SHC Clemsfold Group Limited

Beechcroft Care Centre

Inspection report

West Hoathly Road
East Grinstead
West Sussex
RH19 4ND

Tel: 01342300499
Website: www.sussexhealthcare.co.uk

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**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 a local pub, shopping and residential area and East Grinstead. The service comprises of three 'lodges', one lodge is known as the main building or referred to as Beechcroft. This is where the registered manager and deputy manager's office is based. The other two lodges are Chestnut and Hazel. Together they make up Beechcroft Care Centre. Each lodge has a separate living room, dining room and kitchenette. Rooms were of single occupancy and had en-suite facilities. The service offers the use of specialist baths, a spa pool and physiotherapy. At the time of our inspection there were 23 people living at the service. Some people stayed at the service for short breaks. We reviewed the care of these people as well.

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.

At the previous inspection in January 2018 we found five breaches of regulations in relation to the safe management of risks, treating people with dignity, person centred care, consent and governance. At this inspection we found these breaches continued. We also found two new breaches of regulations relating to safeguarding and staffing.

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 always seen consistently in practice at the service. For example, some people were not treated with dignity and other people were not being supported to be as independent as they could be with activities or communication.

People's experience of using this service:
A number of aspects of the service remained unsafe.
Some people were at risk as some aspects of care or treatment were not being managed safely. Some people with behaviours that may challenge others did not have positive behaviour support plans to help them and their staff manage their anxieties.
People were not consistently protected from abuse as systems and staff did not always recognise when an incident was reportable, such as with an unsafe moving and handling procedure.
Nursing staff had not been consistently supported. There were no clinical supervisions for nurses and competency checks were not complete.

Learning from incidents had not been consistently implemented. Most of the areas of concern we found during this inspection, such as risks associated with health needs not being reduced had already been highlighted to the provider following inspections of some of their other services.
Staff did not have the necessary training they required to carry out their role, such as positive behaviour training.
People's health needs were not being met effectively. People were at risk of not having their needs met in areas such as constipation, epilepsy and monitoring of people's health when there was risk of deterioration.
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; the policies and systems in the service did not support this practice.
Some people were at risk from not drinking enough and fluid charts were incomplete, contained the wrong information or were audited poorly.
People were not consistently treated with dignity and the language some staff used was not person centred.
People did not always receive personalised care. Some people's communication needs were not met in a personalised way.
Leadership at the service was not effective. The previous inspection rated the well led domain as 'Requires Improvement'. At this inspection the rating has reduced to Inadequate. The breaches from the last inspection all remain with two new breaches of regulation.
Quality audits had not been effective in highlighting and putting right all the shortfalls we found at this inspection.
We observed some people receiving caring and kind support.

More information is in the detailed findings below.

Rating at last inspection:
At our last inspection in January 2018, the service was rated "requires improvement" overall with a requires improvement rating in all domains. Our last report was published on 12 June 2018. This is the first time this service has been rated Inadequate.

Why we inspected:
We inspected this service due to our analysis of information of concern from a variety of sources.
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.

Follow up:
The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any

key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

• 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. We will have contact with the provider and registered manager following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our Safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our Effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our Caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our Responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Beechcroft Care Centre

Detailed findings

Background to this 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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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.

Inspection team:
On 16 April 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. Our expert-by-experience had knowledge about care of adults with learning disabilities and autism. On 17 April 2019 the inspection was carried out by three inspectors and a nurse with a specialism in learning disabilities. On 18 April 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 single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection:
This inspection was unannounced.

What we did:
We reviewed information we had received about the home since the last inspection in January 2018. This included details about incidents the provider had notified us about, such as deaths. We used all this information to plan our inspection. We spoke with the local safeguarding adults' team and local health teams. We had not requested a provider information return (PIR). PIR is information we require providers to send us at least annually to give some key information about the home, what the home does well and

improvements they plan to make.

During the inspection we looked at a range of records including: 9 people's care records; records of accidents, incidents and complaints; audits and quality assurance reports; rotas and dependency tools; four staff recruitment files, and supervision and induction paperwork. We spoke with five people using the service; and three relatives. We also spoke with seven members of staff including registered nurses, care staff and members of the management team.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

When we last inspected the service in January 2018 we found one breach of regulation in relation to managing risks to people. At this inspection we found improvements had not been made and the breach remained. We also found new breaches of regulation relating to staffing and safeguarding.

