SHC Clemsfold Group Limited

Beechcroft Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Beechcroft Care Centre is a residential care home that was providing nursing care and support to 19 people with a learning disability and physical disabilities at the time of the inspection. The service can support up to 30 people. There are three lodges in the service. One lodge is known as the main building or referred to as Beechcroft Lodge and this is where the registered manager and deputy manager's office is based. The other two lodges are Chestnut Lodge and Hazel Lodge. Together the three lodges make up Beechcroft Care Centre. During our inspection only Beechcroft Lodge and Hazel Lodge were accommodating people and Chestnut Lodge had been temporarily closed. Each lodge had its' own kitchen, dining area, and clinical room. People had their own bedrooms with en-suite facilities. There was a hydrotherapy pool, spa pool and specialist baths for people. The service is based in its own grounds on the outskirts of East Grinstead.

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

People's experience of using this service and what we found
Some risks to people were not being managed safely. People were prescribed treatments and medicines for long term health conditions and did not always receive these as they should.
Because people did not always receive the treatments they needed in the way prescribed or assessed there was a risk people could be neglected.
Medicines were not being managed safely. Stock control for some medicines was poor and people did not always receive their prescribed medicines as assessed.
Lessons were not effectively learned from past incidents. Some issues highlighted at previous inspections were found at this inspection and concerns from other of the providers locations were also found at this inspection.

Audits had not been effective in highlighting or putting right shortfalls to make sufficient improvement. We found serious concerns with people's care and support. Audits completed by external consultants had not been acted on in good time, so similar concerns were identified at this inspection.
The culture at the service was not in line with current best practice and outcomes for people were not consistently good.
The service worked with a range of professionals, some professionals raised concerns with us about how information was not always used and understood by staff to meet people's needs.
People and relatives were consulted about changes in the service and their opinion was sought.
There were enough staff on duty to keep people safe. The provider had temporarily closed one lodge which helped with staffing levels on the remaining two lodges.

We expect health and social care providers to guarantee autistic people and people with a learning disability

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

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

Right support:
The model of care and setting did not maximise people's choice, control and independence. The model of care delivery at Beechcroft Care Centre focused on people's medical, rather than their social support needs. The service was isolated from the main town and people relied on their staff to be able to go out. Staff wore uniforms and name badges to say they were care staff when supporting people. The size of the service was larger than current best practice guidance. There were signs on the road before the entrance, in the grounds and on the outside of each Lodge to say it was a care home.

Right care:
Care was not always person-centred or promoted people's dignity, privacy and human Rights. Staff did not always respond in the right way when people experienced illness or distress.

Right culture:
Ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services led confident, inclusive and empowered lives. The provider told us they had engaged nationally recognised consultants to review their services for people with a learning disability. However, significant work was still needed to change the existing culture, and ethos at Beechcroft Care Centre in order to achieve this.

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

Rating at last inspection (and update)
The last rating for this service was Inadequate (published 10 April 2020) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been made and the provider remained in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively. Infection control was being managed safely and Beechcroft Care Centre had kept people, visitors and staff safe from risks around Covid-19.

We previously carried out an unannounced comprehensive inspection of this service on 11 December 2019. Breaches of legal requirements were found. We undertook this focused inspection to check whether the provider now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has not changed. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Beechcroft Care Centre on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.
We have identified three breaches at this inspection in relation to safe care and treatment, safeguarding people from abuse, and good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will act in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Beechcroft Care Centre

Detailed findings

Background to this inspection

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

Inspection team
The inspection was carried out by two inspectors on 1 September 2020 and two inspectors on 2 September 2020. A third inspector assisted the inspection after the site visit by speaking with relatives.

Service and service type
Beechcroft Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.
The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short period notice of the inspection due to the Covid-19 pandemic. This allowed us to work with the provider to ensure our site visit was safe and to enable us to review some documents and care plans before our site visit, to minimise the time we spent in the service.

