

SHC Clemsfold Group Limited

Beechcroft Care Centre

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

The inspection took place on 24 and 25 January 2018. This was a comprehensive inspection and it was unannounced.

Services operated by the provider had been subject to a period of increased monitoring and support by commissioners. As a result of concerns raised, the provider is currently subject to a police investigation. One allegation relates to Beechcroft Care Centre specifically. We used the information of concern raised by partner agencies to plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection. Between May 2017 and January 2018, we have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and will report on what we find.

Beechcroft Care Centre is a care home that provides nursing and residential care. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection.

Beechcroft Care Centre is registered to provide nursing and accommodation for up to 30 people who may have a learning disability, physical disabilities and complex health needs. At the time of our inspection there were 23 people living at the home. Accommodation is provided across three units called Beechcroft Care Centre, Chestnut Lodge and Hazel Lodge. Each unit has a separate living room, dining room and kitchenette. Rooms were of single occupancy and had en-suite facilities. The home offers the use of specialist baths, spa pool and physiotherapy.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Beechcroft Care Centre has not been operated and developed in line with the values that underpin the Registering the Right Support and other best practice guidance. Beechcroft Care Centre was designed, built and registered before this guidance was published. However, the provider has not developed or adapted Beechcroft Care Centre in response to changes in best practice guidance. Had the provider applied to register Beechcroft Care Centre today, the application would be unlikely to be granted. The model and scale of care provided is not in keeping with the cultural and professional changes to how services for people with a learning disability and/or Autism should be operated to meet their needs.

These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service should be able to live as ordinary a life as any citizen, but this was not always the case for people. Beechcroft Care Centre is a large clinical setting rather than a small-scale homely

environment. Beechcroft Care Centre is geographically isolated on a campus in rural East Grinstead with many people having moved to East Grinstead from other local authority areas and therefore not as able to retain ties with their local communities. For some people, there were limited opportunities to have meaningful engagement with the local community amenities. Some people had limited contact with specialist health and social care support in the community due to specialist staff (e.g physiotherapy) that were employed by the provider. Some people attended a local college for morning or afternoon sessions. However, most people's social engagement and activities took place either at Beechcroft Care Centre or at another service operated by the provider, such as the provider's day centre.

We found inconsistencies within how risks were being managed on behalf of people. We identified gaps within the guidance for staff who supported people with their continence needs, re-positioning and skin integrity guidance and those at risk of aspiration. On one occasion staff failed to seek the advice of a GP in a timely manner when a person became unwell. This was referred to the West Sussex safeguarding team for their review.

People's consent to care and treatment was not always gained in line with the requirements of the Mental Capacity Act 2005 and people were not always treated with dignity and respect.

Care records were not accessible for the people being written about and they did not always reflect that people received personalised care that met their needs. Some care plans relating to people's specific areas of need lacked detailed information and guidance for staff on how to support people in a responsive way, for example, in expressing sexuality. We also identified staff were not working in accordance with some aspects of agreed care planning such as people's unmet communication needs.

Systems were not effective in measuring and monitoring the quality of the service provided. Where actions were identified, these had not always been completed. There were ineffective systems in place to drive continuous improvement.

Staff received supervisions and appraisals and complimented the training they received which enabled them to carry out their role and responsibilities. They found the registered manager's approach supportive.

People were provided choices on a daily basis regarding what food they ate and clothes they wore and complaints were managed effectively. The provider sought feedback from relatives regarding the care their family members received.

The registered manager was aware of their responsibilities and talked about the new Key Lines of Enquiry (KLOE) which the Commission introduced from 1 November 2017. They told us they were keen to improve the quality and safety of care provided to people living at the home.

At this inspection we found the service was in breach of five of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since the inspection, the provider has given us an action plan of what they have implemented to improve the care experience for people living at the home. This included improvements in how risks for people were managed and improvements to how people's communication needs were being met.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not consistently safe.

Risk were not always managed safely on behalf of people. This included on one occasion the staff failed to seek the advice of a person's GP when they became unwell.

Mostly, medicines were managed safely however there were inconsistencies regarding the application of topical creams.

Staff had received training in safeguarding adults and knew what to do if they had concerns about people's safety.

There were sufficient staff on duty to meet people's needs.

Is the service effective?

Requires Improvement ●

The service was not always effective.

The provider did not work consistently in accordance with MCA legislation.

Staff were provided with training opportunities specific to the needs of the people they were supporting and there was a system of supervision and appraisal.

