to reduce the risks of choking had an 'easy profile' for agency staff to use. Their 'easy profile' stated they were on a normal diet and did not indicate their food needed to be chopped. We raised this with a registered nurse as a concern on the first day of the inspection, but it had still not been changed by the end of the second day. Following a conversation with the registered manager this was completed on the third day of our inspection.

● Another person with a specialised diet had an 'eating and drinking' risk assessment. This referred to normal or thin fluids, but the person required thickened fluids. The risk assessment referred to soft moist and pre-mashed diet whereas the person was assessed for a pureed diet. The risk assessment had been reviewed in November 2019 and it stated 'no changes'. Following our inspection, the provider amended this risk assessment. The same person had an 'easy profile' which failed to reference the need for a pureed diet and thickened fluids. This left the person at risk of receiving food that was not safely prepared for them and increased their risk of choking. Following the inspection, the provider gave assurances that this person's care plans were up to date and sent a copy of the shift handover sheet which highlighted the person had 'stage 2 thickened drinks'.

● Some people were diagnosed with epilepsy and risks around this condition were not being met safely.

One person had a 'management of epilepsy' care plan but this did not mention how to manage and monitor the risk of seizure during the night. Following our inspection, the provide told us that sensor mats had been ordered and put in place to monitor night time seizures. The persons 'management of epilepsy' care plan also failed to direct staff to take the person's PRN medicines with them if they were leaving the service. Following our inspection, the provider sent us an updated copy of the care plan to show this had been updated. The same person had a seizure management plan which did not direct staff to give oxygen with their PRN medicine, although they required this, and also failed to state how often to monitor the person's epilepsy through the night, or how else to mitigate risks of night time seizures.

● We spoke with a registered nurse about how this person's epilepsy was monitored and were told that the person made a specific type of noise when they had a seizure. However, there was no information in their epilepsy care plans or risk assessment about them making these sounds during a seizure. We asked the registered nurse about the risk that both night staff may have to leave the lounge to support people and so not be able to hear the epilepsy monitor. The registered nurse agreed there was a possibility this would happen each night, and perhaps another monitor may be more appropriate. The registered nurse confirmed with the registered manager that a bed sensor had been ordered in June 2019 but was not delivered. This was re-ordered following our inspection.

● The provider had introduced the National Early Warning Score (NEWS), across different locations, since November 2017 and at Beechcroft Care Centre. This is a standardised system for recording and assessing baseline observations of people to promote effective clinical care. The NEWS involves taking a baseline for what a person's normal temperature, pulse rate and oxygen saturations should be. It then states what actions nurses should take if checks they make give results outside of the baseline and a person's health deteriorates further.

● The NEWS tool was not being used consistently at Beechcroft Care Centre. One person with epilepsy had a care plan that directed nurses to complete a NEWS observation following a seizure and this was not done.

● The same person had NEWS charts completed on other dates and we reviewed these. There was an elevated score that would require action to be taken such as a further observation, but this did not happen. We spoke to a registered nurse who was unaware of the increased score and did not know if further observations or other action had been taken.

● A second person had epilepsy and required NEWS charts to be completed when they had a seizure, but we found these were not consistently done. We reviewed four occasions when this person had an elevated NEWS score indicating a possible underlying illness. However, the follow up observation or other action had not been recorded. We reviewed a third person who had instances where they had elevated NEWS scores, but these had also not been followed up with any action.

● We spoke with the registered nurse, deputy manager and registered manager about how NEWS charts were being audited. The registered manager confirmed they sampled some charts but the recording of this was not robust and there were some errors that were not picked up by the audits. The registered manager told us they had given additional training to nurses and raised this as an issue in team meetings. However, people were at risk of not receiving the correct and timely medical treatment they needed when they were unwell. After the inspection the provider told us they had addressed this issue with nurses and sent copies of new handover sheets that were used to embed the checking of NEWS.

● When an incident happened, learning was shared with the staff team to try and reduce the risk of a reoccurrence. However, there was not a consistent response. For example, following a choking incident the management team had shared learning from the incident and re-trained staff. Despite this we found an issue with another person's care plan where this learning had not been implemented, which left the person at risk of choking again. We ensured care documents were updated by the end of our inspection.

● The safe management of risk was raised as a concern in our previous inspections in January 2018 and July 2019. However, we have found that the breach of regulation relating to risk remains at this inspection.