Systems and processes to safeguard people from the risk of abuse

- People were not consistently protected from abuse. Staff practice did not always keep people safe from the risk of abuse. Staff were not consistently aware of what constituted abuse or neglect.
- During the inspection we observed one person being supported to move from the floor. We observed the person being supported to move from the floor with a 'drag lift'. A drag lift is an unsafe moving and handling procedure where people are given support to move by lifting under their armpits. We saw two staff were supporting the person to move, one from the front holding the person's hands and one from behind with their hands under the person's armpits. This technique is unsafe and puts people at risk of injury.
- We checked the person's care plan and found that staff should support the person to move from the floor with a hoist and sling. The person's moving and handling plan did not state how they should be safely moved.
- We spoke with one of the staff who completed the drag lift. We confirmed with them that one staff had their wrist area under the person's armpits. The staff told us, "I suppose it should have been further down [the body]." We described the procedure we witnessed to the nurse on duty and asked the nurse how the person should be moved from the floor. The nurse told us that the procedure we described was correct. When we asked about the sling we were told that the person did not use a sling.
- We made the nurse and the staff aware that the procedure was unsafe and should not be attempted. We raised this with the registered manager. We also raised this as a safeguarding concern with the local adult safeguarding team, as staff supporting the person did not recognise that there was an unsafe process being used.
- We also found significant concerns in regard to how often some people were having their incontinence pads changed. Staff had noted this to be an issue but had not reported this to management or reported to the local safeguarding team.
- Staff told us about one person who on some days typically had a pad changed at 7am and then did not have a fresh pad until 2pm or 3pm. The staff told us, "When we go to change [name], she is in desperate need of a change."
- We looked at the person's daily notes and personal care records. These showed that the person was being left in their incontinence pad for longer than was reasonable to maintain effective and dignified personal care. We raised this concern with the provider. We also raised a safeguarding alert with the local safeguarding team. The provider offered no explanation as to why this was happening. We checked with the manufacturer of the pads and were told that they recommended changing the pads every four to five hours. However, there were instances where this person was being left for up to eight hours in the same pad; which

was neglectful of their needs.
● We also found other people in the same lodge had been left regularly for long periods in incontinence pads without being supported to change into clean pads. We raised this with the registered manager and requested that action was taken. The registered provider informed us after the inspection that a new four hourly continence chart and a daily audit form had been put in place.
● The failure to implement systems that effectively prevent abuse is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Assessing risk, safety monitoring and management
● People were not consistently protected from the risk of harm. One person had epilepsy and regularly experienced prolonged seizures. They were a wheelchair user and had been prescribed a rescue medicine that required them being taken out of their wheelchair before it could be given. The person had other health diagnoses that could cause serious injuries to them if they were moved unsafely, especially during a seizure.

● We spoke to the senior nurse about the correct procedure to administer the rescue medicine, given the person was likely to be seated in a wheelchair for significant periods of the day. The senior nurse confirmed to us that the person was transferred from their chair to be given the rescue medicine. When we asked how this was done the senior nurse told us that it was done manually or with a hoist. As it could be unsafe to transfer the person during seizure activity, we asked to see the care plan or assessment for the safe transfer of the person during a seizure. However, the senior nurse confirmed there was not one.
● When we raised these concerns, the senior nurse, registered manager and deputy manager wrote a risk assessment for this procedure. However, the risk assessment did not explain how to safely move the person, or how to reduce other risks. The risk assessment only mentioned that there was a risk of injury to limbs whilst hoisting the person, and risk to health from missing the rescue medicines. However, national guidance does not support manual handling or the use of hoisting during an active seizure.
● We raised further concerns about the management of this person's epilepsy and were told that the provider was seeking advice from a specialist nurse about a possible change to the rescue medicine that could be given whilst the person was seated in their wheelchair.
● Some people were diagnosed with epilepsy and required support to manage their condition and any seizures they experienced. One person had regular seizures which were described to us by staff as frequently occurring when the person was in bed. The person did not have a sensor mattress that could detect seizure activity when in bed, but they did have a video device.
● However, based on the person's seizure history it was not clear how the alert system being used was sufficient to detect the person's seizures. The monitoring device did not send out an alarm to alert staff to any seizure activity and relied instead on staff observing the video at the right time. This left the person at risk of not having the correct care and treatment during an epileptic seizure.
● Another person had epilepsy recorded as a diagnosis in their initial assessment before they received a service from Beechcroft care centre. However, the person's medical care plan from July 2017 and reviewed monthly until March 2019 listed the persons diagnoses, but epilepsy had been crossed out in pen. The person did not have an epilepsy care plan, yet their epilepsy was referred to in other care documents. A letter from a consultant neurologist from June 2018 described the person's epilepsy as mild, infrequent and difficult to assess over time. However, it also referred to a low risk from sudden and unexpected death during or after an epileptic seizure. There was also no risk assessment in place for epilepsy despite the risk.
● Another person with epilepsy had a protocol for rescue medicine for their epilepsy. However, this lacked detail around the person's seizure type. The document indicated the person can have a second dose of rescue medicine but failed to indicate the maximum dose allowed in 24 hours or describe any side effects. The protocol stated the person cannot be given another dose within two hours after first dose. This conflicted with a letter from a consultant neurologist dated from April 2018. Following this letter, a protocol

was written in June 2018 but made no reference to the letter. This left the person at risk of not receiving the care and treatment they required around the management of their epilepsy.

● We found other risks around moving and handling people that were not being managed safely. One person liked to have baths and use the hydrotherapy pool. We asked staff for a risk assessment for hoisting the person into a bath. Staff could not find specific guidance about how hoisting should be completed. There was only guidance referring to hoisting for the hydrotherapy pool. Staff told us this guidance should be in place. Risks to the person when hoisting them in to the bath could be different from the risks when hoisting to the hydrotherapy pool, but this had not been assessed or the potential risk reduced.