People were supported to have sufficient to eat and drink and people's individual needs were met by the adaptation of the premises.

Is the service caring?

Requires Improvement ●

The service was not consistently caring.

Staff did not always promote dignity, privacy and respect when supporting people.

Confidential information relating to people was not always maintained securely.

People and relatives were given opportunities to be involved in their care.

Is the service responsive?

The service was not always responsive.

Personalised care was not always delivered to people such as unmet communication needs.

Care plans were not accessible to all people.

Complaints were responded to and managed effectively.

Requires Improvement ●

Is the service well-led?

The service was not consistently well led.

There was a lack of effective and robust auditing systems to identify and measure the quality of the service delivered to people.

The registered manager was aware of their role and responsibilities to improve the quality and safety of the care provided to people.

The management team promoted an open and inclusive environment and people and their relatives were routinely asked their views on the care and support they received both informally and formally. Relatives spoke positively about the support they received.

Requires Improvement ●

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 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The planning of this inspection was informed, in part, by an incident which had a serious impact on a person who lived at Beechcroft Care Centre. While we did not look at the circumstances of this specific incident, which may be subject to criminal investigation, we did look at the potential associated risks for people currently receiving care at Beechcroft.

This inspection took place on 24 and 25 January 2018. The first day was unannounced and the inspection team consisted of two inspectors 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. Their area of expertise included learning disabilities and people with complex health needs. The second day was announced and the team included of two inspectors and a specialist advisor. The specialist advisor had specialist clinical experience in supporting people with a learning disability, autism and/or complex health needs.

Prior to the inspection we reviewed the information we held about the service. This included information from other agencies and statutory notifications sent to us by the manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection. The provider had also completed a Provider Information Return (PIR) as the inspection took place prior to the publication of the previous inspection report. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Due to the nature of people's complex needs, we were not always able to ask people direct questions. The majority of people who lived at the service could not tell us about their views of the service they received. Therefore we spent time observing the care and support that people received during the morning, at lunchtime and during the afternoon over both days. We also spoke with three registered nurses who were employed by the provider, three care staff, the deputy manager, registered manager and the area manager,

activity co-ordinator and assistant chef.

We also observed medicines being administered to people. We spoke with three relatives to gain their views.

We reviewed a range of records about people's care which included five care plans. We also looked at three care staff records which included information about their training, support and recruitment record. We read audits, minutes of meetings with people and staff, policies and procedures, accident and incident reports, Medication Administration Records (MAR) and other documents relating the management of the home.

Is the service safe?

Our findings

A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. During our inspection we found inconsistencies regarding how risks to people were managed by staff to keep people safe. For example, one person was at a high risk of developing Aspiration Pneumonia which is a type of lung infection. Aspiration pneumonia can occur if food, saliva, liquids, or vomit is breathed into the lungs or airways leading to the lungs. They had been admitted to hospital three times in the past four years related to this. However, there was no specific care plan or associated risk assessment in place to inform staff how the person presented when they became unwell and what action a staff member should take in the event of this. We checked notes completed by staff supporting the same person before a recent hospital admission. They described the person had become unwell in January 2018 which included an episode of 'vomiting' and a raised body temperature. The notes state registered nurses continued to monitor the person's health which did not improve but they did not contact the person's GP until two days later who advised the person should be admitted to hospital for treatment of their condition. Due to the potential delay in the nursing staff seeking external medical advice from the person's GP, they may not have received the correct treatment to manage their health condition when needed. We raised the concern with the management team at the time of the inspection. The person returned from hospital to the home during the inspection due to improvements in their health. We also shared our concerns with the local authority West Sussex Safeguarding team after the inspection for their review. This was particularly concerning as safeguarding allegations have been made about staff failing to respond quickly and appropriately to a change in people's health in other locations owned by the provider.

On the first day of our inspection we observed a person being supported to eat their lunch. A staff member was positioned next to them and they were holding the person's head with their arm to lift their head up. We spoke with the deputy manager about this as we were concerned the approach being used was restrictive and wanted to know if the person had been assessed for the appropriate equipment. The deputy manager told us this was not an agreed practice and would speak with the staff team supporting the person. They also told us prior to the inspection they had taken action and contacted the person's speech and language therapist as the person's position at mealtimes needed to be reviewed as the person had difficulties with their head rest. Records showed the person had seen the speech and language therapist in August 2017 and they were under continuous review from both the dietician and the speech and language therapist and additional appointments had been made. However, the nutrition care plan in place lacked details on step by step guidance to ensure all staff knew how to support the person at mealtimes which may have influenced an incorrect approach being used. The deputy manager told us they would amend the care plan and associated risk assessment with guidance from the speech and language therapist to avoid any further risks to the person and how they were supported at mealtimes.