● The management of people's needs such with behaviours, epilepsy and constipation were issues we had

found at other of the provider's locations. We found the same issues at this inspection showing that lessons had not been shared and embedded in to practice.
● The failure to effectively mitigate risks to service users is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other risks, for example, around the environment, and fire safety had been managed safely.

Systems and processes to safeguard people from the risk of abuse
At the last inspection in July 2019 we found a breach of regulation 13 relating to the safeguarding of vulnerable adults form abuse. At this inspection we found insufficient action had been taken and the breach had not been met.
● People were not kept safe from the risk of abuse. During our inspection we identified several times when a person had required their PRN medicine to be administered for constipation but did not receive it as required. This medicine was prescribed to relieve the symptoms of constipation at specified times and the person did not have this meaning they may have suffered with the effects of constipation unnecessarily. This had not been identified by the provider as a possible case of neglect or reported as abuse.
● During the inspection a health professional visited the service and discussed with us some concerns about the care and support given to two people relating to possible neglect. This was handed over to the registered provider to raise as safeguarding alerts. After the inspection the provider informed us that they had referred one incident and that two others did not meet the threshold for referrals. Following our inspection, we did not receive a statutory notification for the safeguarding alert that was made. We use information sent to us in statutory notifications to monitor services and respond to risk, so it is important we receive all statutory notifications.
● During the inspection we witnessed these possible safeguarding incidents and staff were present but had not identified the possible risks to people, despite staff having received training in safeguarding people from abuse. This left people at risk of not being protected from abuse.
● The failure to implement systems that effectively prevent abuse is a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Using medicines safely
● At the last inspection in July 2019 we found a breach of regulation 12 relating to the safe use of medicines. At this inspection we found insufficient action had been taken and the breach had not been met.
● One person had been prescribed PRN (as required) medicines for palliative care for use by local hospice nurses when needed, but there was no care plan for their use to direct staff how the medicines should be implemented. We spoke to a nurse who confirmed that there was no care plan for their use. The provider had ensured there was a care plan in place by the end of our inspection.
● Other people had PRN medicines prescribed and the information on their PRN protocols was inconsistent or missing. One person had several PRN medicines with protocols for their use. However, one protocol for a sedative medicine stated the maximum dose in 24 hours was 2 mgs when their medicine administration record (MAR) sheet stated it was 4 mgs. There were also inconsistencies around time intervals between doses. Another PRN protocol for a different medicine had a dosage that did not correspond with the MAR chart. This left people at risk of not receiving the correct dose of medicines.
● Another person with epilepsy was prescribed a PRN medicine to help them recover from their seizures but there was no PRN protocol for this medicine. A third person had a PRN protocol for a laxative medicine, but this failed to state when it should be given. This left people at risk of not receiving medicines as and when they needed them.
● We raised these concerns with the registered nurse on duty. The registered nurse acknowledged the discrepancies and said they would act to rectify the errors. We asked about audits of MAR charts and PRN

protocol to help prevent issues like this. The registered nurse told us there was a weekly audit of MAR charts, and a monthly medicine audit. However, these had not been effective in identifying or putting right the issues we found.

● The failure to ensure the proper and safe management of medicines is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed medicines being administered where registered nurses had supported people to receive their prescribed medicines. We saw good practice with nurses being friendly and kind when speaking with the people receiving support. The trolley was clean with clear labels on containers for each person, and medicines were appropriately written and signed for in MAR charts.

Staffing and recruitment

● At the last inspection in July 2019 we found a breach of regulation 18 relating to failure to deploy enough staff to care for people safely. At this inspection we found that action had been taken and the breach had been met. However, we had identified an issue with staff providing activities and have made a recommendation.

● Since our previous inspection the registered manager had increased the staffing level in one of the Lodges. This had a positive impact on people's care as staff had more time to do care tasks. However, relatives and staff told us that activities staff had left and not been replaced. Therefore, the job of providing activities had fallen to care staff to do, which was not happening as planned.

● One staff member told us, "[I] never think there's enough staff. There have been quite a few issues recently; [it's] difficult for the staff that are here, they are over stretched." The same staff member also told us, "Sometimes hydrotherapy is not achieved for people, due to staffing. People do miss out as staffing isn't available."