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

During the inspection-

We spoke with two people and four relatives about their experience of the care provided. We spoke with the registered manager, deputy manager, the nominated individual , six nurses, and five care staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records including people's care plans, risk assessments, medicines documents, staffing and recruitment files and audits.

After the inspection –
We continued to seek clarification from the provider to validate evidence found. We looked at quality assurance records and requested further documents form the provider that were sent to us.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Inadequate. We found concerns relating to the safe management of people's behaviours, epilepsy, changing health needs, and the safe management of medicines. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management, using medicines safely, and learning lessons when things go wrong.

- At the last inspection in December 2019 we found a continued breach of regulation 12 relating to the safe management of risks around epilepsy, medicines, behaviours that may challenge others and monitoring peoples' changing health needs. At this inspection we found insufficient action had been taken and the breach had not been met.
- Some people living at Beechcroft Care Centre received their nutrition, fluid and medicines to be given through a feeding tube, because they were not able to safely receive this by their mouth. One person had a feeding tube fitted in to their stomach and received all of their food, fluids and medicines through this tube. Their care plans directed staff to stop the feed running for 30 minutes before moving the person. This was to reduce the risk of the person choking on their feed or suffering aspiration. Aspiration is when particles such as food, saliva or medicines go in to a person's lungs and can cause a serious infection. However, the person's fluid charts showed there were times when their feed was not being paused for 30 minutes before moving the person; and on one occasion in the notes we reviewed only for 10 minutes.
- We spoke with the registered manager and deputy manager about the failure to pause feeds for the correct time prior to moving people. The registered manager told us that the failure to pause feeds for some people may have been due to this only recently being communicated to the nurses. However, the need to pause feeds was discussed with the management team at our last inspection in December 2019. This left people at risk of choking or aspirating.
- Some people living at Beechcroft Care Centre were diagnosed with reflux. Reflux is when stomach acid flows back up into the food pipe. Some people can be at risk of choking or aspirating if their reflux is not managed safely. One person with an historical diagnosis of reflux did not have this condition or any possible associated risks consistently explained in their care plans.
- The same person needed their bed to be elevated to reduce the risk of them choking or aspirating, but this was not clear in their care plans. Staff we spoke with were unclear about the reason for elevating the person's bed. The actual bed did not have markings on it to indicate how it should be elevated and pictorial guidance in the persons' room showed them lying flat in bed.
- Another person was diagnosed with reflux and their care plans did not explore this diagnosis at all, and the risk relating to reflux had not been explained or reduced. This left the person at risk from choking or aspirating.
- Other people who were at risk of choking and aspirating needed postural support to ensure this risk was reduced. Care plans for two people we reviewed did not give clear guidance about what angles their beds needed to be at for safe care during support with medicines, personal care and whilst sleeping. Directions

around the times people needed to be elevated were also either missing or unclear.

● One staff member we spoke with described supporting a person with their positioning in ways that were inconsistent with several care plans. The staff member spoke about pausing the person's feed just before moving them which was not the correct support and puts them at risk of choking or aspirating. Inconsistent and confusing directions in care plans left people at risk of receiving incorrect support with their postural support.

● Some people required specific support with their eating and drinking to reduce the risk of choking. Two people we reviewed had confusing guidance as to how their food should be prepared or how they needed to be supported to eat. One person had a choking risk assessment which directed staff to administer a series of back slaps and abdominal thrusts before calling an ambulance in the event of a choking incident. However, the risk assessment did not account for the person's disabilities, and how to safely administer this support while they were seated in a wheelchair, where they spent most of their waking day. This left people at risk from choking.

● One person was prescribed oxygen to be given after a prolonged seizure. The person needed oxygen to help them recover from status epilepticus, which is a single seizure lasting more than five minutes or two or more seizures within a five-minute period without the person recovering between them. This person had two different Medicines Administration Records (MAR) charts that had different rates for giving oxygen recorded. One dated from August 2020 recorded a rate that was three times lower than a MAR chart from June 2020. The person was given oxygen at this lower rate on 2 two occasions in August 2020 following prolonged seizures. A registered nurse told us that the lower rate of two litres per minute that had been given was the correct rate. However, the registered manager confirmed the rate of oxygen administration in August was incorrect on the MAR chart, and the person had not received enough oxygen following prolonged seizures. This left the person at risk of possible harm.