One person's care plan referred to their need to use a catheter to assist in managing their continence. However, there was no specific care plan or risk assessment in place to describe the level of monitoring nursing staff and care staff had to provide to the person with this need. A registered nurse described to us how they supported the person with the washing of the catheter site or surrounding area. What they

described was not recorded within the person's care documents which meant the person was at risk of staff using different methods and approaches when supporting them which may not have been safe and in line with best practice. Inconsistent or poor care of a catheter can lead to the person experiencing discomfort or preventable infections.

The same person had complex physical disabilities which meant they required staff support with all aspects of their care. Care records described they had suffered with a pressure ulcer in 2014 and at the time of the inspection they were receiving treatment for the same pressure area. Due to this they had been assessed as at a, 'very high risk' of further skin tissue damage by the staff team. However, there was limited specific guidance in place to support the person with this need. For example, we were told the person required the support of two staff to assist them with all their moving and handling needs and the person chose to receive most of their care in bed. The person required staff to support them to move regularly to help reduce the risk of a further breakdown in their skin condition. However, there was no guidance available to inform staff how often the person required to be re-positioned throughout the day time. Care notes held some information yet it was inconsistent and failed to demonstrate whether the person was having their moving and handling needs consistently met. The same person required support from staff to apply their prescribed topical cream in relation to their skin integrity. They had been prescribed two different creams in January 2018 to be applied twice a day. We identified three out of eighteen days had not been signed for by staff to state they had been offered and/or applied and no associated code or entry had been made by staff to provide an explanation or advise the reader as to any other action taken; instead the space had been left blank. We queried this with the registered nurse on duty who told us the person often refused to have their creams applied. The registered nurse told us, and records confirmed, that the person's pressure area was healing. However, the gaps within the care records we read failed to demonstrate whether the person was having their skin integrity needs consistently met to reduce the risk of further issues and to maintain a healthy skin condition.

At other inspections of locations operated by the same provider, we have raised concerns about how risks are managed through accurate, complete and correct risk assessments and care plan guidance. However this feedback and learning had not been effectively applied to Beechcroft Care Centre to proactively address the potential risk to service users by not having this in place.

The above evidence demonstrates that not all was reasonably done to mitigate risks to service users. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team at the time of the inspection consisted of the deputy manager and the area manager as the registered manager was on leave. The registered manager contacted us shortly after the inspection to discuss what actions they had already taken to minimise any further risks to people. They provided us with a list of actions they had taken to improve how people were supported. This included further training for registered nurses in responding to deterioration in people's physical health. They had also reviewed and completed an aspiration pneumonia care plan and associated risk assessment for the person who had been recently admitted to hospital. The registered manager also informed us a staff meeting had been held in relation to people's deteriorating health and seeking additional medical advice in a timely manner.

We also observed other examples of care assessed and managed safely and with confidence. We observed care staff supporting a person who suffered an epileptic seizure. They offered the appropriate level of reassurance to the person and took the necessary first aid measure and alerted the registered nurse on duty. The care staff supported the person respectfully and demonstrated they had developed an understanding of epilepsy as they were able to communicate their own observations effectively to the registered nurse on

duty. We also read risk assessments which had been completed satisfactorily, they included people's risk in relation to sun exposure, moving and handling and transportation in the provider's vehicles.

We spoke with registered nurses who were based at Beechcroft Care Centre. They confidently discussed how they administered medicines to people. Registered nurses were knowledgeable as to the reasons why people had medicines prescribed to them, any known side effects and what to do in the event of any concerns. The recording system included a photograph of the person and information that was pertinent to them, this included any known allergies. Tablets were dispensed from blister packs and medicines administered from bottles or boxes were stored and labelled correctly. We observed that the Medication Administration Record (MAR) was completed on behalf of each person by the registered nurse on duty each time someone was supported to take their oral medicines. Oral medicines were administered by registered nurses only.

There were enough staff working across each of the three units. The provider used a dependency tool to ensure there were enough staff on duty. Some people received one to one support and we observed staff were allocated accordingly. In addition to nursing and care staff the provider employed the support of a physiotherapist and activity co-ordinators who were supporting people at the time of the inspection. The provider also employed an administrator, chef, a chef assistant and other domestic staff and maintenance staff including drivers to support the home. Relatives we spoke with felt there was enough staff to meet people's needs and care was delivered safely. We asked one relative who visited their family member regularly why they felt this and they said, "Because of how happy and well [named person] looks", they added, "I don't find any kind of ill treatment".