● We reviewed activities and found that people were not having activities as assessed. We have reported on this in more detail under the Responsive section of this report. We raised relatives and staff concerns, along with our findings on activities with the registered manager. The registered manager described how activities staff were not replaced when they left following a restructure. They told us, "There is a gap now. We have one co-ordinator trying to do everything across the site and staff who are busy doing care." The deputy manager told us they wanted activities assistants back in each building and said, "It is very busy with people getting up at different times, PEG care, support with food, so when is activities taking place? Unless we have external activities, or the co-ordinator is here, we struggle."

● We recommend the provider reviews staffing rotas to ensure people access their assessed activities.

● We checked staff recruitment files and found that correct procedures for safe staff recruitment had been followed. There were up to date documents on file such as references and DBS (Disclosure and Barring Service) status confirmation. The DBS checks help employers make safer recruitment decisions and helps to prevent the employment of staff who may be unsuitable to work with people who use care services.

Preventing and controlling infection

● Beechcroft Care Centre was clean and free from any signs of infection. There were regular infection control audits carried out. One audit had an action plan that mentioned new light covers being required this was then swiftly actioned by the maintenance team. The audit monitored different areas of the service such has the kitchen and was thorough.

● The service was managing risks from infections and had the management team had a clear understanding of what action needed to be taken by whom to keep people safe from infection risks.

Requires Improvement

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. We found concerns with consent, risks around meeting people's health needs such as supporting with feeding tubes, and concerns with people's fluid intake. At this inspection this key question has now improved to Requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to live healthier lives, access healthcare services and support

● At the last inspection in July 2019 we found a breach of regulation 12 relating to meeting people's health needs regarding constipation and feeding tubes. At this inspection we found insufficient action had been taken and the breach had not been met.

● Some people living at Beechcroft Care Centre required nutrition, fluid and medicines to be given via feeding tube because they were not able to safely receive this by mouth. One person had a care plan for their feeding tube. It stated that the feeding tube site needed regular cleaning but did not specify when staff should clean. It did not state when the syringe should be changed or when the tube should be changed. Documents showed that the syringe used with the tube was not being changed every week as recorded on the syringe sheet. The plan also failed to state at what angle the person needed to be positioned when they received nutrition, fluid or medicines via feeding tube at night time to reduce the risk of aspiration (breathing fluids into the lungs).

● We spoke to a registered nurse who confirmed that the person was supposed to be elevated when they had their night time feed. We showed the nurse the two care plans for nutrition and feeding tube and they did not mention elevation. The nurse showed us a risk assessment which stated to elevate the person's head. However, this was not clear as it did not say how much to elevate or for how long after the feed to maintain the elevation and was not mentioned in care plans. This left the person at risk of receiving poor care around their feeding tubes. After the inspection the provider sent evidence that this had been addressed.

● Another person had a feeding tube and had experienced regular chest infections. Their care documents did not specify to elevate the persons head, which would reduce the chance of chest infections. Their feeding regime recorded a rate of feed that did not correspond with the dietician and nutrition care plans.

● We spoke with the deputy manager and asked them where the person received their feed, fluid and medicines and what their elevation requirements were. The deputy manager advised us this was being given only when the person was out of bed and in their wheelchair.

● However, we spoke with a registered nurse on the lodge and they told us the person received their medicines and water flush whilst in bed, and then received their feed later. This did not correspond with the person's daily notes and fluid charts. We asked the registered nurse if the person was elevated whilst receiving their fluids and medicines whilst in bed, and were told they were to 30-45 degrees. The registered nurse told us staff all knew to elevate the head of the bed, although this was not recorded anywhere in their

care plans, and staff would use their judgement and know what to do. The lack of consistent care and practice left the person at risk of not receiving the correct care and treatment they required around their nutrition.

● People with a learning difficulty can be prone to bowel problems such as constipation. Some people living at Beechcroft Care Centre were diagnosed with constipation and needed prescribed medicines to help with this condition. One person had PRN medicine to help relieve constipation. They were prescribed this medicine to be given after 24 hours without opening their bowels. However, there were several occasions when this medicine had not been given as directed. For example, there was a two-day period when this was not given and another time when the person had been on a visit away from the service to stay with relatives and had not received their medicine.