● Other concerns were identified with poor and inconsistent care planning for oxygen. One person had different 'sats' levels identified in their care plans at which they needed their oxygen to be given. In medicine 'sats' refers to the level of oxygen in the bloodstream. Their seizure management protocol failed to state whether the person needed to take oxygen with them in the community, and did not explain and reduce the risk of depressed breathing if a particular rescue medicine was administered. This left the person at risk of not receiving the care they needed with their seizures.

● People with epilepsy had risks that were not being managed safely. 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. However, their seizure management protocol did not specify how staff were to safely administer the person's medicine whilst they were in their wheelchair.

● We spoke with a registered nurse about how they safely supported the person with this medicine, taking in to account their wheelchair and health diagnosis. The nurse told us, "Two staff lift [name] into bed if they aren't in bed so we can give [medicine] there. I'm not sure of the exact guidelines but I think the staff are aware of what to do. It must be two staff to lift them, we cannot use the hoist." However, the person's guidelines stated that three to four staff were required to safely support them to transfer if they had a seizure.

● A second person was diagnosed with epilepsy and had an epilepsy care plan. Their care plans did not consider a succession of seizures where there may be several shorter seizures in quick succession. A series of seizures can place people at risk of failing to fully recover between seizures. If seizures cannot be stopped or if repeated seizures occur one after another, permanent injury or death can occur. People with epilepsy can also die from problems that occur during or after a seizure, such as inhaling vomit. The person had experienced three seizures on the same day, on two occasions in August 2020. The lack of assessment for a cluster of seizures in succession or on the same day, placed the person at risk of not receiving care they may

need.

● A third person had epilepsy and their epilepsy care plan highlighted that they may experience absence seizures as well as tonic clonic seizures. Their care plan failed to state whether the person had cluster seizures or what action should be taken if this occurred. We spoke with a registered nurse about what support the person would need if they experienced cluster or absence seizures. The registered nurse told us, "If [name] had two or three absence seizures in five minutes I would give it [rescue medicine]." However, the person's MAR chart, epilepsy care plan, and seizure protocol all failed to direct staff on when to administer the rescue medicine for cluster or absence seizures. This meant staff may be taking different action depending on who is on shift, as there was no written guidance. This placed the person at risk of inconsistent or unsafe care with their epilepsy.

● The registered provider had introduced the National Early Warning Score (NEWS), across their registered locations, since November 2017, including at Beechcroft Care Centre. NEWS 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 service user's health deteriorates further. The NEWS tool was not being used consistently at Beechcroft Care Centre for some service users.

● One person should have a NEWS chart completed following a seizure. However, there was no NEWS chart completed following a seizure in February 2020. We found similar concerns for another person around the frequency of observations made following a seizure not being followed. For example, in August 2020 the person had a seven-minute seizure. A NEWS chart had not been completed and recorded hourly for 2 hours, or every four hours for next 24 hours, as instructed in their epilepsy care plan. This left people at risk of not receiving the care and support they needed post seizure.

● Another person was assessed as needing a NEWS chart completed after every seizure. The persons NEWS charts had been completed running consecutively in date order, e.g. 1 August, 2 August etc. We found six days where seizures had not been recorded on the person's NEWS charts. Following our inspection, we were sent individual NEWS charts for the missing days and were told they had been found 'in archive'. By recording NEWS observations on different sheets and keeping them separate from the main records there was a risk that nurses would not be able to track the person's deteriorating health.