● Some people living at Beechcroft had behaviours that may challenge others. We found that risks around the management of these behaviours were not managed safely.

● One person's care plan contained conflicting information about how to support them with their behaviour, and important information was not included on other documentation. One document had been written in August 2011 but had not been reviewed since. Another document dated February 2019 did not contain any information to describe how staff could recognise if the person was becoming distressed and how they may present this distress. The document directed staff to observe the person for unusual behaviour and to fill in a behaviour chart. However, there was no description as to what unusual behaviour may be.

● Staff described some of the actions the person would display to show distress, but this was not clear in their care plans. This left the person at risk of new staff not understanding their behaviour or of changes in their behaviour not being monitored effectively.

● The deputy manager gave us an updated positive behaviour support plan (PBSP) which contained more detailed information. However, staff had been unaware of this support plan and the deputy manager confirmed the plan was on their computer, so staff would not have access to it.

● We found other people with behaviours that may challenge others who lacked a PBSP or any proactive strategies to understand the function of the behaviour or guide staff to manage the risks.

● Similar concerns have already been highlighted to the provider about the management of behaviour that may challenge at some of their other services. Learning from these findings had not been appropriately used to improve support people with behaviours that may challenge at Beechcroft Care centre.

● We noticed that one person was wearing a protective helmet and asked staff about this. We were told that the person could bang and knock their head against the wall or floor and that the staff observed this happening about once a week. However, there was no care plan for this or any PBSP.

● The person's care plan had no detailed step by step guidance to inform staff on how to manage these behaviours. There were no records, or behaviour charts of when these incidents or behaviours occurred. The risk was not being managed safely as the reason for the person's behaviour was not explored and there were no plans to reduce the possibility of harm from any head injury, or to monitor the person safely following a head injury.

● Other risks around people's behaviours were not being managed safely. One person had been prescribed an 'as required' sedative medicine to help them manage their anxieties and behaviours. The person had used a large amount of this medicine over a two-month period and then had stopped taking it when they were provided with more staffing hours.

● Records for the administration of the rescue medicine were inconsistent with the person's daily records and behaviour records. In addition, there were no specific guidance documents about how staff should give the medicine to ensure it was used consistently. There had been numerous times when the medicine had been administered with no clear explanation of why the person needed it.

● We looked at 39 instances of the sedative medicine being given between 14 January to 23 March 2019. We found there were concerns and inconsistencies in 21 of these 39 instances. Some of the issues were that the person's daily notes did not record that they were agitated during times that behaviour and medicines charts stated they were given the sedative medicine. Other concerns were that the medicines chart had no

reason for the administration of the sedative medicine. On another occasion a second 'dose' was recorded on their medicines chart, but it was unclear what had been given to the person.
● The person had received a significant number of doses of the sedative medicine between 28 Jan 2019 and 19 February 2019. However, there was no care plan or guidance about side effects from taking the medicine frequently, or from stopping it abruptly. There was no recorded information to state that the frequent use of this sedative medicine had been reviewed by a doctor, or any advice sought when this sedative medicine was stopped suddenly. The nurse on duty we spoke with was unaware this should have happened.
● 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 for some people. One person who had regular epileptic seizures had a seizure plan, that stated a NEWS must be completed after each seizure. Seizure records showed the person had regular seizures, but the NEWS chart showed most seizures were not followed up with NEWS observation. This meant that if the person's health deteriorated after a seizure, they were at risk of this deterioration not being noticed quickly by the nursing staff, and at risk of the appropriate level of medical support being sought.
● 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 were being managed safely. There were up to date fire safety procedures and people had individualised emergency evacuation plans.
● Risks around the environment were managed well and there was a maintenance worker who worked with the registered manager to ensure that water, gas and electricity were all safe.
● Risks around choking had been highlighted to the provider at some of their other locations. We found that people's dysphagia and choking risks were being managed safely at Beechcroft.

Staffing and recruitment
● Staff were not effectively deployed to meet people's needs. Due to a reduction in numbers of people living at Beechcroft Care Centre the number of nurses working each day was reduced from three to two with one based on Beechcroft Lodge and another working between the two other lodges. Staff told us that there were times when staffing levels were low on one of the lodges. One staff confirmed to us that there were times when people were not able to have personal care as they required two staff to support them to move and there were not sufficient staff members working on Hazel Lodge.
● We observed some interactions using 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 saw that some people had minimal interactions during activities.
● Another staff told us that Hazel lodge was understaffed at certain times. The staff member said, "Sometimes there's not enough staff: when they have activities or going to [activity] and only two staff remain here and it's full house. We have only two nurses for three homes and you have to make sure everyone is safe."
● We informed the registered manager that staff felt there were times when there were not enough staff working on Hazel and that this had impacted on people's care, such as with people waiting for long times to have their continence pads changed. The registered manager and deputy manager had not been made aware of this problem by staff.
● We checked the personal care records for one person who had been identified as being at risk of not

having their personal care needs met when there were only two staff on duty in Hazel Lodge. Between 2 February 2019 and 16 April 2019 there were 47 days where the person was supported with personal care early in the morning and then not again until after lunch (approximately 2pm). As the person was up and supported in the morning between 6am and 7am they were mostly going until 2pm without personal care support, meaning an average of seven hours in the same incontinence pad.
Wearing incontinence pads for longer than the recommended time exposes people to risk of poor skin hygiene, bad odours, or skin conditions such as fungal infections, dermatitis or skin breakdown. Although nobody living at Beechcroft had these conditions, the deployment of staff placed people living at Hazel Lodge at risk of them.
● The failure to deploy enough staff with the appropriate support training and professional development to care for people safely is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had followed correct procedures for safe staff recruitment. There were up to date documents on file such as, application forms, interviews notes, 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.