● Other risks concerning people's constipation were not being managed safely. One person had PRN medicine to relieve constipation. Their bowel function risk assessment did not mention the PRN medicine or when it should be given.

● Another person had a history of bowel obstruction, but their bowel chart did not record how many days they should go without opening their bowels before administering PRN medicine. The same person had a medical history care plan. The plan mentioned there was a constipation risk and a history of bowel obstruction, but did not mention two of the PRN medicines the person had. This left people at risk of not receiving the care and support they needed with their bowels.

● The lack of appropriate bowel management has been raised at inspections of a number of the provider's other services. Learning from these findings had not been effectively used to improve constipation care at Beechcroft Care centre.

● At the last inspection in July 2019 we found a breach of regulation 12 relating to effectively monitoring people's fluid intake. At this inspection we found insufficient action had been taken and the breach had not been met.

● Some people were at risk of dehydration and required their fluid intake to be monitored with the use of fluid charts. We checked these for one person and found that they had consistently failed to reach their agreed target. The person was assessed as needing 2226ml a day but was sometimes recorded as having only 900mls.

● The person's nutrition care plan did not state what action to take to detect and prevent the risk of dehydration. The same person had a dietetics review which stated to offer a range of fluids, but this was not evidenced from the fluid charts which frequently had only squash or juice being offered. Their 'eating and drinking' risk assessment failed to identify actions to mitigate the risk of dehydration and just stated to consult a GP or dietician if there were any untoward changes.

● We spoke to a care worker and asked what happens if someone does not drink enough and were told, "Sometimes we offer regularly and write it down to try again and record refused. If someone doesn't drink for three days we let the nurse know and try to offer different kind of drink." However, we checked the person's care records and could not see that this had happened. This left the person at risk of dehydration.

● The failure to effectively monitor people's health needs and fluid intake is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other people were having enough to eat and drink. People and their relatives told us that they liked their food. One relative told us about a condition their loved one had that caused problems with weight loss which had been overcome by staff. The relative told us, "[Name]'s now got their own food cupboard with the things they like, if they don't like what's on the menu; they are keeping his weight up."

Ensuring consent to care and treatment in line with law and guidance

At the last inspection in July 2019 we found a breach of regulation 11 relating to consent and the failure to assess people under the MCA. At this inspection we found sufficient action had been taken to meet the

breach, but we also found some other issues remained and have made a recommendation.
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.
● We found some inconsistencies around MCA assessments and DoLS applications. One person had a 'capacity/decisions' care plan that stated they could make their own decisions. We spoke to a relative of the person who also confirmed they had capacity to decide and informed us that nurses had visited and assessed the person as having capacity. However, this person had an application to deprive them of their liberty. This application should only be made if the person lacked capacity around receiving care or living at Beechcroft Care Centre. We discussed this with the registered manager, and it was not clear that an MCA assessment had been completed prior to the DoLS application being made.
● One staff member we spoke with did not display a sound knowledge of MCA or DoLS and told us that they had not been trained recently on MCA.
● We saw that work had been completed on ensuring compliance around MCA and DoLS for other people. Where people had been assessed as lacking capacity there had been best interest meetings held with relatives where appropriate.
We recommend that the registered manager continues to review people's consent and capacity in line with the Mental Capacity Act Code of Practice to ensure their practice continues to protect people's rights.

Supporting people to eat and drink enough to maintain a balanced diet

Staff support: induction, training, skills and experience
● At the last inspection in July 2019 we found a breach of regulation 18 relating to staff supervision, a lack of clinical competencies for nurses and training for behaviour support. At this inspection we found improvements had been made and this part of the breach was met.
● We checked the staff files for registered nurses and found that nurses were now receiving competency checks for clinical tasks. There were a range of clinical competencies recorded and more booked for imminent dates.
● Staff told us they were receiving supervisions and we saw this was happening. One care worker said, "We have supervisions regularly; I had one a month ago. Mostly it is with the nurse." After our inspection the provider showed us training that had been completed in a scheme called 'Stop Look Care'. This training by the National Institute for Health and Care Excellence [NICE] aimed to highlight and raise awareness of the importance of fundamental care for care workers, by explaining the importance of different observations, what changes to look for in a person and when to take action or refer to another person.
● Staff had been trained and had their competency checked. We reviewed the training matrix and key courses such as safeguarding adults and infection control were up to date. We also saw that behaviour training had been completed by key staff such as nurses and key workers, and had been booked for other staff.
● We received some positive feedback during the inspection from visiting health professionals. One professional told us, "Staff are very switched on; they are expecting us and they know the patents really well. [Staff] are very good at communicating things like a person not having a great day or if persons not feeling good."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Beechcroft Care Centre used nationally recognised guidance, based on clinical evidence, to track people's health outcomes. Tools such as Waterlow charts were used to ensure people's skin remained healthy where people were at risk of pressure areas.