Accidents and incidents were recorded and documents showed the action that had been taken afterwards by the staff team and registered manager. Staff had been trained to recognise the signs of potential abuse and in safeguarding adults at risk. Staff explained how they would keep people safe. They could name different types of abuse and what action they would take if they saw anything that concerned them. All staff told us that they would go to the registered manager for guidance. One staff member said they would, "Go to the manager or deputy or the nurse", if they were concerned about a person. Another staff member said, "My first port of call would be the manager".

Staff recruitment checks were robust and thorough. Staff were only able to commence employment upon the provider obtaining suitable recruitment checks which included; two satisfactory reference checks with previous employers and a current Disclosure and Barring Service (DBS) check. Staff record checks showed validation pin number for all qualified nursing staff. The pin number is a requirement which verifies a nurse's registration with the Nursing and Midwifery Council (NMC). Recruitment checks helped to ensure that suitable staff were employed.

Environmental risks such as hoist equipment and wheelchairs were managed effectively through prompt and regular servicing. Infection control promoted a safe and clean environment. Equipment was seen to be readily available that promoted effective infection control such as antibacterial hand wash, disposable gloves and clinical waste bins. A relative told us, "Everything is clean and tidy". We talked with the assistant chef about the management of kitchen audits and saw audits had been completed in relation to food and meat temperatures, to ensure food had been cooked properly. We also looked at daily audits in relation to the cleaning of the kitchen and other weekly checks. The service had attained a Food Standards Hygiene Rating of 5, which is the highest rating that can be achieved.

Is the service effective?

Our findings

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

We checked that the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The management team had completed a DoLS application for each person who lived at the home. Nine DoLS had been authorised by the local authority. We spoke with the deputy manager about their understanding of assessment of capacity and applications for Deprivation of Liberty Safeguards (DoLS). Their understanding was that everyone accommodated at Beechcroft Care Centre was subject to DoLS, regardless of whether they had been assessed as having capacity or not. One member of staff described a person as very, "Articulate" and very able. Despite this, a DoLS had been applied for in February 2017 on behalf of the person. We checked their care records and there was no mental capacity assessment in place to state they lacked capacity in the first instance. The same member of staff also told us, "Some people are quite able here, sometimes the care plan doesn't reflect what I see". Another member of staff told us, "They all have capacity in their own way". Therefore we queried whether accurate assessments of people's capacity had consistently taken place.

At other locations of the provider, we had already identified this as a concern, that is, where DoLS had been applied for, but people's capacity to consent to specific decisions had not been assessed. The Mental Capacity Act 2005 provides detailed guidance on the statutory principles to be applied in relation to capacity. One of the principles is that everyone is presumed to have capacity unless it is established otherwise. It also states that people should receive support to help them make their own decisions before it is concluded that they might lack capacity. The Act also refers to the kind of support people might need to help them make a decision, such as a different form of communication or information in an accessible format. Considering most people had complex communication needs, we saw no evidence that these different types of support were readily available to ensure they were involved with decisions made about their care. Everyone living at Beechcroft Care Centre had been assumed to lack capacity, with or without a capacity assessment, thus a blanket decision was made to apply for DoLS in every case. For example, MCA assessments were general in their approach and had not considered whether some people may have capacity to make some specific decisions about their care. Whilst staff had attended MCA and DoLS training and they could demonstrate some understanding of the importance to their role and responsibilities, the provider had failed to consistently ensure that consent to care and treatment was sought in line with the requirements of the MCA and associated legislation under DoLS.

The provider had not ensured service users consent to care and treatment had been sought in accordance with the Mental Capacity Act (MCA) 2005. This is a breach of Regulation 11 of the Health and Social Care Act

The provider carried out assessments regarding people's physical, mental health and social needs holistically prior to them moving into Beechcroft Care Centre. This incorporated information regarding people's complex physical and communication needs. The assessment process provided the staff team to involve the person and/or their representative and plan the person's care they needed and wanted. The provider had also completed Disability Distress Assessment Tool (DisDAT) for people which helped staff identify if the person might be in pain or discomfort and require medical attention. This is a nationally recognised tool designed to help identify distress in people who have severely limited communication. The assessment processes in place considered certain protected characteristics as defined under the Equality Act. For example, religious status and disability.