● People with a learning difficulty can be at risk of bowel problems such as constipation. Some people living at Beechcroft Care Centre were diagnosed with constipation. If untreated, constipation can lead to serious health problems. People's PRN medicines to relieve constipation were not always given as instructed. One person had been prescribed two different 'as required' medicines to relieve their constipation. Their PRN protocols were inconsistent and did not describe which medicine should be used first, or if there should be a period between doses, or whether both medicines could be given at the same time.

● The person's elimination care plan did state that one should be given first, and the second medicine should only be given when the first had not been effective. However, the person's continence chart for August 2020 showed they had received the second 'as required' medicine first and this had been given late to the person. We asked a registered nurse, why this had happened, and we were told that they did not know, but could see it was not appropriate. The delay in administering the PRN medicines placed the person at risk from the complications of constipation.

● A second person had been diagnosed with constipation and their MAR charts between 14 July 2020 and 9 August 2020 showed that staff had administered a suppository every other day. The person's suppository was prescribed to be given 'as required' if the person hadn't opened their bowels for 48 hours. However, the person's bowel chart for this period showed records were not consistent and there had been an occasion when they had been administered their PRN medicine significantly sooner than required. The PRN medicine was to be given 48 hours after a bowel movement, but the person received it 7 hours after opening their bowels. This meant the person had not received their medicines as prescribed for constipation care.

● We found other concerns with the management of people's medicines. We identified significant concerns with the safe storage and monitoring of medicines. Medicines stock checks were not robust. There was a running count on some MAR charts, but other MAR charts did not have this running total. This meant staff would not be aware of the stock levels of some medicines. This would leave service users at risk of not having sufficient levels of their medicines.
● We checked one person's medicines and found that one prescribed medicine had been counted incorrectly. There were eight tablets in the box, but the stock level was recorded as nine. A registered nurse later told us that one tablet had been accidentally 'popped out' of the blister pack in the box, and not administered to the person, but had not been counted as accidentally 'used'. The medicine had not been entered in the returns book or re-ordered. Poor stock control of medicines put service users at risk of not having their prescribed medicines when they need them.
● We found very poor stock control of another person's medicines. We checked the drugs received book for this person and the most recent booked in drugs included 270 anti-epileptic tablets, with another 30 booked a few days later. The person's MAR chart for this time only showed a balance of 116 tablets. We were told by a registered nurse that there were at least eight more boxes of this medicine, with further stock in the drugs trolley. There was no way of confirming the number of drugs in stock for this person from their MAR chart or from the drugs received book. There was a significant overstock, and no reliable way to track how many tablets there were. This meant nurses could not account for how many of these tablets were in stock and where they were.
● There was no effective oversight of the medicine ordering process. A weekly audit for MAR charts had been happening regularly. We checked these audits for June, July and August 2020 and found none of the audits had identified any issues with stock control. The poor management of stock procedures meant there was no reliable way of knowing what medicines people had and where they were kept. This was not a safe way of managing medicines.
● Controlled drug books had been used as 'in and out' books to record when controlled drugs were signed out of the service, e.g. for community visits. This made the process of auditing controlled drugs difficult, as there were times when people who had gone out appeared to have no stock of medicines. The registered provider's medicines policy set out how controlled drug record and stock checks should be managed, and the practice we found during inspection was not compliant with this policy. Following this policy would mean that any discrepancy in controlled drug stock could be identified earlier.
● Lessons were not being effectively learned. The registered manager told us that 'lesson learned' paperwork had been sent from the provider's head office. The registered manager had been informed about things that had been found during other inspections, such as postural care. These were discussed at handovers with staff to see if action was required in the service. However, we found concerns such as with pausing people's feeds, constipation care, and epilepsy care that had been identified at previous inspections of Beechcroft Care Centre or other of the provider's locations. The failure to learn lessons left people at risk of receiving unsafe care.
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.

● Following our inspection we were shown examples of stock checks that had been put in place. We were also sent copies of documents evidencing that 30 minute pauses of PEG feeds were now in place

Systems and processes to safeguard people from the risk of abuse
● At the last inspection in December 2019 we found a continued breach of regulation 13 relating to safeguarding people from abuse and neglect. At this inspection we found that not enough action had been taken and the breach remained.