● People with learning disabilities had a DISDAT tool that was kept up to date. A DISDAT tool helps staff to understand when a person with disabilities is upset or in pain.

● There were preadmission assessments for people who moved in to the service. They covered a range of support needs including areas such as health needs, mobility and eating and drinking.

Some people's needs had not been assessed effectively particularly around behaviours. We have reported on these concerns in the Safe section of this report. Other needs around people's activities had been assessed but these assessments had not been put in to practice. We have reported on these concerns in the Responsive section of this report.

Staff working with other agencies to provide consistent, effective, timely care

● One person was planning to move to another service. The registered manager explained how the transition was being managed. The other care service had sent staff to work with the person in Beechcroft Care Centre and this had been supported by staff who knew the person well. The registered manager had shared the person's care plan, support plan and PBSP.

● Photographs and social stories had been used to facilitate a smooth transition. The registered manager told us, "Once [name] has moved we will still be available to help and send [staff] if needed." The registered manager had liaised with the person's family who were happy with the process.

Adapting service, design, decoration to meet people's needs

● The building was designed to meet people's needs. Corridors and doorways were built to be wide and could accommodate moving and handling equipment and larger sized wheelchairs.

● Rooms had 'en suite' bathrooms that were large enough for people to have a shower using specialist equipment. There were hoists and specialist equipment available to people.

● There were accessible garden areas for people to enjoy that met their needs.

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. We found issues with staff respecting people's dignity. At this inspection we found some improvements had been made, but there were other improvements that also needed to be made and 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; respecting and promoting people's privacy, dignity and independence

- At the last inspection in July 2019 we found a breach of regulation 10 relating to protecting people's dignity. We found concerns with staff response to people's distress and the use of inappropriate language. At this inspection we found insufficient action had been taken and the breach had not been met.
- During our inspection we observed some very caring and kind interactions. We saw there had been an improvement in language used when supporting people. However, this was not consistent. We also saw some support that was not compassionate or empathetic during two different lunch services.
- During lunch on the first day of the inspection we observed three people in one of the lodges. Two people were being supported to eat by a permanent care worker and an agency care worker, as the third person looked on. There was no attempt by staff to encourage people to eat independently or use a 'hand over hand' technique to involve people in eating their lunch, as directed in their care plans.
- There was a very poor level of direct interaction with all three people, and the staff members spent the whole lunch service talking directly to each other about their own hobbies and interests. The lunch service was not a positive experience for the people on this lodge.
- We observed another person who was receiving nutrition and fluid via a feeding tube on the second day. The person was sat with other people at the dining table as they ate. However, they became distressed, made vocalisations and started to hit themselves.
- The person had a communication plan that mentioned hitting themselves in a specific way they expressed distress, and this was observed during lunch. Staff acknowledged the person, but they were busy supporting other people who required assistance with eating. The person was primarily left with staff speaking to them about the music being played, but no staff went over to offer comfort, or to engage the person with a different activity. This was not a positive experience for the person. We raised this with the registered manager to address.
- We observed some support that was positive and encouraged people's independence, but we also saw other instances where there were missed opportunities to promote people's independence. For example, at one lunch service we reviewed two people who were being supported to eat and who were assessed as being able to eat themselves with 'hand over hand' assistance from care staff. However, we did not see this type of support attempted. Staff gave people their food directly, without encouraging them to be as independent as possible with their meal.
- We also saw one staff member supporting a person to drink during a morning activity. The staff member

was rushing the person to have their drink and putting the person's protective apron on without asking first. The staff member was not being patient or allowing the person to take ownership of the process. This did not promote the person's independence or choice.
● The failure to protect people's dignity was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other staff supported people in a kind and caring way. We observed staff using respectful language when speaking with people and people responding warmly to their staff.
● Staff were supporting people to be independent and to achieve goals. One staff member told us, "I try to support them, so I know what they're allowed to do alone and teach them to do more including eating and drinking. If they're able to do it I won't do it for them."
● Staff understood the importance of respecting people's privacy, especially during personal care. We saw people were discreetly supported to private areas such as bedrooms for any personal care. One staff member told us, "They can [have privacy] in their room or in the lounge when alone. Personal care is always two staff and we close the door and curtain, and nobody is in the room, only us."