Efforts had been made by the provider to ensure the environment and adaptations of the premises met people's needs in relation to their physical disabilities. Beechcroft Care Centre provides care for adults living with a learning disability or other complex needs and physical disabilities. All people living at the home were wheelchair users. Corridors and doorways were wide enough for people who used wheelchairs to move around the shared areas. Where required bedrooms were equipped with an overhead tracking hoist to assist with safe moving and handling. Some signage was in use, for example, pictorial signs denoted toilets and communal facilities to assist people with their orientation in the building. We noted some information displayed on notice boards was not accessible for a person who used a wheelchair as it was placed too high on walls. We discussed this with the deputy manager who agreed the items could be moved to a more suitable position so all people could view what was on display. We also observed one person, who was able to move their own wheelchair without staff support, was unable to move freely around their home as they had to wait for doors to be opened by staff as they did not automatically open with door pads which restricted their independence. The provider may wish to consider how to make adjustments to doorways to make it easier for people to move independently between different parts of the service.

Staff received training in a range of areas, which the provider had assigned as mandatory and essential to the job role. This included emergency first aid, moving and handling, fire safety, health and safety, infection control, food hygiene and safeguarding. The registered manager had also sought training for all staff relevant to the specific needs of the people they were supporting such as learning disability and epilepsy training. Registered nurses both permanent and agency, had attended additional clinical courses to enable them to carry out their role safely and effectively such as percutaneous endoscopic gastrostomy (PEG) management. A PEG allows nutrition, fluids and medicines to be put directly into the stomach, bypassing the mouth and oesophagus. The provider used four regular agency registered nurses we checked their training profiles and they had all attended the necessary training courses.

New staff were provided with opportunities to shadow experienced staff members until they felt confident themselves. New staff were also required to complete the Care Certificate, covering 15 standards of health and social care topics as part of their induction into working in health and social care. To achieve this, candidates must prove that they have the ability and competence to carry out their job to the required standard. Staff were also encouraged to complete Health and Social Care Diplomas (HSCD). These are work based qualifications that are achieved through assessment and training. This ensured people received care from staff who had been provided the opportunities to gain the knowledge and skills they needed to carry out their roles and responsibilities.

Staff also received additional support in the form of supervisions, appraisals and opportunities to attend staff meetings. A system of supervision and appraisal is important in monitoring staff skills and knowledge. Staff meetings took place monthly and minute's demonstrated staff were provided with opportunities to

discuss all matters relating to the home. This included changes in people's needs and other changes such as best practice guidance and legislation. For example, in January 2018 a discussion was held surrounding further training opportunities for staff and a reminder to all registered nursing staff of what should be handed over at each handover session. Staff we spoke with told us they were happy with the support they received. One staff member said, "We do training every year", they told us they had recently attended epilepsy and Autism and privacy and dignity training. Another staff member told us training was, "Very informative".

People were supported to have sufficient to eat, drink and maintain a balanced diet taking into account individual needs, likes and dislikes. There were allocated kitchen and domestic staff employed to prepare meals on behalf of people. Care plans we looked at included information with regard to people's nutritional needs, for example, in relation to their appetite and how they should receive their nutrition, either orally or via PEG. The type and volume of nutritional fluid was determined by the dietician and guidance was followed by staff. Where people required supplements to augment their calorie intake, these had been recorded in their care records. In addition, if people had difficulties with swallowing, their care plans contained advice about the use of thickeners for fluids. A relative told us the meals were, "Good", they added, "I have lunch here sometimes". Another relative complimented the food and said, "[Named person] seems very contented and gained weight".

We talked with the assistant chef about the catering arrangements at Beechcroft Care Centre. They showed us the menus that were available to people and told us menus were planned by the chef manager. Staff completed forms on behalf of people which recorded their menu choices for each day. The assistant chef told us that people were involved in the drawing up of menus and that staff regularly discussed food preferences and choices with people. The assistant chef was knowledgeable about people's allergies, special diets and preferences. However, they told us of one person who was not to be given cakes because their relative did not wish it. This was an issue we discussed later with the area manager and deputy manager since it was not clear whether the relative had the legal right to make such a decision on the person's behalf. Registered nurses were able to explain what action they would take if they were concerned about a person's weight which included informing the GP and increasing their observations of the person and what they were eating. This ensured people's nutritional needs were regularly monitored for any changes.