● People had not received care and treatment in line with their assessed needs. For example, people had not received their constipation medicine when they needed it. One person had not received their oxygen at sufficient levels when experiencing a prolonged seizure on two occasions. These examples of possible neglect had not been identified by the provider or the registered manager.
● Systems in place for staff and management to report, review and investigate safety and safeguarding incidents were not always effective. People had been placed at risk of harm due to staff neglecting to provide their constipation, epilepsy and feeding tube care needs.
● The failure to implement systems that effectively prevent abuse is a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Staffing and recruitment
● At the last inspection in December 2019 we made a recommendation that the provider reviewed staffing rotas to ensure people access their assessed activities. At this inspection we found action had been taken.
● The registered manager was using a dependency tool as a guide to show what hours were needed to meet peoples care needs. Staffing level were better with one of the three lodges (Chestnut Lodge) closed temporarily. There was a rota that reflected hours worked and during our inspection we found that there were enough staff to keep people safe. The registered manager explained that the provider had made positions available for a trained nurse from abroad, and support staff roles.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections. Covid-19 had been managed safely and people and staff had been protected.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

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

Inadequate

Is the service well-led?

Our findings

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

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

Continuous learning and improving care

● At our last three inspections we found a breach of regulation 17 relating to risk management, oversight of the service, staff culture, a lack of effective quality audits and leadership. At this inspection we did not review all the key questions, but we found insufficient action had been taken to assess, monitor and mitigate risk and the breach had not been met. We will review all areas during our next planned comprehensive inspection.

● We found that quality audits had not been effective in highlighting shortfalls in the service. For example, we found issues relating to risks around choking, medicines, constipation, epilepsy, use of NEWS charts to monitor people's health, reflux, oxygen administration and PEG care.

● We spoke to the registered manager about concerns regarding oxygen administration for one person and failing to pause feeds for service users with feeding tubes. The registered manager told us that they were only recently aware of the need to pause feeds following an inspection at another service run by the registered provider, where this was raised as a concern. However, the concerns with pausing PEG feeds was discussed with the deputy manager at our inspection in December 2019.

● The registered manager told us that for the oxygen issues we found, this should have been identified through a monthly audit and they had addressed this in a staff meeting. Providers who are registered to provide care for vulnerable adults with complex needs are expected to know how to safely care for these service users; understand the risks of not following care plans, and are responsible for ensuring that safe care and treatment is provided and have oversight and governance processes that are sufficiently robust to pick up when improvements and changes are necessary. This has not been demonstrated at Beechcroft Care Centre for four inspections.

● Shortfalls that we identified at this inspection, such as, meeting risks around medicines management, PEG care, reflux, constipation and choking had not been identified or corrected by actions in response to quality audit findings. The SIP (Service Improvement Plan) had outstanding actions but these mostly focused on environmental issues. In addition, actions were marked as completed on the SIP such as, 'Medication audits to be more robust to ensure they are effective in identifying issues i.e. PRN discrepancies'. However, we found issues with medicines management that had not been highlighted by the medicine audits. The SIP contained a completed action point for, '[Names] peg feed regime rate inconsistent in hospital passport/care plan.' This care plan had been reviewed as part of the audit, but the issues we found at our most recent inspection, around pausing PEG feeds and discussed with a member of the management team during our December 2019 inspection, had not been highlighted or put right.

● An external audit had been completed by externally appointed consultants in July 2020 and given an

overall rating of Inadequate. The audit stated, "Risk assessments and support plans were not always detailed, not always reflecting people's current needs and not always consistent." The audit highlighted an example of specific directions regarding a person holding their breath while eating and this information not being carried through to all relevant risk assessments and care plans, thereby exposing the person to high risk. However, during our inspection we found the same issue persisted with one person having reference to this in their choking risk assessment but not in their other care plans. Similarly, we found risk assessments were not detailed nor reflected people's current need. The audit also highlighted lessons were not learned robustly and highlighted issues with checking MAR charts. We found significant concerns with medicines management at our inspection. The audit was written two months before our inspection and improvements had not been made.