Supporting people to express their views and be involved in making decisions about their care
● There was work underway to increase people's involvement in decisions around their care. Care plans we reviewed had been completed by nurses, and there was limited evidence of how people were involved in their care plans or decisions around their care. We have reported further on people not being supported to make choices and communicate effectively in the Responsive domain of this report.
● We raised this with the registered manager who told us they had reviewed one care plan with the person and could see the reaction they gave, as well as body language, to show whether they were happy. The registered manager told us, "Carers know what the person likes and doesn't like, and this process will also help with activities as well. We are starting to use the [pictorial] format." We saw a personalised activity planner for one person in the new pictorial format.
● One person was being supported with a significant decision and had been referred to an advocate. An advocate is a person who supports a vulnerable adult to make decisions about their life. The registered manager had liaised with the person's social worker and the process of advocacy was explained to the person to help them make a decision.

Requires Improvement

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. We found issues with personalised activities, communication and complying with accessible information guidelines. At this inspection this key question has now remained the same. This meant people's needs were not always met.

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

● At the last inspection in July 2019 we found a breach of regulation 9 relating to providing person centred care. We found activities, care plans and communication methods were not personalised. At this inspection we found insufficient action had been taken and the breach had not been met.
● One person had a behaviour plan that outlined the importance of activities outside of the service and they had not been supported to leave the service. We checked their activities care plan and there was a lack of detail about how to support the person with external activities. The person's activity records had not been completed consistently, with several days missing. The days we reviewed did not state the person had been out and did not correspond with their activity planner. A staff member we spoke with, who worked regularly with the person, told us this was due to a lack of time.
● Another staff member told us that activities paperwork had not been completed. They told us, "Staffing levels don't allow it. Sometimes there's only myself and a female carer on shift. I am taken away to go and support someone else; I don't have the time." The lack of accurate activities records meant that people's activities were not being monitored effectively, and where people were not receiving their assessed activities action was not taken to put it right. The registered manager told us, "We will look at how we can support staff and the activities co-ordinator to make sure this is operating more effectively. We rely on staff to give us the information [about activities]; this doesn't always happen."
● Relatives had told us about concerns they had around activities provision. One relative told us, "I think they could do with another care staff especially as their role has expanded to include activities." Another relative commented, "Honest opinion is staff are quite stretched. All staff we speak with are really good, but they could do with more carers. They don't have activity staff in each Lodge. Now they have people coming in. Activities staff left and weren't replaced."
● We spoke with staff about another person and were told they liked holding and touching different sensory items. This was not reflected in their social care plan. The activity coordinator advised us that the person loved water, and also enjoyed running their hands through sand. These activities were also not referenced on their social care plan or activity timetable and were not happening.
● Staff had raised concerns with the management team during a meeting in October 2019 that they were finding it hard to support people with their activities, as per their new responsibilities. There was no change in activities provision following staff raising these concerns.
● We spoke with the registered manager about activities and were told that care staff would be responsible for 'in house' activities and this had already started. The registered manager described a new process for planning and providing activities, but this was still to be embedded in practice. This meant people were not

receiving activities in a planned and structured way that reflected their individual needs and interests.
● In addition to concerns with in-house activities, we found that people were not accessing off site activities as frequently as care plans indicated. For example, staff confirmed for one person that they loved going out and this was reflected in their social care plan. However, care plans showed that in the past year they had only gone out five times. Another person had activities they enjoyed listed as going to a fast food restaurant, bowling, cinema, and shopping. From 23 September to 16 November 2019 there was no evidence that any of these trips had happened.
● People's care plans were not consistently person centred. For example, one person had a mental wellbeing care plan that did not detail personalised information about how to support the person. Staff were directed to 'act appropriately' in order to meet the person's need but this was not explained. The person required meaningful activities to reduce anxiety, but this was not explained in the care plan to indicate what was meaningful to that person.
● Some of the support we saw was not person centred. For example, one person was being supported with a meal. This person needed to have a drink before they could eat. The person was not engaging with the staff supporting them to drink, and their food was going cold. Staff had not arranged for the person's meal to be brought out later after their drink, so it sat for a long time getting cold. Another person was being supported to eat at the same time. They were making noises and staff asked them to be quiet and discussed taking the person out. Staff did not engage directly with the person.