Using medicines safely
● We found some areas of medicines management that was not safe. Some people stayed at Beechcroft for short breaks. We reviewed one person's care records and saw that the person's care plan for elimination noted the use of 'as required' laxative medicines to aid constipation. However, the nurse on duty was unaware of the use of 'as required' medicines for constipation.
● The person's medicines chart did not contain reference to any 'as required' medicines for constipation. The registered nurse confirmed there were no 'as required' constipation medicines prescribed and sent with the person from their parents' home. The nurse acknowledged that despite being reviewed monthly, the elimination guidance was not accurate and needed updating.
● There was a review document from September 2017 that listed medicines used at that time, including 'as required' constipation medicine. However, there were none of these medicines available to the person at the time of this inspection and the registered nurse could not give an explanation as to why.
● We observed some practices that were not safe. We saw the senior nurse administer medicine to a person via their feeding tube. The senor nurse failed to flush the feeding tube with water before administering the medicine. The senior nurse did flush the feeding tube afterwards, but this was not the advice given on the person's feeding regime. It stated to flush with water before the administration of medicines. This is to clear the feeding tube of any residual feeds and to prevent blockages. Failing to do this put the person at risk of a blocked feeding tube.
● The failure to ensure the proper and safe management of medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were trained in medicines administration and were competency checked.
● Each Lodge had a clinical room where medication was stored. We looked at two lodges. These rooms were neat and tidy, and temperature controlled with air conditioning that is recorded each day.
● Each person's medicines were kept separately. Extra stock held was stored in locked cupboards and the remainder in a medicines trolley. We checked a sample of people's medicines and those checked were named and in date.

● Learning lessons when things go wrong
● Lessons had not been learned effectively. Staff did not consistently raise concerns when they arose. For

example, in the issue of people's incontinence pads not being changed frequently enough, and when witnessing a 'drag lift'. The registered manager and deputy manager had not been made aware of these issues by staff.

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

● The management of health needs such as epilepsy and constipation were issues we had found at other locations run by the provider. We found the same issues at this inspection showing that lessons had not been shared and embedded in to practice.

Preventing and controlling infection

● Infection control audits had been completed for each of the lodges in March 2019. Some additional cleaning and housekeeping tasks had been identified in the audit such as dusting and cleaning the drug room floor in one lodge.

● The senior nurse and deputy manager had been identified as infection control champions, in line with national guidance.

● Staff had access to protective equipment such as gloves and aprons to use during personal care. During our inspection we saw that staff used these when supporting people, such as when carrying out care tasks.

● There was a daily cleaning schedule and a weekly cleaning schedule and a housekeeping team who worked every day, including weekends.

● The service was very clean and tidy and free from any unpleasant odours.

● Staff we spoke with were aware of how to keep people safe if there were infectious diseases or illnesses in the service.

Inadequate

Is the service effective?

Our findings

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

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

When we last inspected the service in January 2018 we found one breach of regulation in relation to consent. At this inspection we found improvements had not been made and the breach remained. We also found other sections of the same regulation were in breach and a new breach of regulation relating to managing people's health needs.

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

- The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 with appropriate legal authority. 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
- Some people had MCA assessments completed in line with the MCA code of conduct; however, where people were found to lack capacity around a specific decision there was only a best interest checklist. This did not demonstrate a best interest meeting, or the process that considered others views or that the least restrictive options, had been considered.
- Another person had an MCA assessment stating that they lacked capacity to make decisions around their personal care. There was a best interest checklist but no records from any best interest meetings. In addition, two staff we spoke with about the person told us that the person was very clear when making decisions; particularly around personal care. Staff told us they didn't know why there were capacity assessments in the person's care plan stating they lack capacity, as the person made lots of decisions around what they like and don't like. Staff told us the person would let staff know what they wanted.
- Another person had a recording device to monitor their epilepsy at night time, but there had not been any capacity assessments or best interest decisions made around the use of recording equipment in the persons bedroom.
- The failure to ensure service users consent to care and treatment had been sought in accordance with the Mental Capacity Act (MCA) 2005 is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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

- Monitoring of people's health needs was not effective or safe. Some people received their food and

medicines through feeding tubes. One person received some nutrients and their medicines through a feeding tube. We checked the persons care records and were unable to find a care plan for the safe management of the feeding tube. At the time of our inspection the person had a PEG (surgical opening in their abdomen) that required a daily dressing. The care of the PEG site was also lacking a care plan, body maps or information about the condition.