Care plans we looked at recorded the involvement of health care professionals and that people had been referred to specialists and consultants when needed. We noted people had attended Annual Health Checks in line with current guidance. The Annual Health Check scheme is for adults and young people aged 14 or above with learning disabilities, who need more health support and who may otherwise have health conditions that go undetected. Where people required support from the provider's physiotherapy staff, their needs had been appropriately assessed and recorded. We saw from records that people had regular check-ups with their dentist and optician as needed. Hospital passports had been completed for people. These were documents which included information about people's health care needs, including likes and dislikes, in an accessible format for hospital staff. A relative told us the professionals their family member had access to, "Physio, nutritionist, reflexologist, aromatherapist and access to dentist, opticians, doctors every week and whenever you want them". Another relative told us, "[Named person] gets regular dentist treatment, they get their teeth cleaned".

Is the service caring?

Our findings

At this inspection we observed occasions where staff failed to demonstrate a caring approach and did not give due consideration and respect for people's dignity. Most people had complex mobility and communication needs and were completely reliant on the staff providing their support. On the first day of the inspection we observed a registered nurse support a person with their meal through a PEG tube. The person was positioned in the corridor and whilst the registered nurse was supporting them they had lifted the person's top up and exposed their underwear. The registered nurse made no attempt to adjust the person's top to cover their underwear throughout their mealtime experience. The registered nurse also held a conversation with another person's relative whilst providing this support, therefore, exposing the person's underwear to them. This practice was not dignified and did not respect the person's right to privacy.

On the same day we were speaking with the same registered nurse about how they administered medicines to people. We were approached by a person who lived in the home. The registered nurse, in front of the person, discussed physically challenging behaviours they had displayed as if to warn the inspectors to stand away from the person. The registered nurse showed limited respect towards the person when discussing them and failed to consider how this might have made them feel at the time.

People living at the home had complex communication needs. Some people presented with echolalia which meant they may continuously repeat words or phrases. On the second day of the inspection we observed a person continually saying they were going out. Some staff acknowledged the person in a respectful way that they had heard what they had said. However, we overheard another staff member saying, "Oh my God, everyone has known since yesterday she's going out". This comment showed a lack of understanding the staff member had for the person's condition. Another person was observed repeating phrases, the same member of staff was observed mimicking the person and copying what they had said. Whilst the comments were out of earshot of the person and other people living in the home so they did not hear, they demonstrated a lack of understanding of people's needs and respect for them as a person.

During both days of our inspection, we found written confidential information relating to people was not maintained securely. This included information relating to people's dietary and hydration requirements displayed on notice boards and other files such as night time daily care records and GP visit record on shelves in public areas and not in a secure environment such as a lockable office. This meant personal information relating to people's care had been accessible to any visitors to the home. We made one staff member aware documents should be locked away, they responded, "So this is not alright" implying this was common practice. We discussed this with the provider throughout our inspection as this practice was not in accordance with data protection legislation and it did not respect people's right to privacy.

Whilst people could not tell us the impact the examples described had on them due to their complex communication needs the approaches used did not promote and respect people's dignity and privacy and were not in line with caring values.

The above evidence demonstrates staff did not treat people with dignity and respect at all times. This is a

breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We fed back our observations to the management team and also shared we had observed other positive interactions between staff and people. We observed other examples of staff engaging with people using appropriate levels of humour which created a happy and pleasant ambience. A relative told us, "[Named person] was happy from the start". They added, "[Named person] can't tell you how she feels but you can get the feeling if she's not happy, you see her laughing". On one occasion we observed a person became agitated. The staff member supporting them de-escalated the situation immediately by offering them a drink which seemed to please the person and their mood became more positive and lifted. We also observed a staff member assisting a person to complete a jigsaw puzzle. The staff member had a reassuring and gentle manner and guided the person on which pieces they might select to complete the jigsaw. The person was fully engaged in completing the puzzle and the interaction between the person and the staff member was positive, warm and friendly.

The staff we spoke with were able to describe the support individual people needed, what they liked and disliked. We also observed staff knocking on people's bedroom doors before entering and gaining consent from people prior to supporting them with a particular aspect of care, such as supporting them at mealtimes with food and drink. People looked at ease and comfortable in the company of staff supporting them. Staff told us they encouraged people to be as independent as possible when supporting them with their personal care. This included choices offered to people about what they wore each day, what they ate and drank and how they spent their day. One staff member said, "All the time we ask their opinion, for example, do you want jeans or jogging bottoms".