Meeting people's communication needs, and end of life care and support.
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.
● Some people who lived at Beechcroft Care Centre had communication difficulties. We reviewed one person's communication plan which failed to mention information about their sight or visual impairment. Furthermore, there was no mention of the pictorial menu or other pictorial communication aids as outlined in their hospital passport. The communication plan did outline the person was able to choose between two objects. However, the person was not observed to be supported to make choices using this method during observations on the first two days of our inspection.
● Another person was registered blind and this was not referenced in their communication plan. The plan did direct staff how to approach the person and described what they person may look like if they were distressed or were in pain. However, there was a communication summary from a specialist hospital which referred to staff using intensive communication strategies such as repeating some of the person's sounds. This was not reflected in their communication care plan. This left people at Beechcroft Care Centre at risk of not receiving the correct care and support with communication.
● Work was underway to implement 'end of life' care plans for people's final days, but further work was needed to complete these. One person's planning future care booklet had been completed by their family, but the information had not been supplemented by the provider. For example, a spirituality care plan identified the person's religion, but the future care plan only had 'yes' recorded under spiritual care. As a result, it lacked personalised detailed information about how the person would need to be cared for to meet their religious needs.
● The failure to provide person centred care was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw some positive support around activities. During one craft session staff were seen giving choices of colours and shapes to people to promote some independence in making decisions. The co-ordinator was enthusiastic and was telling people what was going to be happening next was able to get everyone's

attention. They also said, "Shall we learn a Christmas Makaton song?" and was seen teaching staff some Makaton as well. This was a positive experience for people.

Improving care quality in response to complaints or concerns

- There was an accessible complaints policy in each lodge that was prominently displayed.

The complaints policy was reviewed in 2018 and reflected current best practice. It set out different stages of the complaint and people's roles in dealing with complaints. We reviewed one complaint which had been handled as per the provider's policy.

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. We found concerns relating to leadership and putting right shortfalls in the service and with some staff culture. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care

● At the last inspection in July 2019 we found a breach of regulation 17 relating to risk management, oversight of the provider, staff culture, a lack of effective quality audits and leadership. At this inspection we found insufficient action had been taken and the breach had not been met.

● Audits had not been effective in identifying and putting right shortfalls found at this inspection. We found issues relating to risks around choking, safe management of people's behaviours, epilepsy, use of NEWS charts to monitor people's health and fluid charts. These are issues we have also identified at other locations run by the provider.

● There was a service improvement plan used by the provider to ensure that improvements were monitored and actioned. However, areas that we found were not safe or effective, such as fluid charts and care plans for behaviours were marked as completed meaning action had been taken to put them right. This meant that oversight of the service was not effective.

● Other audits had highlighted concerns such as risk assessments not being effective, or having too many risk assessments for people [to be effective]. However, sufficient action had yet to be taken to put this right.

● From December 2018 we have imposed conditions on the provider's registration, due to repeated and significant concerns about the quality and safety of care at several services they operate. The conditions are therefore imposed at each service operated by the provider, including Beechcroft Care Centre. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. However, the information sent was not always in line with what we saw during this inspection. For example, we were told that the provider was offering training to agency staff to maximise their knowledge, competencies and skill set, yet we found that agency staff competencies were not evidenced.

● This is the third consecutive inspection where the well led domain has not been rated as good. The well led domain was rated as inadequate at the last inspection as there were five continuing breaches and an additional two more breaches of regulation identified. At this inspection we found six of these breaches relating to personalised care, dignity, safe care, safeguarding, good governance and staffing were still not met.