● We raised these concerns with the deputy manager who produced a care plan on the day. However, it lacked detail and only referred to a blocked feeding tube. There was no step by step guidance in the care plan to guide staff on how to safely support the person with their feed. The care plan also lacked infection control measures and failed to cover the current stoma site management. This left the person at risk of not receiving the correct care and treatment for their feeding regime and for the care of the stoma site.

● Other health needs were not being supported as fully as possible. People with a learning difficulty can be prone to bowel problems such as constipation. Beechcroft Care Centre had elimination care plans to help people manage bowel problems. One person was diagnosed with constipation and was prescribed different medicines to manage this condition. The persons' care documents were contradictory and did not contain complete information.

● Their PRN (as required) protocol stated one laxative was to be given after 48 hours of no bowel movements. However, their elimination care plan stated for the same PRN medicine to be given after three days without a bowel movement. There was a fax from a GP stating the PRN laxative should be given after three days without a bowel movement, but this was written before the PRN protocol, which stated it should be given after two days.

● We checked the person's medicines charts and saw they were prescribed a suppository for constipation, in addition to the laxative. We confirmed with the senior nurse that there was no mention of the suppository on the person's care plan or PRN protocol. This left the person at risk that they would not receive the correct medicine, at the correct time, to relieve their constipation. We asked for the information to be updated.

● Other care plans we reviewed also lacked consistent and clear guidance around the safe management of people's constipation. For example, another person had an elimination care plan and bowel charts. Both of these documents gave very limited guidance for staff on actions they should take, including how many days was safe for the person to go without a bowel movement. The elimination care plan directed staff to inform the GP and dietician of any changes in the person's elimination. This generalised guidance would leave the person at risk of not having their health needs met in relation to constipation.

● 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 appropriately used to improve constipation care at Beechcroft Care centre.

Staff support: induction, training, skills and experience

● Not all staff had sufficient supervision to carry out their roles. We spoke with one registered nurse who had been working at Beechcroft since August 2018. The nurse confirmed with us that they had not had any supervisions since starting their employment.

● We asked the registered nurse if they had any clinical supervisions at Beechcroft and were told they had not. The registered nurse informed us that they had been inducted to the service by a senior nurse. However, when we checked the records for the senior nurse we also found that they had not received any clinical supervision and had no formal supervision since November 2018.

● We raised this with the registered manager and asked if any nurses received clinical supervision. The registered manager told us, "Here what they [registered nurses] do is come and speak to me if they have a problem or need training and I access the training academy." We asked if nurses received clinical competency checks. he registered manager confirmed that some of the nurses had been competency checked for the airway clearance device and around people's feeding tubes. However, there were areas relevant to nurses clinical practice that had not been competency checked, such as around PEG care.

● Some people living at Beechcroft Care Centre had behaviours that may challenge others. Staff had not received adequate training to manage these situations. There was no course on positive behaviour support on the training planner. We spoke to the registered manager and were told that the registered manager would be attending a training course run by the local authority. There were also training courses run by the provider's autism lead. However, there was no record of staff attending this training.
● Other people living at the service communicated using Makaton. Makaton is a language programme that uses signs and symbols with speech, to help people with learning disabilities to communicate. Only four staff had completed the Makaton training course. During our inspection we found that some staff were unaware that people used Makaton to communicate and did not see Makaton being used.
● The failure to provide staff with the training and support they needed to be effective in their roles is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● Some people were at risk of not receiving sufficient fluids and had fluid monitoring charts in place, so nursing staff could check that they were drinking enough for good health.
● We found that fluid charts were not being completed correctly. For example, for the two weeks before our inspection, one person had two different volumes of fluid recorded on their fluid charts as their recommended daily allowance (RDA). Only once during this two-week period did the person receive enough fluid to match the lower of the two RDA's.
● For the other days of the two-week period we reviewed there were dates when the person was recorded as having significantly less than their RDA. We spoke to the senior nurse about the person's fluid intake but were told that the nursing staff did not audit this person's charts. We asked what action had been taken in regard to the person not having sufficient fluid and there had been no action taken. We asked the senior nurse what action should happen on days when the person only consumed two thirds of their RDS. The senior nurse told us that they would ask the dietician to review the person. We asked the senior nurse to show us what was done on these days and the senior nurse confirmed that staff had not contacted the dietician or GP about the persons fluid intake.
● For other people with fluid charts we were unable to establish what their RDA was. As such, nurses could not know if the person had drunk enough fluid to maintain good health. The RDA recorded on fluid charts for one person varied from 600ml to 1350mls. We could not find any guidance from the dietician for this person and asked another registered nurse, who confirmed the guidance was not in the person's care plan.
● A third person had a fluid balance chart in use. Some of these charts did not specify an RDA and on others they varied from 850mls to 2100mls per day. In addition, the chart had not been consistently totalled by staff. Fluid records were confusing, RDA's varied on fluid charts and registered nurses were not consistently recording the total amount which showed a lack of governance and auditing being carried out.
● For all people we reviewed, amounts of fluid consumed were routinely low and records showed this. When this was the case their daily notes did not record staff had acted to address this risk to dehydration and constipation.
The failure to effectively monitor people's fluid intake is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us that they liked the food at the service. One person told us, "I like the food I get to choose it here." One relative told us, "I'm here for mealtimes and it looks good and smells good." Another relative commented, "[name] lapped it up and he's a fussy eater. When they do the catering for events the food is amazing. [name] has put on weight here."