Resident meetings and care plan reviews gave people and their relative's opportunities to discuss what was important to them. We discussed the resident meeting minutes with the deputy manager as we noted they were presented in a written format which was not necessarily accessible to people living at the home who may be reliant on pictorial images. Care plan reviews included the person, their family representative and the relevant health and social care professionals. A relative who represented their family member told us they were very much involved in the person's care and said, "Anything at all they ring me".

Is the service responsive?

Our findings

Each person had a care record which included a care plan, risk assessments and other information relevant to the person they had been written about. We looked at a range of care plans in relation to people's care and support needs.

The Accessible Information Standard (AIS) is a requirement of NHS and adult social care services to ensure that people with a disability or sensory loss are given information in a way they can understand. In one care plan we found a copy of information relating to the AIS. Following this, information was provided about the person's way of communicating and how staff should communicate with the person. In some parts of the care plan, information in summary had been written in short, simple sentences. However, no assessment had been completed to show how information should be recorded or shared with the person in an accessible way that specifically met their communication needs. This was true of all the care plans we looked at. Reasonable adjustments had not been made to ensure that people's information needs had been identified or met according to their needs. There was no AIS plan in place to show how people's specific needs had been identified, assessed or met. This meant that people could not contribute fully, or as much as they were able to, with planning their care and support.

We checked to see if any people were using specialist equipment to aid their communication needs and found there had been missed opportunities regarding how people were being supported. For example, one person had limited verbal communication. Their communication care plan wrote about a piece of equipment that enabled them to communicate more effectively with others. We spoke with a registered nurse who said the person did not use it in the home; however this conflicted with what had been written in their care plan. Another person had a computer tablet which had a Voice Output Communication Aid (VOCA) system. This is a speech generating device which enables the user to speak using digitised speech when a button or key is pressed. We spoke with staff supporting the person and noted that staff did not know how to use the system. We also identified one person used Makaton. Makaton is a type of sign language. Staff supporting the person told us the person used very few signs however during the inspection we did not observe any staff using Makaton with them. We fed back our findings to the management team as some people's communication needs were not being met or fully explored.

We looked at records relating to how people might express their sexuality and the support they needed. One record stated the person should be able to express their sexuality appropriate to their age, but the information following this statement was vague and imprecise and did not clearly communicate to staff what the person's sexual needs were. We saw two examples in care plans which provided unclear information about how people expressed their sexuality and what staff were expected to do. We discussed the lack of clarity in expressing sexuality records with the deputy manager and with the area manager.

People's personal histories, likes, dislikes and preferences were recorded and account taken of their cultural and spiritual needs. We read that one person wanted to be encouraged to attend church and that they celebrated Christmas. However, we read that another person also liked to celebrate Christmas and that they were a Muslim, yet on their admission details, it recorded their religion as 'Church of England'. This was

inconsistent information and could have been confusing for staff who supported the person.

Care plans noted that each person had a named nurse and keyworker. Care plans included information about people's medical conditions and health needs. Pre-assessments were completed before people came to live at Beechcroft Care Centre. Some care plans recorded the involvement of relatives. For example, we read that a relative had been unable to attend the review meeting of their family member's care plan but that they were happy with the care provided. We have discussed the inconsistencies within how risks were assessed and managed within people's care records within the Safe section of this report.

The 'need to be involved in community activities' was recorded in some care plans. However, opportunities to engage or participate in the wider community were limited. We looked at the activities that people engaged with and these were often restricted to activities offered at the home or at another of the provider's facilities. People had access to hydrotherapy, yoga or sensory experiences, music and access to the grounds surrounding Beechcroft Care Centre. However, regular outings, for some people further afield were limited according to the availability of staff and transport. Some people visited their families on a regular basis. Whilst people's likes and dislikes were recorded, the activities organised on site were generic, for example, painting, arts and crafts and watching television. Activities offered to people were not consistently person-centred or planned in accordance with people's needs and wishes.

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

The registered manager explained they were introducing the National Early Warning Score (NEWS). This is a standardised system for recording and assessing baseline observations of people to promote effective clinical care. For example, it will include a baseline for what a person's temperature, pulse rate and oxygen saturations should be and what actions nurses should take if physiological checks they take are outside of the baseline and a person's health deteriorates further. The registered manager told us there were only two registered nurses who required the training and then they could fully implement the system.

Complaints were looked into and responded to in a timely manner. There was an accessible complaints policy in place available for both people living at the home and their relatives. There was a clear log of all complaints and the actions taken by the management team. There were no formal complaints open at the time of our inspection.