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

● Despite seeing improvements in some areas, such as around consent and improving the language staff used when speaking with people, there were continued concerns that had been raised at previous

inspections.
● There was a registered manager in post. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.
● At our last two inspections the registered manager and provider had told us that action had been taken to put things right. However, we found this had not happened. At this inspection not enough action had been taken to put things right. The registered manager and the registered provider had a duty as part of their registration with CQC to ensure the service was compliant with Health and Social Care Act (Regulated Activities) Regulations 2014.
● We spoke with the registered manager about whether they had the resources they needed to develop staff teams. The registered manager told us, "We need some more staff especially activities minded staff. We have three care staff and one house keeper vacancy. We have a few staff on maternity and we cover carers with agency."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● At our last inspection we identified some concerns with the way in which staff spoke with people, and the use of childlike language staff used when supporting people. At this inspection we found improvements had been made and staff spoke with, and about people, in a respectful way. However, the overall culture in the service was not positive. The service was not safe, people were not supported in a personalised way, outcomes for people were not good and health needs were not being managed effectively.
● The registered manager did regular walk arounds of the service where staff, including night staff, were given the opportunity to speak about any concerns or help they needed with paperwork. Relatives were able to speak to the registered manager or deputy manager when they needed to. One relative told us, "When we found [name] was making themselves unwell I rocked up on Monday morning and asked to speak with the management and in 10 minutes we were all sat in room discussing it." However, we have reported in the safe domain about how safeguarding issues, and self-injurious behaviours were not identified or reported by staff, including the registered manager. This meant that people in a very vulnerable situation were not able to rely on the leadership team to keep them safe and the culture in the service had not promoted positive outcomes for these people.
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
● The registered manager reported that staff were more open, and they understood that they would not get into trouble for reporting issues. The registered manager told us, "[Staff] fill out forms and report things through and since the last inspection they are more confident and transparent in reporting. Previously there was a culture where they reported to nurses and that was it, but here we are saying you saw it you report it." However, we found that there were times when people did not receive safe or effective care, and this was not recognised by staff or reported correctly.
● We reviewed one choking incident and it had been reported to the family openly and swiftly under the duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff were actively involved in developing the service. Some staff had painted pictures on a wall in the sensory room in one of the lodges. Staff had asked to do make improvements to the activity rooms and sensory room; staff told the management team the sensory room needed new equipment, so the registered manager sent the request to head office. However, when staff raised concerns around their ability to support with peoples' activities and the impact this was having on people, there was not a swift and inclusive

response from the provider.

● There was a lack of engagement with people. People had not been fully consulted around their leisure time and activity preferences. People's protected characteristics, specifically their disabilities as recognised under the Equality Act 2010, were not fully taken in to account or consistently assessed to enable open and accessible communication.

Working in partnership with others

● The management team were working very closely with the local authority safeguarding team to implement learning from past incidents with the view to ensure people experienced safe care. The local authority community learning disability team had been involved with reviewing people's care and some people were on a waiting list for communication support. However, the provider has been unable to ensure people's safety and staff were not consistently recognising when people were being exposed to the risk of harm.

● A range of professionals were supporting the service such as dietician, chiropodist, GP and pharmacy and specialist nurses. There was an occupational therapist from the local authority who had been supporting people with specialist moving and handling tasks. However, the guidance from these professionals had not been consistently implemented and followed by staff. The failure to follow and implement guidance from professionals left people at risk of harm and of not meeting their health needs around conditions such as constipation, dysphagia (choking), epilepsy, and choking.

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

● The registered manager said they had support from the provider to manage the service. There had been changes to the senior management team and these had been beneficial to the registered manager. The chief executive had visited the service and the chief operating officer had visited and had been responsive to the registered manager's questions via email. The registered manager told us, "We are planning to do family meetings once a month in an evening; it will also be senior managers. Every Monday there is a skype call to discuss the [service improvement plan] and talk through if something needs doing and discuss what has been done and what needs to happen."

● The registered manager was aware of challenges facing Beechcroft Care Centre and had identified changing the mindset of some staff as the main challenge. We spoke about how some staff had worked in a particular way for many years, and were now aware of the need to change. The registered manager said, "If I talk to staff in supervision or in meeting you are trying to coax them forward to give information. Because they have worked for so long it's getting them out of that mindset." We spoke to staff who also agreed the service was changing. One staff told us, "We are trying to show that we can look after people. We are trying to promote more trips out; [people] can't always see the effort we are trying to make."

● Information was shared with other professionals via a secure email and it had been encrypted via a specialist programme. Peoples personal data was protected by the provider when sending information.