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.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The service was using nationally recognised, evidence-based guidance, to track people's health outcomes, such as Waterlow charts to ensure peoples' skin was healthy.
● People with learning disabilities had a DISDAT tool to help staff understand when they were 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. However, we found some examples where this information had not been transferred to care plans accurately.

Staff working with other agencies to provide consistent, effective, timely care
● Staff did not consistently work with other agencies to provide effective support. For example, one person had been referred to the community learning disability team regarding their agitation and distress. The learning disability nurse had written a list of recommendations. However, these were not reflected in the person's care plan. When we spoke to the nurse in charge of the person they were unable to tell us how these recommendations had been implemented or what the plan was to enact these.

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

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

When we last inspected the service in January 2018 we found one breach of regulation in relation to dignity. At this inspection we found improvements had not been made and the breach remained.

Ensuring people are well treated and supported; equality and diversity

- Although we saw some good and caring support, not everyone was treated well and supported with kindness. During an observation in Hazel Lodge activity room, we observed one person who had been sat away from the table and other people. The person was not engaging in activities. There were six people altogether in the room and one consistent member of staff who was writing notes at the table. There were two other members of staff who were coming in and out of the room.
- During this time, the person who was sitting away from the table was at first saying something quietly. However, the staff ignored them. The person then started to shout, "it hurts", and "I'm in pain." Staff continued to ignore the person and did not respond verbally or physically. Over the next few minutes the person said again several times, "I'm in pain", "it hurts" and "oww", and staff still continued to ignore them.
- We approached the person, gently introduced ourselves and asked if the person was in pain. The person replied, "yes". We then asked the person if they were able to point to where the pain was. The person then pointed to the part of their body and said, "here". We acknowledged this and thanked the person.
- We made the staff who was based in the room aware of what the person had told and shown us. The staff member said that the person had been in pain all afternoon, and they would inform the doctor who was visiting that afternoon. The staff also said, "We can't do anything" in relation to the person.
- It was not until after we spoke to the person and the staff about these concerns that staff then began to speak to the person and reassured them that they would see the Doctor in the afternoon.
- After a few minutes the staff offered the person to go for a walk, to which they said, "yes". When they returned, staff said, "Is that better?", "Is that better?", "Is that better?", before the person replied "Yes". The staff member was persistent in repeating the same question and did not give the person time or space to respond.
- Another member of staff asked the person, 'Would you like to lie down on your bed?' to which they said 'yes', and staff respected this and took them to their bedroom where we were informed that the Doctor saw them. However, staff had shown no acknowledgement, response, or offered any reassurance to the persons distress, and vocalisations of pain, until after we intervened. We shared these concerns with the registered manager and the provider.

Respecting and promoting people's privacy, dignity and independence

- People were not always supported in a way that maintained their dignity. During our inspection we heard several instances of staff using child-like language with people. For example, one staff member was trying to get a person to drink, and said, "Be a good boy, go on drink." The person was an adult, and this was not

dignified for them.
● During the course of the inspection we frequently heard people being referred to as 'good boy' or 'good girl by staff'. Other staff did not challenge this approach when they observed it.
● We asked the registered manager if they challenged staff's language or practice. The registered manager confirmed they had not had the need to do so for some years.
● We observed an activity session in Chestnut Lodge. There were two staff sitting with people around a small table. The two staff were talking to each other, but not with the people who were present for the activity.
● One of the staff moved a person to sit next to them without their permission or speaking to them first. The person then hit the staff member on the bottom. The person then gently pushed the staff's arm to which the staff responded by pushing their arm away without saying anything. Staff then continued the activity without any interaction. This support did not uphold the person's dignity or respect their independence.
● Another staff member moved the straps on a person's wheelchair and put a protective bib on them for lunch, without saying what they were doing or talking to the person.
● A person was making a loud noise and shaking their head. Two staff did not engage or respond to them. The person had a communication passport which stated this could mean agitation or the person is not happy. The communication passport also stated the person did not like being ignored.
● 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.

● People and their relatives told us that they found the staff to be kind and caring. One person told us, "I like the staff". One relative said, "I can't fault the staff here now and the ones here are the right people."
● We observed some kind and caring interactions between people and their staff. Most staff appeared caring and friendly with people. Staff were talking and smiling with residents and respecting their wishes and choices. For example, during morning observation in Beechcroft activity room, staff were laughing and joking with residents and supporting them to make choices within the activity.