● People's needs were not known, care plans were inaccurate, and systems of oversight were ineffective. This had an impact on the safety and the quality of care people received. Action taken by the registered 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, these actions had not been embedded and sustained and we found areas where the quality of care had deteriorated since that time.

● During our inspection on 24 and 25 January 2018 we found five Health and Social Care Act regulations were breached, including breaches of Regulations 12 for Safe care and treatment and 17 for good governance. These regulations have remained in breach since. Service users were at risk from issues identified at other locations run by the provider, that were highlighted by CQC more than 24 months ago. The governance framework had not managed risk safely as serious concerns identified at the provider's other locations, such as epilepsy management, constipation, safe medicines practice and choking and reflux issues, were identified at this inspection.

● Concerns about risks associated with constipation, epilepsy, feeding tube management, effective use of NEWS, reflux, and safe use of medicines have all been repeatedly highlighted to you at your other services. This information had not been properly shared or used to improve safety and quality at Beechcroft Care Centre.

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

● At our last inspection we found there had been some improvement around staff culture. However, we received some information, including from whistle blowers, that indicated a closed culture. A closed culture is a poor culture in a health or care service that increases the risk of harm. The registered provider had engaged a nationally recognised specialist to review their learning disability provision and will be working with this organisation to improve the culture in their services. Staff wore uniforms and name badges to show they were caring for people. There were signs outside the service on the main road to state the location was a care home.

● Some health outcomes for some people were at risk as assessed treatments were not being consistently provided. The overall culture in the service was not in line with current best practice. The service was not safe, outcomes for people were not good, and the provider's oversight of the service was inadequate.

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

● Despite seeing some marginal improvements in some areas, such as with the use of fluid charts, continued concerns remained that had been raised at previous inspections.

● There was a registered manager in post. The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

● At our last three inspections the registered manager and provider had told about action they had been

taken to put things right. We found this had not happened or been sustained. At this inspection not enough action had been taken to make improvements. The registered manager and the registered provider have 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.

Working in partnership with others

● There were a range of professionals and services involved with peoples care at Beechcroft Care Centre. The registered manager told us that they were working more closely with external professionals, such as pharmacist, GP, Speech and language, dietician, and hospitals. However, some professionals shared concerns with us about how information was not followed up or known to staff. For example, one person had some recommendations made in 2018 related to speech and language support. These had not been followed up and the staff did not understand the information. For two other people the professional was working with, staff did not know about communication books that had been in place when the people had moved to Beechcroft Care Centre and there was no record of communication books being used.

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

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong. Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The registered manager and provider had submitted statutory notifications to CQC for one safeguarding incident and one expected death. Following our inspection, we also received a notification for the incident where a person received oxygen at a lower rate than needed following prolonged seizures. The registered manager told us, "An incident form is done, and we send it to the quality department, their feedback is received, and we have a file with incidents and safeguarding on paper as well as online." Relatives confirmed they were contacted by staff if and when anything happened. One relative told us, "If our son becomes unwell, they must inform me straight away, as we know his needs and they do call."

● We spoke with the registered manager about whether there were clear and transparent processes for staff to account for their actions, and performance. The registered manager told us that staff had training and could ask for additional courses; we were told about one staff who was being given support in gaining experience and training around catheterisation.

● People's views and experiences were being gathered to shape the service provided. The registered manager told us, "We send [questionnaires] to relatives and give to people we support a questionnaire and they choose who to fill it in with. One person told us about relatives visiting and wanted at different times and I reassured person, rang their relative and arranged for different visits."

● One relative told us, "Generally they ring, have conversations around what was happening, emails are sent out and I found those useful; communication has generally been good. I know the management; never had any problems in reaching them and they do listen to me."

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 Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had failed to implement systems that effectively prevent abuse