There was no one who was being supported at the end of their life at the time of our inspection. However, procedures were in place with the GP so that people would receive a comfortable, dignified and pain free death. This included access to pressure relieving equipment and pain relief medicines.

Is the service well-led?

Our findings

At this inspection we found systems to assess and monitor the service were in place. However, these failed to ensure a delivery of consistent, good quality care across the service. Whilst the management team responded to our findings during the inspection by implementing changes needed, the provider had failed to pro-actively identify all the issues we found during the inspection. For example, area managers visited the home on a monthly basis. During these visits they spoke with staff and people and sampled records relating to people's care and the management of the home. They would then complete a document accordingly of any areas which required improvement and present this to the manager of the home. In addition, a clinical nurse auditor employed by the provider had carried out an extensive audit on 19 December 2017. These processes had failed to highlight and capture the issues we found such as the inconsistencies with how risks were being managed on behalf of people and inconsistencies with how the principles of the MCA were being applied.

There was also a lack of records, relating to routine analysis of unexpected hospitalisations, or other incidents that had taken place, to enable the management team to proactively learn from unexpected events to ensure staff have acted consistently, appropriately and in line with best practice at the time. This included routine reflective practices which would be carried out at the time of any incident, including when a person became acutely unwell and required emergency treatment, to assure themselves the staff team had effectively responded to situations impacting people. This was particularly relevant considering this had been raised as a concern at other locations of the provider and had been the theme of a safeguarding concerns raised about Beechcroft Care Centre. The gaps we found held potential risks for people living at the home regarding the quality and safety of care they were receiving.

The above evidence shows that the provider was unable to demonstrate the systems or processes in place operated effectively to ensure compliance with requirements. There was a failure to assess, monitor and mitigate the risks relating to health, safety and welfare of service user. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the registered manager separately shortly after the inspection. They told us they understood their responsibilities and accepted we had identified some areas regarding how care was delivered which required improvement. They shared some of the actions they were taking to minimise further risks to people. This included a review of their care planning process, the introduction of additional training for staff and the shadowing of staff on duty to ensure the quality and safety of the care delivered to people was in line with best practice. They told us, "They (people) should be treated like you and I".

The registered manager had knowledge about when they formally had to send the Commission notifications. A notification is information about important events which the provider is required to tell us about by law. On the 1 November 2017 amendments to the Key Lines of Enquiry (KLOE) came into effect with five new KLOE and amendments to others that all regulated services are inspected against. The registered manager was aware of the changes and had attended a conference in London held by CQC in 2017. They also shared with us communications by the provider about how the amended KLOE would

impact on location inspections such as the introduction of a 'Lessons learnt' folder to show what action was taken when things went wrong to drive improvements regarding the quality of care provided to people living at the home.

All staff were provided with opportunities to enable them to be involved with developing the service they offered to people. We spoke with care staff who had been working at the nursing home for many years they all spoke positively about the registered manager. One staff member said, "I feel [named registered manager] is a manager you can approach about anything". Another staff member said, "We can always ask our managers for help".

We checked how the provider gained people's and relative's views of the quality of care provided. Surveys were sent out monthly from the providers head office. The ones we read were all positive and demonstrated the staff team offered an open door policy which helped promote an inclusive atmosphere. We also read cards and thank you notes the provider had received from relatives, one stated, 'This is to tell you how impressed our family and friends were by you and your team. The cheerful can do attitude of staff featured very much in the comments we received, as did the pervading lovely atmosphere'.

The registered manager and deputy manager told us they worked alongside other health and social care professionals and partner agencies and were keen for this to continue to benefit the people living at the home. For example, some people living at the home were funded by West Sussex. We read monitoring reports from the West Sussex learning disabilities Contracts and Commissioning team who's role it was to establish whether a provider is meeting their contractual obligations. They had visited the home three times since the last CQC inspection and the feedback within their reports regarding the quality of care provided to people was positive.

On the 3 May 2018 the provider gave us an action plan of what they had implemented to improve the care experience for people living at the home. This included a review of people's care plans, associated risk assessments and reviewed how the staff team responded when people's health deteriorated. They also shared they had implemented audits and checks for the registered manager to complete to assess and monitor the effectiveness of such changes. We will review the impact of the action plan regarding people's care at the next inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care 9 (1) (a) (b) (c) The provider failed to ensure care and treatment of service users was appropriate and met their needs and preferences consistently
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect 10 (1) Failure to consistently treat service users with dignity and respect
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent 11 (1) The provider did not consistently work in accordance with MCA 2005 legislation