Supporting people to express their views and be involved in making decisions about their care
● People's involvement in their care plans had not been recorded. We reviewed nine people's care documents and found a consistent lack of involvement.
● Care plans had been written about people but there was no evidence that people had been involved in, or had been given copies of, their plans in a different format.
● Care plans were electronically signed as completed by nursing staff or managers. We asked one registered nurse how they involved the person in the care plan they had written for them. The registered nurse said, "All of us write care plans: nurse, physio, we try to write the care plan with [name] but he walks away." We asked the nurse how people were involved in writing care plans. We were told that people can't be involved because of their conditions. The nurse said, "If they like things they will show us. It's with them, about them, but they're not going to be vocal about it."
● We asked another nurse how they ensured people were involved in their care plans. The nurse told us, "It's hard for some to be involved as they are non-verbal, but we use the body map and ask family if they prefer creams or shower shampoo or something."
● There was no other evidence shown of people being involved in their care plans.
● There was no evidence of reviews taking place. The registered manager told us, "We discuss between ourselves but don't put anything in writing. If there is a need we would go through referral." One relative commented, "I've not had one in a long time I don't know if that's down to Beechcroft or social services."
● People were supported to maintain important relationships. There were notes in peoples' care plans to show when relatives had called or visited people. One relative told us, "Last time I came here staff were [helping to send] a text message to the person's sister and they were asking do you want smiley face or kiss."

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met.

When we last inspected the service in January 2018 we found one breach of regulation in relation to person centred care. At this inspection we found improvements had not been made and the breach remained.

Planning personalised care to meet people's needs, preferences, and interests, choice and control.

- People's activities were not consistently person-centred. For example, one person had an activity planner that showed they should have trips out twice a week. The persons social participation care plan detailed how they enjoyed going on trips out. However, the person had only been out twice in the four months prior to our inspection.
- People's care plans did not always contain up to date, personalised information. For example, one person had a document called 'my relationship circle' which listed other individuals important to them. Staff told us this had not been updated to reflect the recent position for this person and their family.
- There was no goal or outcomes setting for people. One person used to go out and staff were trying to encourage them to do this, but there was no planned approach. This meant that staff could not support the person in a consistent way. Consistent support would be very important for the person as they found transitioning and lack of routine difficult. We spoke to staff about goal setting and they were not aware of the concept.
- In the person's communication passport from January 2019 it described how staff could help the person with communication. There were directions for staff to give eye contact and keep a respectable distance. It also reminded staff to be aware of their DISDAT (disability distress assessment tool to help identify the signs of distress in people with limited communication), show picture cards, speak clearly, and give the person time to respond. However, picture cards were not being used and staff did not have an awareness of the DISDAT. We asked a staff who regularly worked with the person and they could not explain it.
- In another document called 'A book all about me' from October 2012, it directed staff to use supporting Makaton, gestures and objects of reference to help the person understand. However, we did not see any Makaton used and there was no information around what signs the person understands and is familiar with.
- The same document described an important routine around bath times in the morning and at night. We asked another staff member about the lack of a hoisting risk assessment in the person's care plan and how they are safely supported to bathe. The staff told us that the person is hoisted when going in the bath, but they have not had a bath in a long time because they do not like it. However, the person's care plan said how important baths were. The staff agreed that this should have been updated as an agency or new staff would not know the person currently does not enjoy baths.
- There was conflicting information about people's preferences. One person had a care plan that stated they did not like crisps. During the inspection we observed the person eating crisps on several occasions. A staff member confirmed this information was also out of date.
- We checked activities for another person. Their social care plan dated from March 2018 stated the person enjoyed listening to music, but due to their vision problem they were not keen on watching the television.

However, their activity programme had television on four out of seven activities in the evening and watching a DVD for another. This meant that on five out of seven evenings their planned activity was one which they were known to find difficult and not enjoy.

● This was an example of poor care planning. The person's vision difficulty was referred to in the providers' preadmission assessment. However, the information had not been transferred into activity care planning.

● The socialising/activity care plan dated from March 2018 did not refer to TV and DVD watching as an activity the person would enjoy. Their likes and dislikes care plan dated from March 2018 did not refer to TV and DVD watching; however, this was planned for most evenings.

● The Accessible Information Standard document did not refer to problems with vision, yet this would be important when discussing the person's communication needs. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information in a format that they can understand.

● The principles of registering the right support were not upheld. There was no goal setting, and a lack of integration into society for everyone. The culture did not promote integration and staff seemed unaware; and people were not supported in a person-centred way.

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

● Some support was person-centred. We observed a 'pampering session' with one person. Staff asked them if they wanted to have their nails painted. Staff understood that the person communicated with their eyes and responded accordingly. Staff asked the person what colour they would like and gave other choices, such as having two colours or having a different colour on each nail. There was positive interaction throughout where the staff was consistently talking and joking with the person. Staff ensured there was calm music playing in the background which the residents seemed to like.

Improving care quality in response to complaints or concerns

● The complaints policy was in an accessible format, with Makaton symbols to help people with communication difficulties to understand it. The complaints policy was up to date and included the correct information.

● We reviewed one complaint from February where a communication breakdown had occurred, and this was resolved in line with the provider's complaints policy. There had been two complaints recorded in the past 12 months and both were responded to appropriately and in line with the provider's policy.

● People and their relatives told us they knew how to make a complaint. One person told us, "I would talk to [manager]." One relative described how a situation had improved after they had complained to the provider.

End of life care and support

● There was nobody receiving end of life care at Beechcroft Care Centre.

● The provider had end of life books ready for people and their families to complete when they were ready to do so.

● Most staff had received training in end of life care to prepare them for the future possibility of caring for someone in their final days.

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

When we last inspected the service in January 2018 we found one breach of regulation in relation to good governance. At this inspection we found improvements had not been made and the breach remained.

Continuous learning and improving care

● Concerns about risks associated with epilepsy, bowel management, feeding tube management, effective use of NEWS, staff training, and MCA and DoLS had all been repeatedly highlighted to the provider at others of their services. This information had not been properly shared or used to improve safety and care at Beechcroft Care Centre.

● There had been a lack of oversight by the provider and registered manager to identify the deterioration in standards of care at the service.

● At our previous inspection we had identified five breaches of regulation and at this inspection we found that all five breaches remained. We also found a further two breaches of regulation.

● We found people did not consistently receive personalised care and their dignity was not consistently upheld. We found people's consent was not being obtained before decisions were made on their behalf. People were not protected from a range of risks to their health, safety and well-being. We found people were not being safeguarded from abuse or neglect. We found audits and management checks were not effective, and staff were not deployed safely.

● Quality audits had not been effective in highlighting all shortfalls in the service. We spoke to the registered manager about audits and were told, "As a manager I do bedrails, mattress audits, laundry, infection control, medication audit". We reviewed the audits undertaken by the manager. The bed audit didn't contain a mattress pressure check for people on air mattresses so now it does." However, other shortfalls that we identified at this inspection, such as care plans not containing up to date information, mental capacity assessments not being completed correctly, and people's dignity not being protected, had not been put right by actions in response to quality audit findings.

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

● Leadership of the service was ineffective. The provider and registered manager had failed to ensure that people's needs were known, care plans were effective, and staff were supported. This had an impact on people's safety, and the quality of care they received.

● 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.

● This is the second consecutive inspection where there has not been a rating of Good, where concerns and some breaches of regulations were identified. At our inspection in January 2018 we rated the well led

domain as 'Requires Improvement'. At this inspection we found the service had deteriorated and the well led domain is now rated as Inadequate. Action taken by the provider to improve the service had not been effective.

● The registered manager had told us following our previous inspections that action had been taken to put things right. However, this had not been embedded and sustained and we found areas where the quality of care had deteriorated since that time. 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.

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 Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● The registered manger felt supported in their role. The registered manager told us, "There is assistance for example for the [provider's] autism lead. We have an involvement and inclusion director who has been involved and looked at activities and worked with autism lead around [name] to look at what we can put in place." The registered manager had highlighted some improvements in the environment and had been requesting resources to make improvements.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

● The registered manager was an active presence in the service. However, there were some issues we found with the day to day culture in the service, such as people being spoken to in a child-like manner, and people's dignity not being upheld. Staff did not challenge their colleagues when inappropriate language was used. We found that several of the issues found at this inspection related to one specific lodge and shared this concern with the registered manager.

● The registered manager was aware of the duty of candour to be open and honest with people, or their families, when something goes wrong. The registered manager commented, "If it was serious we would ring relatives to establish the contact straight away. On the day of the incident we inform them. We have relatives who don't live together and try to let both parties know."

● Some staff told us that they did not see the registered manager enough. We asked the registered manager about this and were told, "I work on the floor. I have only done up in Hazel a couple of times I must admit. I go around each home every day but maybe they are getting people up. I also come in early and work late so some staff may not see me."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and staff were involved in the service. The registered manager encouraged staff to give suggestions for outings or trips that people may enjoy. Staff were consulted about garden furniture ad there were two suggestions boxes in Beechcroft Care Centre to encourage staff to come forward with ideas.

● The registered manager told us that people were involved in the service and their local community. The registered manager commented, "Some people attend church. People go out to café, shopping, restaurants, local pub, and bowling. There is a big new sensory place in Broadridge Heath. We have outside entertainment coming in and people coming in with animals and music. "

● Staff were encouraged to personalise people's bedrooms with them. The registered manager discussed with people and families and families bring things in for their loved ones to decorate their rooms. Some people had electronic tablets and talk online to their relatives. Some relatives ring the phone and staff hold it to the person. Other people have social media accounts and staff sit with people and communicate to relatives. One person loved showing the photos of shopping trips and to SeaWorld.

Working in partnership with others

● The registered manager explained that the service had close working relationships with the speech and language team and dietician team at the local hospital. The local authority safeguarding team also are involved in the service along with the Sussex partnership learning disability team, who provide training for staff. The registered manager said, "We have links with the tissue viability nurse, but don't need them at the moment; special dentistry; opticians; aromatherapy; reflexology; and the music therapists who visit." There was also close working links to the specialist nurse who oversees people's feeding tubes.

● Information was being shared appropriately and safely. The service had secure systems and could send information using encrypted messages. The registered manager told us, "We now use a code for each person rather than a name and emails are encrypted. If people request over the phone, we ask for an email, so we can send safely."